THE UNIVERSITY OF
MELBOURNE

Independent evaluation of the Head to Health Digital Mental Health Gateway

Progress report and preliminary findings

Bridget Bassilios, Leo Roberts, Katrina Scurrah, Michelle Banfield, Andrew Tan, Maria Ftanou, Anna Machlin, Shaminka Mangelsdorf, Long Le, Matthew Spittal, Cathy Mihalopoulos, Jane Pirkis

24 December 2021

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Executive summary

Background

In October 2017, the Australian Government launched the Head to Health National Mental Health Gateway (www.headtohealth.gov.au) to improve access to, and navigation of, digital mental health services. It provides a directory of 693 government-funded clinically effective Australian digital mental health resources, including apps, online programs, online forums, phone services and digital information resources.[1]

The objectives of Head to Health are to:

- give Australians the tools and information they need to understand when everyday distress requires additional support and to successfully navigate the mental health system and make informed choices about their care;
- improve access by bringing together, streamlining, and providing access to evidence-based information, advice, and digital mental health treatments through a centralised portal;
- provide people needing additional support a range of options, including practical tips and advice on how to connect with support;
- make it easy to access a range of clinically effective Australian digital mental health services that are often free or low cost, accessible from anywhere/anytime, and offer an effective alternative or complement to face to face services; and
- foster a sense of trust and confidence in using digital services listed on Head to Health by ensuring they meet an agreed minimum quality standard.

Head to Health replaced mindhealthconnect, an e-Mental health web portal that provided access to trusted online mental health resources and programs.[2] mindhealthconnect was operational from July 2012 to 13 November 2017; and managed by Healthdirect Australia, on behalf of the Australian Government.[2]

In response to recommendations of the 2020 Productivity Commission Mental Health Inquiry Report,[3] the Australian Government is in the process of transforming Head to Health into a new national mental health platform. This transformation aims to develop Head to Health into a comprehensive national mental health platform that will provide Australians with greater choice in accessing the treatment and services they need, and more seamless connections across the broader health and mental health system.

Evaluation aims

The Centre for Mental Health at the University of Melbourne has been commissioned by the Department of Health to undertake the independent evaluation of the Head to Health website's appropriateness, effectiveness, and efficiency. The purpose of the evaluation is to inform the development of the national mental health platform and the Australian Government's consideration of digital mental health services and infrastructure.

The evaluation is guided by the six key evaluation questions (KEQs) including:

- **KEQ 1:** How effective has Head to Health been to date and what can we learn from it?
- **KEQ 2:** Who are the current users of the Head to Health website?
- **KEQ 3:** What are the experiences of users of the website?
- **KEQ 4:** What are the needs of current users of the website? Are these being met? What needs should be met by the planned national mental health platform?
- **KEQ 5:** How effective is Head to Health in achieving its objectives?
- **KEQ6:** How efficiently and effectively has Australian Government funding for Head to Health been used?

Data sources

We are using a mixed-methods evaluation approach, involving collecting and analysing data from a range of primary and secondary quantitative and qualitative data sources, which are briefly described below.

Existing data

We will utilise existing data provided to us by the Department of Health, Liquid Interactive (the Head to Health website developer) and three key Australian digital mental health services (DMHS) providers (Mental Health Online, MindSpot and THIS WAY UP) including:

- Head to Health google analytics and user feedback data;
- DMHS website analytics data;
- Financial data, including development and maintenance costs; and
- Data from a previous Head to Health survey of 258 users, conducted by the Department of Health in 2019.

Consultations with key stakeholders

We will conduct consultations with a broad range of stakeholders who are familiar with Head to Health, including:

- Users of the Head to Health website with lived experience of mental health problems via survey (and optional interview)
- Health professional users of the Head to Health website via survey (and optional interview)
- Other key stakeholders via survey (or interview), e.g., Head to Health (and the new national mental health platform) website developers, management staff from the DMHSs, funders, partners, and others in the mental health sector (e.g., representatives from relevant health professions and peak bodies for people with lived experience).
- Additional people with lived experience via three community conversations using a modified World Café method.[4]
- Additional health professionals (with or without experience using Head to Health) such as GPs and mental health professionals (e.g., psychologists, mental health nurses, psychiatrists, social workers, occupational therapists) via survey through professional associations.

Interim findings

Interim findings are based on existing data (provided by the Department of Health, Liquid Interactive and three key Australian DMHSs), including google analytics data, financial data, website visits to DMHSs and secondary survey data. We also present selected preliminary findings from three online community conversations involving 16 people with lived experience.

Findings from these data sources are summarised according to the six KEQs. Note that KEQs are addressed by different combinations of, and not necessarily all, data sources.

KEQ 1: How effective has Head to Health been to date and what can we learn from it?

Data from Head to Health google analytics, website analytics from three key digital mental health services and community conversations with lived experience participants contribute to addressing KEQ 1.

Google analytics data

From October 2017 to October 2021, the mean number of unique users per month was 50,5694, and almost all appeared to be new users (mean = 48,509). The mean number of sessions was 62,357, and the mean number of views per month was 97,235. This suggests that the monthly mean uptake has halved compared with equivalent monthly average data for mindhealthconnect from February to June 2017 (e.g., 103,136 unique users; 185,140 page views).[2] Although uptake figures were higher during campaign periods (e.g., 84,620 unique users; 151,162 page views), these were still below the mindhealthconnect equivalent monthly averages from February to June 2017.[2]

However, the Head to Health average monthly bounce rate over its life is much better than that of mindhealthconnect from February to June 2015 (25% cf 75%),[2] which means proportionally less sessions involved users not interacting with the website before leaving.

Furthermore, despite the lower than expected monthly average uptake, the trend from October 2017 to October 2021 has been for the overall uptake of Head to Health to increase over time.

A range of devices are being used to access Head to Health. In 2021, 49% of sessions were accessed via desktop, 47% via mobile and 4% tablet devices. Search engine results are the main source of traffic to Head to Health, and most referrals come via Facebook.

Website analytics from digital mental health services

In a 3.75 year period (October 2017 to June 2021), Head to Health referred almost double the number of visitors to three digital mental health services websites as mindhealthconnect in a 3.25 year period (July 2014 to September 2017; 69,595 cf 36,455). However, because the overall number of visitors to the websites of these services more than tripled, proportionally there were fewer referrals from Head to Health than from mindhealthconnect (1% cf 2%). These findings suggest that although more people have continued to become aware of Head to Health over time, people are also increasingly becoming aware of digital mental health services through pathways other than through Head to Health.

Community conversations

Lived experience community conversation participants described the site as a broad and credible gateway suited to family members or those new to mental health. However, they reported insufficient tailoring for those with complex needs, who frequently miss out in "one-size-fits-all" approaches and may need their own section or site to cover information and programs relevant only to people with severe illness and complex needs.

Lived experience participants also expressed concern that the website does not include specific groups such as Aboriginal and Torres Strait Islander peoples, those who identify as LGBTIQ+ and those from different cultural backgrounds. They viewed the overall language as clinical or pathologising and complex, requiring a level of literacy and digital literacy that may exclude some users, including people from non-English speaking backgrounds or with disabilities.

Some lived experience participants thought the volume of information was overwhelming, but at the same time, they felt that some issues and specific apps were not described well enough. This reduced the site's effectiveness as they struggled to navigate what was needed, and then found the site did not have enough depth to the information on the topics in which they were interested.

KEQ 2: Who are the current users of the Head to Health website?

Data describing the users of Head to Health are not routinely collected. However, secondary data from the Department administered survey provide some insight into the characteristics of survey respondents.

Secondary survey data

Of the 258 respondents who completed the survey, most were female (73%) and of mixed age groups, most commonly 18-50 years (62%) followed by 51-65 years (18%) and under 18 years (17%). Survey respondents represented all states and territories and a range of hard-to-reach minority subpopulations. Survey respondents most commonly heard about Head to Health through an internet search or a friend/co-worker/family member.

Interestingly, of the 16 lived experience participants we recruited for the community conversations, 44% had heard of Head to Health, and 25% had used it.

KEQ 3: What are the experiences of users of the website?

Data from Head to Health google analytics, the Department survey and community conversations with lived experience participants address KEQ 3.

Google analytics data

Google analytics data provide insights into how users engage with the Head to Health website.

On average, only 1-2 pages are viewed per session, and the average session duration is 2.5 minutes. Overall, engagement with Head to Health has declined over time, irrespective of campaigns. One in 10 Head to Health sessions results in a conversion (e.g., completing a desired action including search completions, chatbot completions, and emailing or printing resources). The Head to Health conversion rate is somewhat lower than that of mindhealthconnect at 13%,[2] but the absolute number of conversions has increased over time.

A relatively small number of users provide data on whether or not they perceive the pages they use to be helpful. Pages relating to COVID-19 support, Health professionals, Meaningful life, Mental health difficulties, Supporting someone else and Supporting yourself are more often rated as helpful than not (~60-80%).

Secondary survey data

Just under two-thirds of respondents of the Department administered survey reported that the website was easy or very easy to use, most (88%) reported moderate to high trust in the content, and around 60% reported a good or great user experience. Around two-thirds indicated a relatively high likelihood (≥ 7/10) of recommending Head to Health.

Community conversations

Based on demonstration of its functionality during the community conversations, lived experience participants' positive feedback related to experiencing the site as warm, user-friendly and easy to use. They particularly appreciated the comprehensive menu system that allowed drilling down to specific information, the ability to bookmark important parts, and that the site is mobile friendly. They commented that it is "not a typical government website" and were impressed by the comprehensive information presented on a very broad range of issues, including specific disorders and COVID-19.

The negative feedback from lived experience participants related to lack of user friendliness, particularly the nature of the content, its organisation and the overall feel. Some felt that the site was too broad and overwhelming to navigate. Some content, particularly regarding LGBTIQ+ populations, was reported to be outdated, and other areas too focused on self-help and information rather than providing a true gateway to mental health services. The cartoon characters were particularly unpopular and made it feel like the site did not take mental health seriously.

The other major area lived experience participants viewed as a barrier was accessibility. Some expressed concern that Head to Health may systematically exclude some of the most vulnerable, For example, people without reliable technology, people with vision impairment, and people from different cultural backgrounds, including Aboriginal and Torres Strait Islander peoples.

Importantly, some lived experience participants reported that the crisis resources were not easy to find and were too superficial.

KEQ 4: What are the needs of current users of the website? Are these being met? What needs should be met by the planned national mental health platform?

Data from the Department's survey and the community conversations contribute to addressing KEQ 4.

Secondary survey data

The most commonly used features of the Head to Health website according to respondents of the Department administered survey are the topic and content pages and the search resources (58% and 57%, respectively). More than half (61%) of survey respondents reported that the resources were relevant or extremely relevant. This suggests that these are features that are performing relatively well and should be retained in the planned national mental health platform.

Survey respondents suggested that some features could be improved including:

- providing more information/content/resources (e.g., specific disorders or subpopulations; and information about accessing face-to-face services, particularly based on location; costs and other requirements for entry into suggested services; and including with lived experience views, for example in providing user ratings of services);
- updating outdated information;
- further refining both chatbot and search functionality and to ensure that suggestions are tailored to the individual; and
- website design (e.g., look and feel, and ease of navigation of the website, as well as its speed).

Community conversations

Community conversation participants echoed several of the suggestions made by survey respondents in addition to offering other characteristics of an ideal mental health gateway including:

- a visually appealing site with use of calming colours, and that is less childish-looking;
- comprehensive information (on all mental health issues, not just the most common), organised in a way that is not overwhelming and assists users to find the depth they need;
- the site being accessible to everyone, so easy to read and compatible with screen readers for example;
- removal of medical jargon and complex language, replaced with plain language and recovery-oriented information;
- better information that normalises mental health issues and recovery, and connects to options beyond mainstream mental health approaches, such as peer services;
- input from peers in design and navigation;
- links to physical (real world) services such as mental health professionals, support groups and non-digital tools; and
- addition of live chat or interaction with a real person rather than a robot to help people in distress find what they need.

KEQ 5: How effective is Head to Health in achieving its objectives?

This section lists each of the objectives of Head to Health and indicates whether it has been achieved based on the data sources used to inform the current report. However, we will be better placed to answer how effective Head to Health is in achieving its objectives when we have completed our consultations with consumers, providers, health professionals and other key mental health sector stakeholders.

1. **Give Australians the tools and information they need to understand when everyday distress requires additional support and to successfully navigate the mental health system and make informed choices about their care.**

None of the available data sources provide information about the first part of this objective (i.e., when everyday distress requires additional support). As far as we can tell, Head to Health provides Australians with tools and information to navigate digital mental health services but not necessarily the mental health system in it entirety, which will be a focus of the new national mental health platform. As reported in response to KEQs 1 and 3, community conversation participants and survey respondents indicated that there is a desire for more compresive mental health system options (e.g., face-to-face and peer support services; and services for all mental health problems, minority groups and people with complex needs).

2. **Improve access by bringing together, streamlining, and providing access to evidence-based information, advice, and digital mental health treatments through a centralised portal.**

As mentioned in response to KEQ 1, the trend has been for the overall uptake of Head to Health to increase over time. However, it is not the only source of visits to the websites of key Australian digital mental health services (referring only 1% of visitors).

3. **Provide people needing additional support a range of options, including practical tips and advice on how to connect with support.**

The available data sources did not directly assess this objective. However, as mentioned in response to the first objective, users expressed a desire for a more comprehensive gateway to mental health services, not just digital mental health services and mainstream majority population services.

As reported in response to KEQ 4, survey respondents and community conversation participants also suggested that the range of support options could be improved either by further refining both chatbot and search functionality to ensure that suggestions are individually tailored, or through the addition of complementary live chat or interaction with a real person rather than a chatbot to help people in distress find what they need.

4. **Make it easy to access a range of clinically effective Australian digital mental health services that are often free or low cost, accessible from anywhere/anytime, and offer an effective alternative or complement to face to face services.**

As reported in response to KEQ 3, just under two-thirds of respondents of the Department administered survey reported that the website was easy or very easy to use. The community conversation participants appreciated the comprehensive menu system and the broad content; but also felt that navigating the website was overwhelming and criticised the lack of user-friendliness and content targeting minority groups. However, these findings do not directly inform the ease of accessing services themselves.

5. **Foster a sense of trust and confidence in using digital services listed on Head to Health by ensuring they meet an agreed minimum quality standard.**

As mentioned in response to KEQ 3, 88% of survey respondents reported moderate to high trust in the content of Head to Health. This was corroborated by the lived experience community conversation participants' view that the site was a trustworthy starting point for seeking information and links to professionals for mental health issues.

KEQ 6: How efficiently and effectively has Australian Government funding for Head to Health been used?

KEQ 6 was addressed using Head to Health google analytics data and expenditure reports provided by the Department of Health.

For most outcomes, the cost per unit has decreased over time, with the costs in 2020-21 per visit, unique visitor, new user, and conversion being $2.91, $3.57, $3.74 and $35.57. Based on the current data available to us, there is evidence to suggest efficiency of resource use from the allocated budget. However, further evaluation is necessary to determine the cost-effectiveness of Head to Health.

Interim conclusions

A significant number of people use Head to Health each month, many of whom interact with the website in a meaningful way and go on to access digital mental health services. However, on average users only spend 2.5 minutes per session on the website, suggesting that people either quickly find what they need or are unable to find what they need and leave the website. The latter interpretation is supported by data indicating that only one in 10 people complete a key or desired action. In its current form, although a high proportion of users report high trust in the content, only some users experience Head to health as easy to use, and report a good experience. Stakeholders report mixed views about the design, look and feel of the Head to Health website. Our consultations with lived experience participants indicated that the website is simultaneously overwhelming in its current volume of information, and there are gaps in the information provided. Thus, the challenge for developing the new mental health platform will be to strike a balance between providing comprehensive information for navigating the mental health system (more broadly than digital mental health services) while not overwhelming users. Our planned consultations with consumers, providers, health professionals and other key mental health sector stakeholders may shed further light on who the current users of Head to Health are, whether Head to Health is effective in achieving its objectives, and whether it is cost effective.

Background

A major review (Review) of Australia's mental health programs and services conducted in 2014 by the National Mental Health Commission, highlighted poor integration of existing digital mental health services amongst other findings calling for reform of the mental health system.[5] As part of its response,[6] the Australian Government funded the digital mental health gateway, Head to Health (www.headtohealth.gov.au). Head to Health provides a directory of 693 government-funded clinically effective Australian digital mental health resources, including apps, online programs, online forums, phone services and digital information resources.[1] Launched in October 2017, this gateway website, aims to improve access to, and navigation of, digital mental health services by:

- enabling people and professionals to choose the products and services that can best support a person's mental health and wellbeing;
- connecting people with resources and support, conveniently, safely, and securely; and
- complementing and enhancing, not competing with, existing digital mental health services.

The objectives of Head to Health are to:

- give Australians the tools and information they need to understand when everyday distress requires additional support and to successfully navigate the mental health system and make informed choices about their care;
- improve access by bringing together, streamlining, and providing access to evidence-based information, advice, and digital mental health treatments through a centralised portal;
- provide people needing additional support a range of options, including practical tips and advice on how to connect with support;
- make it easy to access a range of clinically effective Australian digital mental health services that are often free or low cost, accessible from anywhere/anytime, and offer an effective alternative or complement to face to face services; and
- foster a sense of trust and confidence in using digital services listed on Head to Health by ensuring they meet an agreed minimum quality standard.

Head to Health replaced mindhealthconnect, an e-Mental health web portal that provided access to trusted online mental health resources and programs.[2] mindhealthconnect was operational from July 2012 to 13 November 2017; and managed by Healthdirect Australia, on behalf of the Australian Government.[2]

More recently, the 2020 Productivity Commission Mental Health Inquiry Report noted the potential benefits of digital mental health services.[3] It recommended that the Australian Government continue developing and improving Head to Health and using it to inform the development of a new National Mental Health Platform.[3] In response, the Government is transforming Head to Health into a new national mental health platform. This transformation aims to develop Head to Health into a comprehensive national mental health platform that will provide Australians with greater choice in accessing the treatment and services they need, and more seamless connections across the broader health and mental health system.

Transformation of Head to Health is timely in the context of COVID-19 pandemic related lockdowns, restrictions and social distancing, all of which are worsening the population's mental health and increasing demand for mental health services.[7] Evidence based digital mental health services can play a greater role in the mental health system to help meet this demand; and a single national mental health platform has the potential to help improve access to both digital and face-to-face services.

Evaluation aims

The Centre for Mental Health at the University of Melbourne has been commissioned by the Department of Health to undertake the independent evaluation of the Head to Health website's appropriateness, effectiveness, and efficiency. The purpose of the evaluation is to inform the development of the national mental health platform and the Australian Government's consideration of digital mental health services and infrastructure.

The evaluation is guided by the six key evaluation questions (KEQs) and associated sub-questions outlined in the Request for Quote (RFQ) including:

- **KEQ 1:** How effective has Head to Health been to date and what can we learn from it?
- **KEQ 2:** Who are the current users of the Head to Health website?
- **KEQ 3:** What are the experiences of users of the website?
- **KEQ 4:** What are the needs of current users of the website? Are these being met? What needs should be met by the planned national mental health platform?
- **KEQ 5:** How effective is Head to Health in achieving its objectives?
- **KEQ6:** How efficiently and effectively has Australian Government funding for Head to Health been used?

Sub-questions associated with the six KEQs are shown in Appendix 1.

Evaluation method

Our evaluation will be guided by the program logic for Head to Health shown in Table 1.

We are using a mixed-methods approach, involving collecting and analysing data from a range of primary and secondary quantitative and qualitative data sources, which are briefly described below.

Existing data

We will utilise existing data provided to us by the Department of Health, Liquid Interactive (the Head to Health website developer) and three key Australian digital mental health services (DMHS) providers (Mental Health Online, MindSpot and THIS WAY UP) including:

- Head to Health google analytics and user feedback data;
- DMHS website analytics data;
- Financial data, including development and maintenance costs; and
- Data from a previous Head to Health user survey conducted by the Department of Health.

Consultations with key stakeholders

We will conduct consultations with a broad range of stakeholders who are familiar with Head to Health, including:

- Users of the Head to Health website with lived experience of mental health problems via survey (and optional interview)
- Health professional users of the Head to Health website via survey (and optional interview)
- Other key stakeholders via survey (or interview), e.g., Head to Health (and the new national mental health platform) website developers, management staff from the DMHSs, funders, partners, and others in the mental health sector (e.g., representatives from relevant health professions and peak bodies for people with lived experience).
- Additional people with lived experience via three community conversations using a modified World Café method.[4]
- Additional health professionals (with or without experience using Head to Health) such as GPs and mental health professionals (e.g., psychologists, mental health nurses, psychiatrists, social workers, occupational therapists) via survey through professional associations.

Purpose of this report

This report provides an update on our progress to date. Additionally, it provides preliminary findings based on existing data (provided by the Department of Health, Liquid Interactive and three key Australian DMHSs), including google analytics data, financial data, website visits to DMHSs and secondary survey data. We also present selected preliminary findings from online group conversations with people with lived experience.

Table 1. Program logic for Head to Health

Program Objective: To improve access to, and navigation of, digital mental health services						
PROBLEM STATEMENT	**INPUTS**	**OUTPUTS: ACTIVITIES**	**OUTPUTS: PARTICIPATION**	**SHORT-TERM OUTCOMES**	**MEDIUM-TERM OUTCOMES**	**LONG-TERM OUTCOMES**
Almost one in five Australians experiences mental ill-health, and many more experience mental health problems in a given year. Many do not receive the treatment and support they need, which results in preventable distress; disruptions in education, employment and relationships; stigma, and loss of life satisfaction and opportunities.[3]	**Funding** **Management and governance** policies, guidelines, standards **Key stakeholder staff** digital mental health service providers, partners, referrers, gateway website developers **Community and consumer stakeholders** **Technology** **Research and evaluation expertise** **Head to Health - specific resources**	**Head to Health planning and development** **Client (consumer and provider) needs identification** **Stakeholder education and support** e.g., promoting Head to Health/educating potential providers, referrers and consumers	**Head to Health gateway developed and maintained** **Head to Health gateway evaluated**	**Increase in number of appropriate users (referrers, consumers, providers) of Head to Health gateway** **Improved navigation of digital mental health services**	**Improved access to mental health information and digital services** **Head to Health gateway meets consumer needs** **Consumers satisfied with Head to Health gateway**	**Increase in number of consumers using appropriate digital mental health services** **Improved adherence to digital mental health services** **Improved mental health outcomes** **Cost-effective Head to Health gateway website**
Assumptions: Head to Health complements and enhances existing digital mental health services; the community and particularly people with mental ill-health (or problems) and those providing them with mental health care are aware of, will use and engage with, and benefit from Head to Health; Head to Health connects people with resources and support, conveniently, safely, and securely; Head to Health enables people and professionals to choose the products and services that can best support a person's mental health and wellbeing.				**External Factors:** Funding and contracts, other mental health directories and services available to consumers, research and evidence on Head to Health gateway and digital mental health services, COVID-19 related quarantine, restrictions and lockdowns, other disasters or crises.		

Note. Stakeholders include people with lived experience of mental health problems, providers delivering digital and other mental health services, partners, referrers, others in the (mental) health sector, website gateway developers, funders.

Progress to date

Progress is reported in five areas – ethics approval, data collection and analysis, stakeholder engagement, challenges, and next steps.

Ethics approval

Approval for the evaluation was sought from The University of Melbourne's Human Research Ethics Committee (Greater than Low Risk – Science, Technology, Engineering, Mathematics and Medicine [STEMM]; Reference Number: 2021-22702-24169-5).

The application was submitted on 27 August, and approval was obtained on 18 October 2021.

Since then, we have submitted two amendments to:
1) combine consultations with several stakeholder groups (additional people with lived experiences, additional health professionals and other key stakeholders) for the Head to Health evaluation with the complementary evaluation of supported DMHSs; and
2) clarify that identifying information provided in the consent process will be separated from survey/interview responses prior to analysis and extend the user survey period from one week to three months.

The first amendment was submitted on 4 November, approved 10 November, and ratified on 3 December. The second amendment was submitted on 7 December and approved on 10 December 2021, with ratification anticipated at the 28 January 2022 meeting.

Data collection (and analysis)

Existing data

Routinely collected administrative service use data from digital mental health services

We have collected and analysed data from multiple data sources including:

- Head to Health google analytics and user feedback data (provided by Liquid Interactive);
- DMHS website analytics data (provided by Mental Health Online, MindSpot and THIS WAY UP);
- Financial data including development and maintenance costs (provided by the Department of Health);
- Campaign dates and costs (provided by Liquid Interactive and the Department of Health, respectively); and
- Previous Head to Health user survey conducted by the Department of Health (provided by the Department of Health).

Consultations with key stakeholders

Users of the Head to Health website

The survey for consumers and providers who use the Head to Health website went live on the Head to Health website on 8 December 2021. The survey can be accessed on the homepage and via the news and announcements tab.

On 16 December, the Department of Health advertised the survey through their internal newsletter that reached 3,885 staff members. On 17 December, the Department of Health advertised the survey via the Head to Health newsletter to 5,021 subscribers. Throughout December, January and February, the Department of Health will also advertise the survey through their websites and social media (LinkedIn, Facebook, Twitter, and Instagram). On 17 December, eMHPRac sent the survey link and advertisement to 3,000 subscribers via their newsletter.

In January 2022, the Black Dog Institute has agreed to send the survey and link to 9,000 of their newsletter subscribers, and we will also advertise the survey through the University of Melbourne social networks.

As of 21 December 2021, two consumers and two providers have completed the survey.

Other key stakeholders

We have contacted other key stakeholders (51 individuals) within mental health, including Head to Health (and the new national mental health platform) website developers, management staff from the digital mental health services, funders, partners, and others in the mental health sector (e.g., representatives from relevant health professions and peak bodies for people with lived experience).

The list of organisations includes:

- Australian Indigenous Psychologists Association (AIPA)
- BeyondBlue
- Black Dog
- BrookRED
- Butterfly Foundation
- Department of Health/Head to Health
- eMHPrac
- Headspace
- Helping Minds WA
- Lifeline
- Liquid/Speedwell
- Lived Experience Australia
- Mental Health Australia
- Mental Health Carers Australia, VIC
- Mental Health Carers NSW
- Mental Health Families & Friends Tasmania
- Mental Health Online
- Mental Illness Fellowship of Australia (NT)
- Mental Wheels Foundation
- MH@Work
- Mind Australia, Vic
- MindSpot
- National Mental Health Commission
- Orygen Digital
- ReachOut
- SANE
- Selected academics
- Smiling Mind
- Tandem
- THIS WAY UP/CRUfAD/St Vincent's Hospital
- WA Primary Health Alliance

As of 21 December 2021, 12 individuals have consented - 6 have completed the survey, 3 interviews have been scheduled in January 2022, and 3 have started but not completed the survey. An additional 9 people have expressed interest in completing the survey/interview.

Additional people with lived experience

We conducted three community conversations with people with lived experience of mental illness using a modified World Café method.[4] Further details about our methods and findings are reported in the corresponding preliminary findings section of this report.

Additional health professionals

We have contacted the Royal Australian College of GPs (RACGP), Australian Psychological Society (APS), Royal Australian and New Zealand College of Psychiatrists (RANZCP), Australian College of Mental Health Nurses (ACMHN), Australian Association of Social Workers (AASW), and Occupational Therapists Australia (OTA).

The survey was advertised on 8 December 2021 via the ACMHN's newsletter and the AASW's website.

We will communicate with members of the RANZCP (via a newsletter) and RACGP (via email to a special interest group in psychological medicine) in January. We are in discussion with these associations to confirm dates for these communications.

We are discussing with the APS and OTA how to best engage with their members. We have had two phone conversations and sent several emails to the APS, most recently including providing requested documentation (methodology summary, surveys, PLS and consent forms, recruitment material and ethics approval) on 30 November 2021. We followed up the APS with an email on 14 December 2021 and a phone call 21 December 2021 during which they indicated they will revisit our request in the new year. OTA have indicated they are willing to recruit professionals from their membership.

As of 21 December, 2 respondents from the ACMHN membership have completed the survey. We will explore the opportunity to advertise via the professional associations' social media platforms. We will also encourage the professional associations to send out subsequent communications to help bolster response rates.

Stakeholder engagement

We have engaged with stakeholders as described above (Consultations with stakeholders).

Additionally, we are in very regular contact with the Department of Health (by Webex, email and phone) to provide updates, request information, and solve any issues as they arise.

We are in video or email contact with the Head to Health web team (Liquid Interactive) on an as needs basis.

We are in regular email and phone, and occasional video, contact with the three supported DMHSs.

Our evaluation team meets weekly, set goals, reviews progress and milestones and responds quickly to any issues as they arise.

All stakeholders have been responsive and engaged in the evaluation of Head to Health.

Challenges

Stakeholder engagement

Due to unforeseen circumstances at the Department of Health, an advisory group was not set up and a permanent Department of Health contact person was only allocated to the project in month 3 of the 11-month contract. This has led to delays in getting the information needed to progress the project. As of

September 2021, a permanent/consistent Department person was allocated, and this has helped with accessing the information needed to conduct the evaluation.

Engaging with (mental) health professional associations to assist with recruitment of their members has met some hurdles, such as the time of the year and the associations' competing commitments. We have, therefore, been flexible with the means of communicating about survey participation and have discussed engaging with members via newsletters, website noticeboards, social media and direct emails. Although the ACMHN and AASW have been able to commence dissemination of recruitment materials this year, we are being flexible with the timing of advertising the survey and working towards recruiting from other associations in 2022. We have also been persistent in maintaining contact with the professional associations to continue to foster a line of communication that will facilitate our ability to engage with their members.

Similarly, this has proven to be a busy time of year for other key stakeholders (e.g., managers, directors, funders, peak bodies, etc.) so we will send follow up emails and reach out via phone in early 2022. It has also been challenging to ensure the list of organisations is sufficiently broad and targeted. We have reviewed our list of organisations with the Department, as well as the three key services and have revised the list according to their feedback.

Google analytics data

Summary google analytics data in the form of multi-tab excel files and example summary reports were provided by Liquid Interactive. We received these data on 1 October and 3 November 2020, respectively. However, these did not offer us a complete dataset to analyse (some metrics in the excel file had full monthly data, but others did not). There was also a significant challenge for the team to understand the nature and source of the summary data without needing to request and go through the process of examining the raw data. Furthermore, having the complete raw data was highly advantageous in terms of increasing options for various analyses.

We were granted access to the raw data on 12 November 2021. Understanding and processing the raw data took considerable time. However, doing so put us in a better position for examining the data appropriately. We found some minor differences between the raw data and the summary data provided by Liquid Interactive. We sought clarification, which took some additional time. Ultimately, the differences were not of concern.

There were some issues with the user feedback data component of the google analytics data. These data are collected via a survey accessed by clicking a "Feedback" tab on the lower right corner of the website. This survey presents four general questions about the website and three more specific questions about the page that the user is on (e.g., the homepage or a topic page). Specifically, there was some Initial confusion about how to obtain the full feedback dataset. There were further delays in obtaining feedback data due to being provided with a partially incorrect dataset. We sought clarification from Liquid Interactive who explained that their developer had manually retrieved user feedback data from the old site and have since provided us with a new data file. Given the late receipt of the correct user feedback data, in December 2021, these will be analysed and reported on in a subsequent evaluation report.

Next steps

The next steps are to:

- Analyse additional existing data (if needed);
- Collect and analyse data from the following stakeholder groups: users of the Head to Health website (consumers and health professionals), additional health professionals via their professional bodies and additional key stakeholders;
- Synthesise and interpret data from all sources; and

- Draw conclusions about the Head to Health website and make recommendations for the new national mental health platform.

Including this report, we have provided six of nine deliverables to the Department of Health. The remaining deliverables are:

- **Deliverable 7: Part 2 of Phase 1 report.** This report will update the Phase 1 report and be based on additional analysis of existing data (if needed). Subject to survey completion rates at this time, it will also be based on surveys completed by people with lived experience and professionals recruited via the Head to Health website including updating the cost benefit analysis, and recommendations from this report. It will describe the next steps in the evaluation. We will submit this report on 25 February 2022.
- **Deliverable 8: Final Reports.** We will prepare a Final Stakeholder Report containing the outcome of consultations with key stakeholders throughout the evaluation. We will also prepare a Final evaluation report(s) providing conclusions on how well Head to Health has been implemented to date; the appropriateness of its design and the extent to which it meets users' needs; conclusions on Head to Health's effectiveness in achieving its intended outcomes; findings on its value for money; and key learnings and recommendations to inform the national mental health platform's ultimate state. This deliverable will be submitted on 29 July 2022.
- **Deliverable 9: Presentation of findings.** We will verbally present the findings of the evaluation to the Department and other relevant stakeholders in July 2022.

Table 2 shows the remaining milestones and deliverables for the evaluation.

Table 2. Timeline for remaining milestones and deliverables

Milestones	2022						
	J	F	M	A	M	J	J
Evaluation administration activities							
Reporting meetings	■	■	■	■	■	■	■
Tasks							
Data analysis of existing data (if needed)	■	■					
Stakeholder consultations	■	■	■				
Consultations with users of Head to Health (people with lived experience of mental illness and health professionals)	■	■	■				
Consultation with additional health professionals (and additional people with lived experience, if needed)	■	■	■				
Consultation with other key informants (e.g., website developers, digital mental health services)	■	■	■				
Quantitative and qualitative data analysis (including economic evaluation)	■	■	■	■	■		
Data synthesis and interpretation					■	■	
Deliverables and reporting							
Evaluation Phase 1 findings report		■					
Interim report		■					
Final report(s)							■
Presentation of findings							■

There is a risk that recruitment rates for stakeholder consultations over the December/January period will be low, which will mean that we are unable to update findings for the February deliverable. We will manage this risk by closely monitoring recruitment rates and considering means for improving recruitment (e.g., advertising, incentives etc.) together with the Department.

Preliminary findings: Google analytics and service data

Google analytics data

Our approach

We used raw google analytics data from October 2017 to October 2021 provided by Liquid Interactive. Liquid Interactive also provided some summary data (a multi-tab Excel file) and example monthly reports, which were useful to cross-check with the raw data. Summarised monthly data were analysed using STATA v16.1.

The relationships between monthly counts of all uptake measures (users, new users, total sessions, total views, bounce rate) were estimated using Pearson's correlation coefficients. Plots showing the counts for each month over time with trend lines were also produced (details in Appendix 2). These analyses were repeated for four measures of engagement: pages per session, duration, total conversions, and conversion rate.

Our methods are elaborated in Appendix 2.

Findings

Uptake

Head to Health website uptake (usage) data were available for 49 months in total, 16 months during which campaigns were running, and 33 months without campaigns. Campaign dates are listed in Appendix 2.

Table 3 provides the mean and standard deviation (SD) per month for Head to Health uptake measures – overall and for campaign and non-campaign periods. The mean number of unique users per month was 50,5694, and almost all appeared to be new users (mean=48,509). The mean number of sessions was 62,357, and the mean number of views per month was 97,235. In about 25% of sessions, users did not make any recorded interactions on the website before leaving.

Appendix 2 displays plots for each Head to Health uptake measure over time, including trend lines, from October 2017 to October 2021 (Figures A1-A5). These plots show that the numbers of users, new users, total sessions and total views have increased over time, and tended to be higher during campaigns, especially during the two most recent campaigns (which ran in 2020 and until February 2021). The bounce rate varied over time, but the mean did not appear to change (systematically) over time or between campaign and non-campaign periods.

There was very high correlation (> 0.98) between users, new users, total sessions and total views, which was expected.

Table 3. Head to Health monthly uptake overall, and during non-campaign and campaign periods, October 2017 to October 2021

		Overall				Non-campaign		Campaign	
Measure	Description	mean	sd	min	max	mean	sd	mean	sd
Users	An estimate of the number of unique people who have visited the website.	50,694	37,569	14,603	139,783	34,244	16,684	84,620	45,823
New users	A 'new user' is counted when a visitor to the website does not have an existing browser cookie from Head to Health.	48,509	36,445	13,583	134,749	32,453	15,869	81,624	44,455
Total sessions	The number of groups of user interactions (hits) that have occurred within a discrete time frame.	62,357	45,591	18,574	167,628	42,421	20,094	103,474	55,787
Total views	The total number of times pages on the website were viewed (total number of views for each page, summed).	97,235	65,136	33,971	258,851	68,180	24,818	157,162	81,084
Bounce rate	[Bounces] / [Sessions] – the proportion of sessions which bounced (i.e., did not make recorded interactions on the website before leaving)	0.246	0.0595	0.138	0.392	0.244	0.0596	0.250	0.0611

Device use and referral source

Figure 1 shows that there has been a small decline in the use of desktop devices to access Head to Health from 52% in 2017 to 49% in 2021. The use of tablets has also halved from 8% in 2017 to 4% in 2021. Correspondingly, there has been an increase in the use of mobile devices from 40% in 2017 to 47% in 2021.

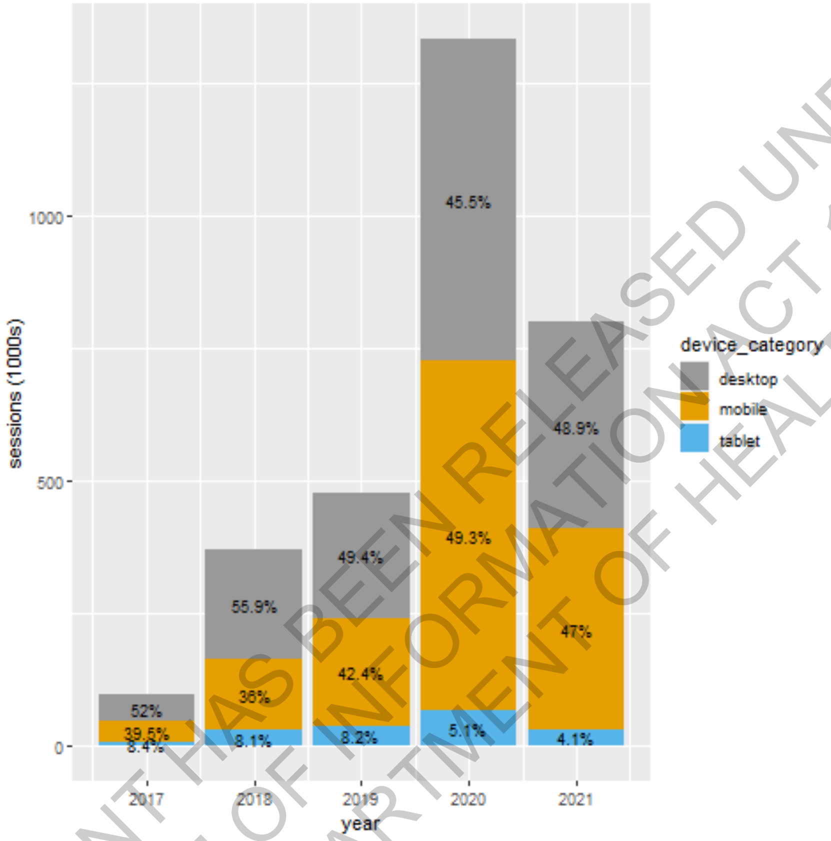

Figure 1. Device types over time

Figure 2 shows the top five traffic sources to Head to Health by year from 2017 to 2021. It shows that organic searches (search engine results that were not paid ads) have accounted for the majority of traffic from 2018 to 2021. As of 2021, this is followed by directly typing the Head to Health URL in the web browser address bar or using a bookmark, and then referrals (from hyperlinks on external websites excluding ads), paid searches, and social media.

Figure 3 displays the top 5 referral sources to Head to Health by year from 2017 to 2021. A referral source refers to a web location that directed a Head to Health visitor to the website. It shows that in all years, the majority of referrals came from Facebook. In 2020, this was followed by referrals from the Department of Health website.

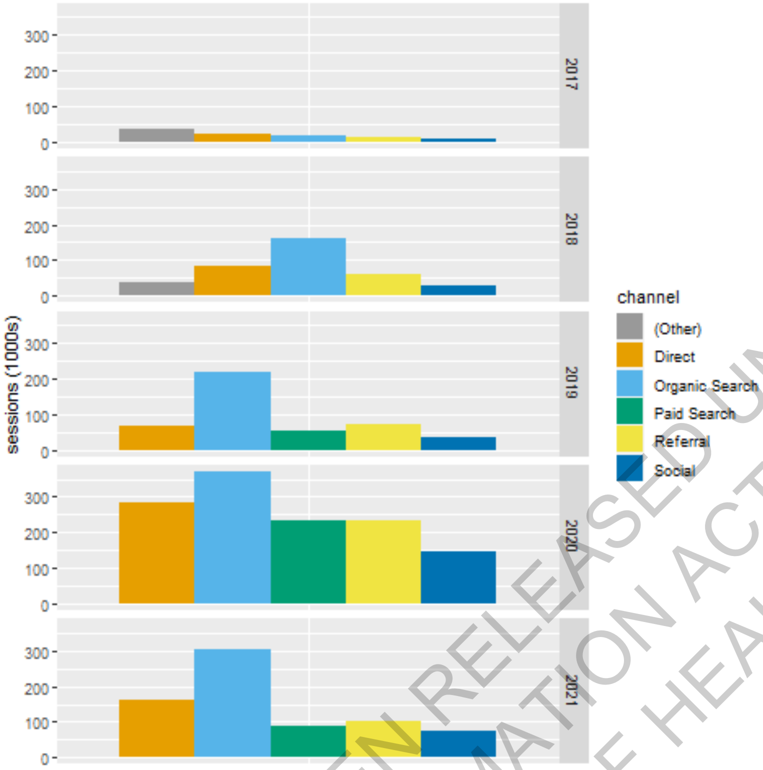

Figure 2. Top five traffic sources over time

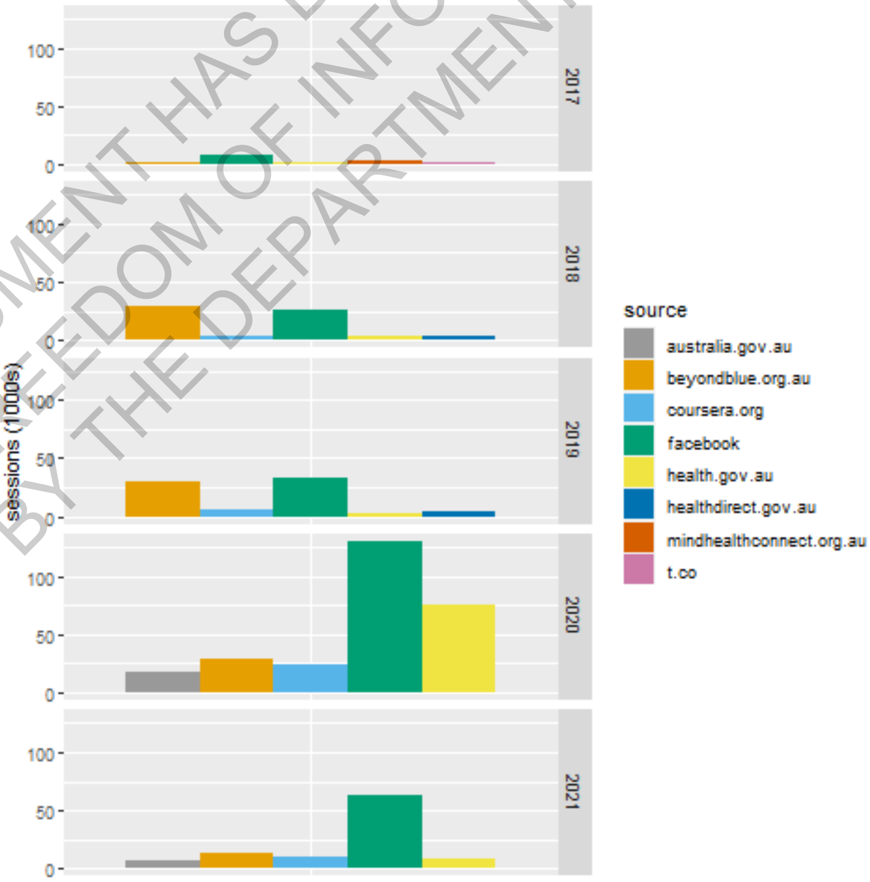

Figure 3. Top five referral sources over time

Engagement

Measures of engagement provide information about how users engage with the Head to Health website. These include the number of pages viewed per session, the average length of time spent on the website per session and the number of conversions. A conversion is the completion of a key or desired action, including search completions, SAM (chatbot) completions, emailing resources, and printing resources. Table 4 displays the Head to Health monthly engagement overall, and during non-campaign and campaign periods, from October 2017 to October 2021.

The overall mean number of pages viewed per session was quite low (1-2). The average time spent on the website per session was about 2.5 minutes. A relatively small number and proportion of sessions included a conversion (~ 10%).

Figures A6 to A9 in Appendix 2 display the monthly engagement with Head to Health, and include trend lines, from October 2017 to October 2021. These figures show that the number of pages per session, duration, and conversion rate have decreased over time, during both campaign and non-campaign periods.

The number of conversions has increased over time (until early 2021), with peaks during the 2020-2021 campaigns, which is overall a very similar trend to those observed for users, new users, total sessions and total views. The total number of conversions was higher in campaign than non-campaign periods.

There was a high negative correlation between number of users and duration (-0.83).

Table 4. Head to Health monthly engagement overall, and during non-campaign and campaign periods, October 2017 to October 2021

		Overall				Non-campaign		Campaign	
Measure	Description	mean	sd	min	max	mean	sd	mean	sd
Pages per session	Average number of pages viewed per session	1.673	0.168	1.430	2.346	1.723	0.163	1.570	0.131
Duration	Average length of time (seconds) spent on the website per session	152.4	31.16	79.25	216.5	166.7	21.44	123.1	27.61
Total conversions	Number of sessions in which key or desired actions are completed	5,609	3,322	1,654	13,912	4,142	955.4	8,635	4,345
Conversion rate	Proportion of sessions which include a conversion	0.103	0.0314	0.0267	0.160	0.110	0.0322	0.0880	0.0242

Note. Each conversion is counted only once per session – i.e. unique count of conversions. Thus, a user who makes 2 "search completions" and 2 "email resources" will be counted as having made two conversions only.

Page helpfulness

Appendix 2 provides details on the source of data on page helpfulness that is the focus of this section.

Figure 4 displays the percentage of webpage ratings that were helpful by webpage topic category over the life of the Head to Health website, excluding any topic categories with <10 responses. The N in the figure below (the denominator) is the number of occasions that the pages under these topic headings were rated for helpfulness (i.e., the number of rating events). The Y axis is the percentage of all ratings that were helpful (i.e., 100 * (helpful ratings/total ratings). It can be seen that the *Meaningful life* topic was the most rated (N = 4844) and, excluding topics with <10 responses, the *For health professionals* topic was the least rated (N = 77) in terms of helpfulness. Each topic was more likely to be rated as helpful than not helpful, with each topic endorsed as helpful in around 60-80% of occasions.

Figure 5 displays the percentage of webpage ratings that were endorsed as helpful by webpage subtopic category over the life of the Head to Health website, excluding any subtopic categories with <10 responses. It shows that the subtopics most frequently (> 75%) rated as helpful were: What helps us thrive (Meaningful life), Chatstarter (COVID-19 support), Find support that works for you (COVID-19 support), Domestic violence (Supporting yourself) and Self-harm (Mental health difficulties). It should, however, be noted that for four of these five subtopics the total number of ratings in either direction was only n ≤ 66; whereas the total number of ratings for What helps us thrive (Meaningful life) was more substantial at 2027. The three subtopic pages least endorsed as helpful (in < 50% of ratings) were Impacts on everyday life (COVID-19 support), COVID-19 support (Mental health difficulties) and Seeking support (Supporting yourself). However, these subtopics were rated on a relatively small number of occasions (n = 19, 76 and 110, respectively).

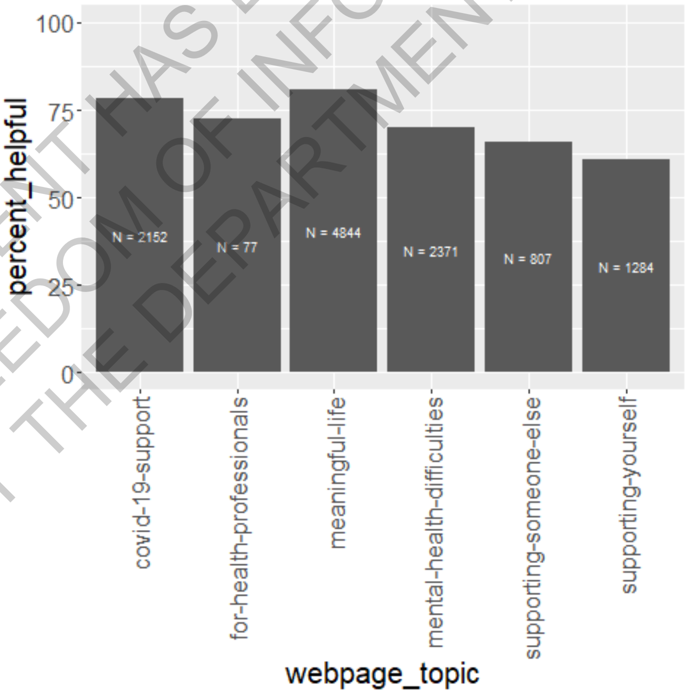

Figure 4. Proportion of webpages endorsed as helpful by topic, October 2017 to October 2021

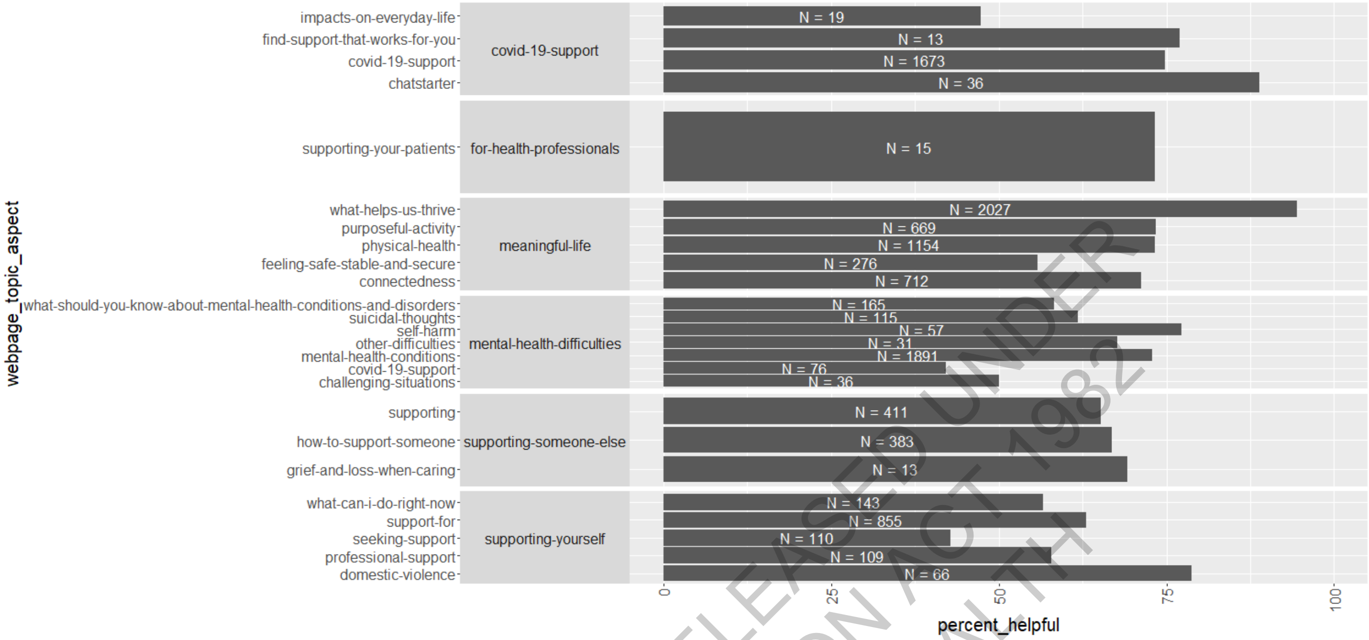

Figure 5. Proportion of webpages endorsed as helpful by subtopic, October 2017 to October 2021

Service data

Our approach

We requested monthly data from July 2014 to June 2021 on total number of unique website visitors and number of unique website visitors via Head to Health (October 2017-June 2021), and its predecessor mindhealthconnect (July 2014-September 2017), from three key Australian digital mental health services (DMHSs)– MindSpot, ThisWayUp and Mental Health Online. Mental Health Online provided data on 'total' and 'new' rather than unique visitors, and we chose to use 'new' users as the equivalent of 'unique' users for our analyses.

We calculated the proportion of website visitors via Head to Health and mindhealthconnect. We also produced plots showing the counts for each month over time and included a trend line to assess both short-term and long-term trends.

Findings

Overall service uptake and referrals from Health to Health

Table 5 provides data on the total number of visitors to each of the three DMHSs from July 2014 to June 2021 and the number of referrals from mindhealthconnect and/or Head to Health. It shows that, in the 3.75 year period (October 2017 to June 2021), Head to Health referred almost double the number of visitors to the websites of three key digital mental health services as mindhealthconnect in a 3.25 year period (July 2014 to September 2017; 69,595 cf 36,455). However, because the overall number of visitors to the websites of these services more than tripled, proportionally, there were fewer referrals from Head to Health than from mindhealthconnect (1% cf 2%).

Proportionally, the impact of mindhealthconnect and Head to Health has been the same for MindSpot (1.2% for both). By comparison, there was a decrease in the percentage of referrals to ThisWayUp and an increase in the percentage of referrals to Mental Health Online from Head to Health compared with mindhealthconnect (3.1% cf 0.5% and 7.0% cf 8.0%, respectively).

Table 5. Total visitors, and referrals from Head to Health/mindhealthconnect, to DMHSs, July 2014 to June 2021

	MindSpot	ThisWayUp	Mental Health Online	Total
Jul 2014-Sept 2017 (3.25 years)				
Total number of visitors	1,021,566	563,619	101,905	1,687,090
Number of referrals from MHC	11,767	17,461	7,227	36,455
Percentage of referrals from MHC	1.15%	3.10%	7.09%	2.16%
Oct 2017-Jun 2021 (3.75 years)				
Total number of visitors	1,787,745	5,343,793	238,572	5,363,235
Number of referrals from H2H	21,620	28,760	19,215	69,595
Percentage of referrals from H2H	1.21%.	0.54%	8.05%	1.30%
Jul 2014-Jun 2021 (7 years)				
Total number of visitors	2,809,311	5,907,412	340,477	8,427,933
Number of referrals from MHC/H2H	33,387	46,221	26,442	100,161
Percentage of referrals from MHC/H2H	1.19%.	0.78%	5.64%	1.19%

H2H, Head to Health; MHC, mindhealthconnect.

Trends over time in monthly service uptake and referrals from Head to Health

Table 6 provides the mean monthly uptake of the three DMHSs and the mean monthly proportions referred via Head to Health/mindhealthconnect.

Like the data on total numbers of visits, the mean monthly proportions show that for:

- MindSpot the mean monthly proportion of referrals from mindhealthconnect and Head to Health were about the same (1.3% cf 1.2%);
- ThisWayUp the mean monthly proportion of referrals from Head to Health was smaller than that attributable to mindhealthconnect (5.1% cf 0.8%);
- Mental Health Online the mean monthly proportion of referrals from Head to Health was somewhat larger than that attributable to mindhealthconnect (8.9% cf 8.4%); and
- All three services combined the mean monthly proportion of referrals from Head to Health was smaller than that attributable to mindhealthconnect (4.9% cf 3.6%).

Figures 6-8 display the monthly proportion of website visitors referred via Head to Health or mindhealthconnect from July 2014 to June 2021, and include a trend line.

For MindSpot, the trend line suggests that the proportion of referrals appeared to increase over the Head to Health time period (from October 2017 until June 2021), with a maximum monthly proportion of 3%. The trend for This Way Up was less clear but the trend line suggests that the proportion of referrals over the Head to Health time period appeared to initially decrease (October 2017 until July 2018), then remain steady for some time (until around November 2020) when there was a sharp increase for 4 months (to 3%), before dropping back to the previous steady proportion of about 1%. For MHO, the trend line suggests that the proportion of referrals appeared to be relatively stable for the initial Head to Health time period (from October 2017 until about April 2021), and then decrease, although there was considerable fluctuation during the entire Head to Health period with minimum monthly proportion of 3% and a maximum of 18%.

Table 6. Mean monthly uptake of digital mental health services, overall and via Head to Health/mindhealthconnect, July 2014 – June 2021.

	MindSpot		ThisWayUp		MHO*		All	
	mean	sd	mean	sd	mean	sd	mean	SD
Jul 2014-Sept 2017 (3.25 years)								
Number of unique website visitors during MHC period	26,194	8,186	14,452	11,971	2,613	853.4	14,420	12,752
Number of unique website visitors referred from MHC	301.7	143.0	447.7	96.43	0	0	249.8	211.7
Proportion of unique website visitors referred from MHC	0.0132	0.00814	0.0507	0.0293	0.0841	0.0694	0.0493	0.0522
Oct 2017-Jun 2021 (3.75 years)								
Number of unique website visitors during H2H period	39,728	8,540	118,751	52,842	5,302	2,179	54,593	56,699
Number of unique website visitors referred from H2H	480.4	262.1	639.1	359.4	427	151.0	515.5	283.9
Proportion of unique website visitors referred from H2H	0.0121	0.00560	0.00756	0.00760	0.0893	0.0330	0.0363	0.0425
Jul 2014-Jun 2021 (7 years)								
Total number of unique visitors	33,444	10,745	70,326	65,453	4,053	2,161	35,941	46,845
Number of unique website visitors referred from MHC/H2H	397.5	232.0	550.3	286.3	314.8	174.2	420.8	253.9
Proportion of unique website visitors referred from MHC/H2H	0.0126	0.00687	0.0276	0.0298	0.0869	0.0528	0.0424	0.0476

H2H, Head to Health; MHC, mindhealthconnect; MHO, Mental Health Online
*Data from MHO are counts of new website visitors (not unique website visitors).

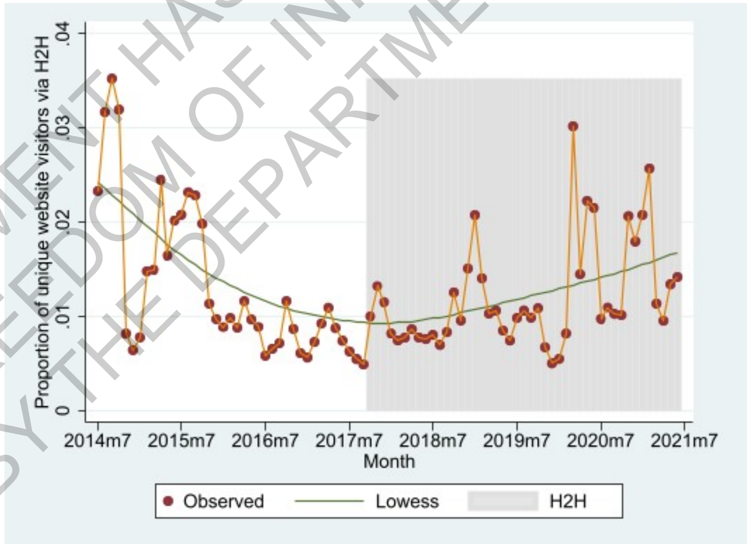

Figure 6. Monthly proportion of MindSpot unique visitors referred from mindhealthconnect or Head to Health, July 2014 to June 2021

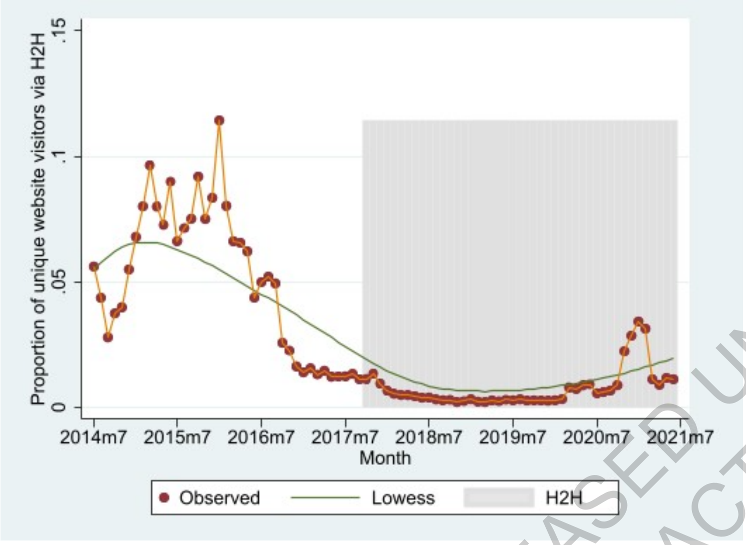

Figure 7. Monthly proportion of ThisWayUp unique visitors referred from mindhealthconnect or Head to Health, July 2014 to June 2021

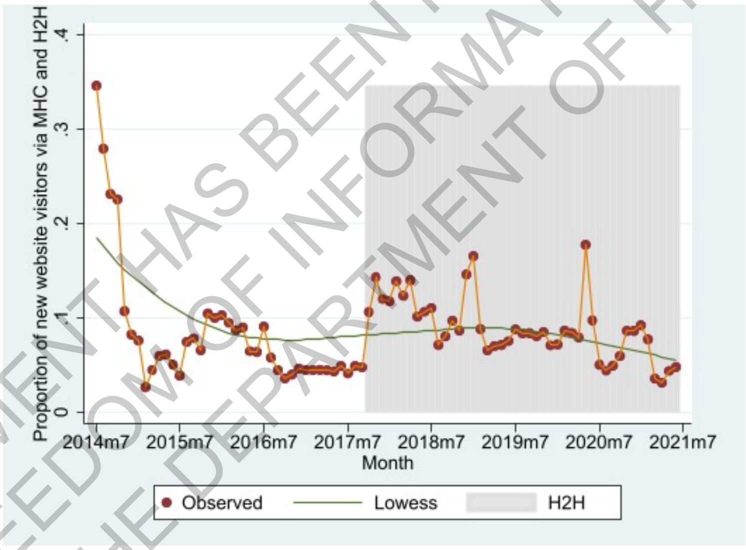

Figure 8. Monthly proportion of Mental Health Online unique (new) visitors referred from mindhealthconnect or Head to Health, July 2014 to June 2021

Preliminary findings: Cost-outcome

Our approach

We examined both the costs and outcomes of Head to Health. The costs associated with delivering Head to Health were based on internal financial and budgeting documents obtained from the Department of Health. These costs were separated into six categories – operations (includes staffing), technology and infrastructure, marketing, governance, capital purchases and COVID-19 enhancements – and aggregated by financial year from 2017-18 to 2020-21. The outcomes used in this cost-outcome description were number of visits to the Head to Health Gateway, unique visitors, conversions, completion rate, search rate and bounce rate. We used monthly data totalled and averaged for each financial year to enable meaningful comparisons between costs and outcomes, including cost per unit of outcome.

Findings

Costs by financial year, 2017-18 to 2020-2021

Table 7 presents the costs associated with Head to Health by financial year. The majority of the costs were related to technology and infrastructure expenditure, primarily from the engagement of an external website delivery partner (Speedwell/Liquid). Operations expenditure, including staffing, was on a general decline from 2017-18 onwards until a significant increase in 2020/21. Expenditure related to enhancing the Head to Health website with COVID-19 materials formed 9-10% of the total costs in the last two financial years. Since its inception, the total costs of delivering Head to Health amounted to approximately $17 million, with the highest annual cost incurred in 2017-18 at $8.2 million.

Outcomes by financial year, 2017-18 to 2020-2021

Table 8 presents selected outcomes from Head to Health by financial year. It should be noted that data were not available for July, August and September in the financial year 2017-18 because Head to Health was not yet operational then. The numbers of visits, unique visitors, new users and conversion have grown over time, with the highest year-on-year growth occurring between 2017-18 and 2018-19, ranging from 80 to 118 percent. On the other hand, the pages sessions, duration and service finder search rate declined from 1.84, 168.60 and 0.06 in 2017-18 to 1.53, 125.65 and 0.04 in 2021-21, respectively. The completion rate improved between 2017-18 and 2018-19 but has declined slightly since then. The bounce rate generally decreased from 2017-18 to 2020-21.

Cost-outcome by financial year, 2017-18 to 2020-2021

The cost per unit for the majority of outcomes decreased between 2017-18 and 2020-21, indicating efficient usage of budget in the delivery of Head to Health. Figure 9 presents the cost per unit of visit, unique visitor, new users and conversion during the study period. In 2017-18, the cost per visit, per unique visitor and per new user were $30.82, $38.07 and $39.91, respectively, while the cost per conversion was $288.70. All three metrics experienced a significant decline by 2020-21, with the cost per visit, per unique visitor and per new user dropping by approximately 90% to $2.91, $3.57 and $3.74, respectively, while the cost per conversion dropped by 88% to $35.57. Based on the current data available to the evaluation team, there is evidence to suggest efficiency of resource use from the allocated budget. However, further evaluation is necessary to determine the cost-effectiveness of Head to Health.

Table 7. Costs of delivering the Head to Health from 2017-18 to 2020-21

Category	2017-18		2018-19		2019-20		2020-21	
	$	%	$	%	$	%	$	%
Technology & Infrastructure	5,205,416	63	1,417,923	43	1,500,000	74	1,900,000	58
Operations	701,139	9	388,783	12	300,000	15	600,000	18
Governance	703,694	9	.	0	.	0	.	0
Marketing	276,691	3	376,710	11	4,000	0	500,000	15
Capital Purchases	1,354,775	16	1,104,901	34	.	0	.	0
COVID-19 Enhancements	.	0	.	0	210,113	10	300,000	9
Total	8,241,715	100	3,288,317	100	2,014,113	100	3,300,000	100

Table 8. Selected outcomes of Head to Health from 2017-18 to 2020-21

Outcomes	2017-18		2018-19		2019-20		2020-21	
	Total	Monthly average	Total	Monthly average	Total	Monthly average	Total	Monthly average
Visits	267,392	29,710	487,371	40,614	888,086	74,007	1,137,632	94,803
Unique visitors	216,515	24,057	391,538	32,628	731,215	60,935	923,188	76,932
New users	206,501	22,945	371,341	30,945	704,171	58,681	883,197	73,600
Conversion	28,548	3,172	62,341	5,195	77,734	6,478	92,763	7,730
Completion rate	.	0.11	.	0.13	.	0.11	.	0.08
Service finder search rate	.	0.06	.	0.05	.	0.04	.	0.04
Bounce rate	.	0.27	.	0.24	.	0.25	.	0.23
Pages sessions	.	1.84	.	1.74	.	1.66	.	1.53
Duration	.	168.60	.	165.43	.	159.26	.	125.65

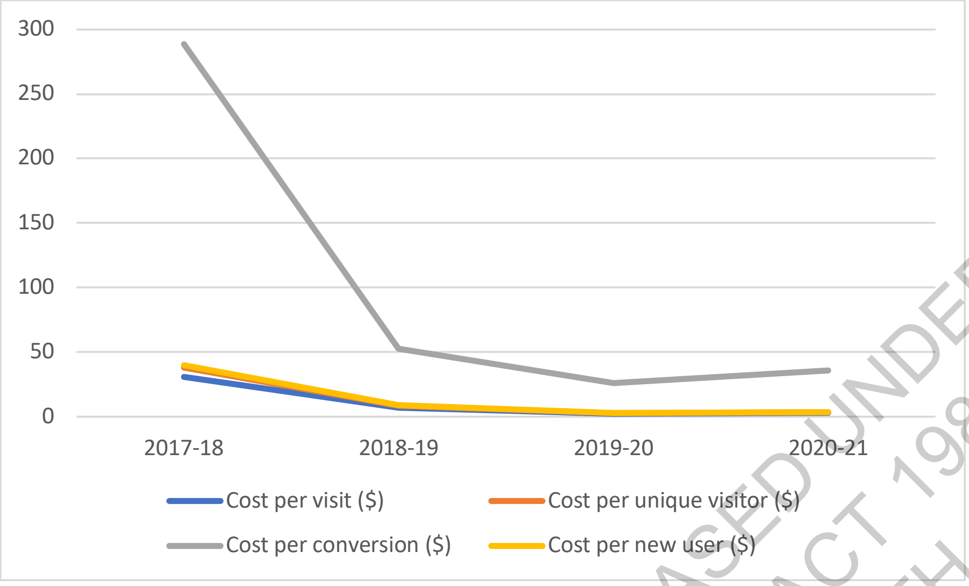

Figure 9. Cost per unit of outcome, 2017-18 to 2020-21

Preliminary findings: Secondary data from user survey

Our approach

We used secondary quantitative and qualitative data from a survey conducted by the Department of Health from 10 July 2019 to 18 November 2019. Visitors to the Head to Health website were invited to participate in an online survey, which included closed and open-ended questions about their demographics, reasons for accessing Head to Health, experience of using Head to Health, and feedback on features, ease of use, relevance and potential improvements of the website. A total of 258 individuals responded to the survey.

Findings

Socio-demographic characteristics of survey respondents

Table 9 shows the demographic characteristics of survey respondents. The majority of respondents were female (73%) and half were aged 35 years or younger. Over one quarter (27%) of respondents resided in NSW and 24 % in Victoria. Close to 20% resided in a rural or remote location. Forty-six percent of respondents had lived experience of mental illness. Twenty percent of respondents identified as LGBTIQ.

Table 9. Characteristics of survey respondents (N = 258)

Characteristic	Frequency	%
Gender		
Female	187	72.5
Male	60	23.3
Prefer not to answer	2	0.8
Self-described	9	3.5
Not answered	0	0
Age range		
Under 18 years	43	16.7
18-35 years	86	33.3
36-50 years	73	28.3
51-65 years	46	17.8
66-79 years	9	3.5
80 years or older	1	0.4
Not answered	0	0
State		
Australian Capital Territory	12	4.7
New South Wales	70	27.1
Northern Territory	3	1.2
Queensland	47	18.2
South Australia	23	8.9
Tasmania	7	2.7
Victoria	61	23.6
Western Australia	32	12.8
Not answered	2	0.8
Population groups identified with[a]		
Aboriginal and Torres Strait Islander	10	3.9
Culturally and linguistically diverse/ main language spoken at home is not English	21	8.1
Living in a rural or remote location	50	19.4
Lesbian, Gay, Bisexual, Transgender, Intersex and Queer people	51	19.8
Person who has personally experienced mental illness (lived experience)	120	46.5
Person with a disability	36	13.9
Person who provides unpaid care/support to family members/friends who have a disability, mental illness, chronic condition, terminal illness, an alcohol or other drug issue or who are frail aged (Carer)	42	16.3
Veteran	5	1.9
Not answered	65	25.2

[a]Multiple responses permitted.

Tables 10 and 11 show how respondents first heard about Head to Health and their reasons for visiting the website, respectively. As shown in Table 10, one third of respondents first heard about Head to Health through an internet search, with 17% hearing about it from a friend, co-worker or family member. Respondents who provided additional information (free text response) and indicated they heard about it elsewhere (n = 60), most commonly indicated they heard about it from their workplace (n = 18), a mental health service (n=10) or their school or educational institution (n = 10). The most commonly cited reason for visiting the website was to find mental health resources for oneself (39%) followed by finding mental health resources for a friend, family member or co-worker; and seeking resources for a client or patient (see Table 11). Of those who indicated they were visiting the website for another reason (n = 64), 20 indicated it was related to their schoolwork, 11 to activities at work and 10 to search for general information.

Table 10. How respondents first heard about Head to Health (N = 258)

Source	Frequency	%
Friend, co-worker or family member	45	17.4
A GP or health professional	20	7.7
Social media	33	12.8
Internet search (e.g., Google)	92	35.7
I don't remember	11	4.3
Other (please specify)[a]	57	22
Not answered	0	0

[a] Sixty respondents provided additional information in the free text space.

Table 11. Reason for visiting Head to Health (N = 258)

Source	Frequency	%
I'm looking to find mental health resources for myself	100	38.8
I'm looking to find mental health resources for a friend, family member or co-worker	40	15.5
I'm a carer looking to find mental health resources for someone I care for	9	3.5
I'm a health professional or GP looking to find mental health resources for my client/patient	40	15.5
I am a service provider listed on Head to Health	6	2.3
Other[a]	63	24.4
Not answered	0	0

[a] Sixty-four respondents provided additional information in the free text space.

Head to Health user experiences

User experiences of Head to Health were assessed in a series of questions concerning ease of use, rating of the experience and likelihood of recommending the website. As shown in Table 12, 62% of respondents indicated that the website was easy or very easy to use, with less than 10% indicating it was very hard. Forty-three respondents provided further details about ease of use, with 22 of these respondents indicating information was limited and 10 respondents reporting other difficulties.

When asked about the extent to which they trusted the information and resources on Head to Health, 59% of respondents indicated a great deal or a lot of trust, 29% indicated a moderate level of trust and 5% indicated not at all trusting the information or resources (Table 13). Thirty individuals provided additional feedback on trust, 10 of whom cited missing information as inhibiting their trust in the site, and nine respondents provided further positive information that promoted their trust in the website.

Sixty percent of respondents rated their experience of using the Head to Health website as good or great, with around two-thirds reporting a relatively high likelihood ($\geq$ 7/10) of recommending the website (see Tables 14 and 15). Thirty-one respondents provided additional feedback on their rating of the website, 15 of whom provided positive feedback, seven reported difficulties using the website, and four suggested updating or including additional information.

Forty participants responded to the question about recommending Head to Health to a client or patient experiencing mental health concerns. Over half of these respondents (52.5%) had not recommended the website.

Table 12. Ease of using Head to Health (N = 258)[a]

Level of ease	Frequency	%
Very easy	63	24.4
Easy	97	37.6
Neither easy or hard	60	23.3
Hard	14	5.4
Very hard	24	9.3
Not answered	0	0

[a]Forty-three respondents provided additional feedback in the free text space.

Table 13. Extent of trust in information and resources on Head to Health (N = 258)[a]

Level of trust	Frequency	%
A great deal	74	28.7
A lot	79	30.6
A moderate amount	75	29.1
A little	17	6.6
Not at all	13	5.0
Not answered	0	0

[a]Thirty respondents provided additional feedback in the free text space.

Table 14. Rating of experience of using Head to Health (N = 258)[a]

Rating	Frequency	%
Terrible	11	4.3
Bad	18	7.0
Okay	75	29.1
Good	93	36.0
Great	61	23.6
Not answered	0	0

[a]Thirty-one respondents provided additional feedback in the free text space.

Table 15. Likelihood to recommend Head to Health (N = 258)

Likelihood	Frequency	%
0 – not at all	16	6.2
1	5	1.9
2	10	3.9
3	6	2.3
4	12	4.6
5	28	10.8
6	12	4.6
7	23	8.9
8	39	15.1
9	25	9.7
10 – Absolutely	82	31.8
Not answered	0	0

Head to Health user needs

The most commonly used features of the Head to Health website were the topic and content pages (58%) and the search resources (57%) (Table 16). Thirty-seven respondents provided additional feedback on features. This feedback most commonly related to limited information provision (n = 17), poor website design (n = 8) and outdated or inappropriate information (n = 6).

Sixty-one percent of respondents found the resources to be extremely relevant or relevant and 8% indicated the resources were not at all relevant (Table 17). Thirty-three respondents provided additional feedback on resource relevance, with 11 respondents indicating missing information, six identifying gaps in certain digital resources and five mentioning barriers to using the recommended resources.

Table 16. Features used on Head to Health (N = 258)[a, b]

Feature	Frequency	%
Sam the Chatbot	51	19.8
Search resources	154	56.7
Save resources	33	12.8
Topic/content pages (e.g., Anxiety disorders, Depressive disorders, Contentedness, Purposeful activity etc.)	150	58.1
Not answered	41	15.9

[a] Multiple responses permitted.

[b] Thirty-seven respondents provided additional feedback in the free text space.

Table 17. Relevance of resources on Head to Health (N = 258)[a]

Relevance	Frequency	%
Extremely relevant	52	20.2
Relevant	106	41.1
Somewhat relevant	50	19.4
Not very relevant	18	7.0
Not at all relevant	21	8.1
Not answered	11	4.3

[a] Thirty-three respondents provided additional feedback in the free text space.

Twelve percent of respondents (n = 30) had recommended a specific digital mental health resource to a patient or client. Twenty-seven respondents provided further details about the services they recommended. Eight respondents had recommended Beyond Blue, six headspace, four SANE, and three each mentioned Head to Health, Lifeline, moodgym, and Beyond Now (multiple responses permitted). When asked if there were any reasons for, or barriers to, recommending digital mental health resources, five respondents provided further details related to a lack of awareness or experience using digital mental health resources.

Respondents were also asked about additional services, topics, features or other improvements they would like to see. Respondents (n = 133) made specific requests for additional content or resources, including information for specific disorders or subpopulations; and information about accessing face-to-face services, particularly based on location. Comments also included the need to improve the look and feel and ease of navigation of the website and its speed. Some respondents reported that the site was adequate as it was. Others expressed that the gateway needs to outline costs and other requirements for entry into suggested services, as well as including the voices of those with lived experience, for example, in providing user ratings of services. Others also commented on needing to further refine both chatbot and search functionality and to ensure that suggestions are tailored to the individual.

Preliminary findings: Community conversations

Our approach

We conducted three online community conversations using a modified World Café method.[4] Each conversation involved 4-8 people who identified as consumers or carers, and was held during November 2021, using Zoom.

These community conversations were combined with discussion of supported online mental health services to reduce participant burden. The conversations focused on four areas:

1) What are the strengths or enablers for use of the Head to Health website?
2) What are the weaknesses or barriers for use of the Head to Health website?
3) How effective is the Head to Health website, particularly for different groups e.g., symptom severity, cultural diversity, socioeconomic background etc.?
4) What are the:
    a. Most important features to create the optimal Head to Health Digital Gateway
    b. Least important features to create the optimal Health to Health Digital Gateway?

Methods and analysis details are provided in Appendix 3.

Findings

Participant characteristics

Table 17 presents the demographic characteristics of the 16 participants in the three community conversations. One participant did not provide any demographic or service use data, and one did not provide their age.

The demographics demonstrate participation by a range of people, representing multiple genders and age groups. Four participants were located in regional areas and none in remote locations, and all but two used the NBN to access the internet. None of the participants identified as Aboriginal or Torres Strait Islander, but during discussions, several identified strongly as Culturally and Linguistically Diverse or reported disabilities.

Participants' familiarity with online mental health services was mixed. Only three reported that they had not used digital mental health services, but half reported that they had not heard of the Head to Health website, and only four of the 16 reported ever using it. Therefore, community conversation facilitators accessed the website and shared their screens with participants to facilitate exploration in real time.

Table 17. Demographic characteristics of community conversation participants (N = 15)[a]

Characteristic	Frequency	%
Gender		
Male	7	46.7
Female	5	33.3
Non-binary	3	20.0
Age[b]		
<20	2	13.3
20-29	5	33.3
30-39	3	20.0
40-49	2	13.3
50-59	1	6.7
60-69	1	6.7
Location		
Major cities	11	73.3
Inner regional	2	13.3
Outer regional	2	13.3
Type of internet		
NBN	13	86.7
Wireless	1	6.7
Mobile	1	6.7
Used digital services		
Yes	12	80.0
No	3	13.3
Heard of Head to Health Digital Gateway		
Yes	7	46.7
No	8	53.3
Used Head to Health Digital Gateway		
Yes	4	26.7
No	11	73.3

[a]An additional participant did not provide any demographic information.
[b]One participant did not provide their age.

Strengths of the Head to Health website

Discussions about the strengths of the Head to Health website focused mainly on user friendliness and the scope of content. Since most participants had never used the site, their experience was limited to demonstration of its functionality during the community conversations, with little time to explore its content and functionality in any depth. Many participants commented that the site has a warm, user-friendly feel and is easy to use. They particularly appreciated the comprehensive menu system that allowed drilling down to specific information, the ability to bookmark important parts, and that the site is mobile friendly. They commented that it is “not a typical government website.” They were impressed by the comprehensive information presented on a very broad range of issues, including specific disorders and COVID-19, and thought that the site was a trustworthy starting point for people seeking information and links to professionals for mental health issues. The full word clouds created in each conversation are contained in Appendix 3.

Weaknesses of the Head to Health website

The weaknesses of the website and barriers to its use tended to mirror the strengths. The largest focus of discussion was on user friendliness, and in particular the nature of the content, its organisation and the overall feel. Although some users had found the breadth and depth of content a strength, others felt that the site was too broad and overwhelming to navigate. Some content, particularly regarding LGBTIQ+ populations was reported to be outdated, and other areas too focused on self-help and information rather than providing a true gateway to mental health services. The cartoon characters were particularly unpopular, described as “Humpty Dumpty people" that infantilised or patronised people with mental health problems and made it feel like the site did not take these issues seriously.

The other major area considered to be a barrier was accessibility. There were concerns about the Head to Health Digital Gateway being the major way of gaining information and referral within the system when there were people without access to technology such as smartphones and the internet. As a gateway, people were uncertain whether the Head to Health website was meant to be a primary point of entry to the entire system, and were thus concerned that it may systematically exclude some of the most vulnerable who did not have reliable technology. Likewise, the accessibility of the design was questioned for people with vision impairment. Finally, the diversity of appeal and accessibility to people from different cultural backgrounds was questioned due to the complexity of the English used, and the limited translations available. The figure holding the tiny Aboriginal and Torres Strait Island flags was commented on as "tokenistic."

One group focussed on the crisis and suicide resources on the site, which is a critical area of any mental health resource. They commented that the crisis resources were not as easy to find as possible and were too superficial. This group also thought that the site would benefit from involving peers in co-designing the platform.

Appendix 3 contains the word clouds for barriers.

Effectiveness of the Head to Health website

In the third session, participants were asked to consider the effectiveness of the Head to Health website, especially for different groups such as those from different cultural backgrounds or with different levels of mental health problem severity. Consistent with the discussions about strengths and weaknesses, the breadth of the site was viewed as a double-edged sword. Participants described the site as a broad and credible gateway that was particularly well-suited to providing general introductory information and may appeal to family members or those new to mental health who were seeking this type of information. However, they observed that there was not sufficient tailoring for those with complex needs, who frequently miss out in "one-size-fits-all" approaches and may need their own section or even site to cover information and programs relevant only to people with severe illness and complex needs. Further, there was concern that specific groups such as Aboriginal and Torres Strait Islander peoples, those who identify as LGBTIQ+ and those from different cultural backgrounds may feel "alienated" by the site due to the relative lack of information specific to these groups.

Some participants thought the volume of information was overwhelming, but at the same time felt that some issues and specific apps were not described well enough. This reduced the site's effectiveness as they struggled to navigate to what was needed, then the site did not have enough depth to the information on the topics in which they were interested. They suggested it would be helpful to add further layers of detail to drill down on all mental health issues, not just the most common, again to reduce the sense of being excluded if not in a majority group. They also suggested it would increase the site's effectiveness and profile as a gateway if the information also included referrals or searchable databases of physical services rather than just digital services, and had a section on peer services.

The other major area of focus was on accessibility. As for the weaknesses, there was concern that the literacy and digital literacy required to use the site may exclude some users. Participants described the overall language as quite clinical or pathologising, with both complex language and an approach to mental health that many with lived experience do not favour. Some also found navigation difficult, and were unsure they were getting the information they needed. Further, there were concerns that people from non-English speaking backgrounds or with disabilities may not be able to effectively interact with the site due to its complex language and setup.

The word clouds containing all the suggestions for effectiveness are included in Appendix 3.

What would an optimal Head to Health website look like?

In the final session, participants were provided with the word clouds produced in the strengths, weaknesses and effectiveness discussions and asked to consider what they thought an optimal Head to Health website would include. They were informed that the site was under redevelopment and encouraged to consider the features that would be useful to include in an ideal world, along with those they would like to see removed.

Interest for the most important features focused primarily on design and navigation. Participants wanted a visually appealing site with use of calming colours, and that is less childish-looking. They wanted information to be comprehensive but organised in a way that is not overwhelming and assists them to find the depth they need. Some suggested that addition of live chat or interaction with a real person rather than a robot would assist with this. They also stated that an ideal site should be accessible to everyone, so easy to read (e.g., compatible with screen readers).

The second major area that was described as most important was the overall focus of the site. Participants described the Head to Health Digital Gateway as an “opportunity to normalise, to reduce stigma and self-stigma, and promote help-finding,” but thought it was largely missing this opportunity by using a deficit-based, medical approach. They wanted to see better information that normalises mental health issues and recovery, and connects to options beyond mainstream mental health approaches, such as peer services.

The final area on the wish list of most important features was links to physical (real world) services such as mental health professionals, support groups and non-digital tools. Participants were unsure of the scope of the digital gateway, but thought that describing it as a “gateway” implied that there was more than just basic digital health links to be found.

Discussion of the least important features was more limited, and focused on the few issues about which participants felt most strongly. They suggested that the medical jargon and complex language needed to be removed, replaced with plain language and recovery-oriented information that deals with topics in sufficient depth. They also wanted the cartoon figures replaced with something less childish and with broader appeal. One group also disliked the chatbot, suggesting that interacting with a robot when in distress was not useful.

The full lists of most and least important features are included in Appendix 3.

Interim summary and conclusions

Summary

This section summarises findings from all the data sources used in this interim report according to the six KEQs. Note that KEQs are addressed by different combinations of, and not necessarily all, data sources.

KEQ 1: How effective has Head to Health been to date and what can we learn from it?

Data from Head to Health google analytics, website analytics from three key digital mental health services and community conversations with lived experience participants contribute to addressing KEQ 1.

Google analytics data

From October 2017 to October 2021, the mean number of unique users per month was 50,5694, and almost all appeared to be new users (mean = 48,509). The mean number of sessions was 62,357, and the mean number of views per month was 97,235. This suggests that the monthly mean uptake has halved compared with equivalent monthly average data for mindhealthconnect from February to June 2017 (e.g., 103,136 unique users; 185,140 page views).[2] Although uptake figures were higher during campaign periods (e.g., 84,620 unique users; 151,162 page views), these were still below the mindhealthconnect equivalent monthly averages from February to June 2017.[2]

However, the Head to Health average monthly bounce rate over its life is much better than that of mindhealthconnect from February to June 2015 (25% cf 75%),[2] which means proportionally less sessions involved users not interacting with the website before leaving.

Furthermore, despite the lower than expected monthly average uptake, the trend from October 2017 to October 2021 has been for the overall uptake of Head to Health to increase over time.

A range of devices are being used to access Head to Health. In 2021, 49% of sessions were accessed via desktop, 47% via mobile and 4% tablet devices. Search engine results are the main source of traffic to Head to Health, and most referrals come via Facebook.

Website analytics from digital mental health services

In a 3.75 year period (October 2017 to June 2021), Head to Health referred almost double the number of visitors to three digital mental health services websites as mindhealthconnect in a 3.25 year period (July 2014 to September 2017; 69,595 cf 36,455). However, because the overall number of visitors to the websites of these services more than tripled, proportionally there were fewer referrals from Head to Health than from mindhealthconnect (1% cf 2%). These findings suggest that although more people have continued to become aware of Head to Health over time, people are also increasingly becoming aware of digital mental health services through pathways other than through Head to Health.

Community conversations

Lived experience community conversation participants described the site as a broad and credible gateway suited to family members or those new to mental health. However, they reported insufficient tailoring for those with complex needs, who frequently miss out in “one-size-fits-all” approaches and may need their own section or site to cover information and programs relevant only to people with severe illness and complex needs.

Lived experience participants also expressed concern that the website does not include specific groups such as Aboriginal and Torres Strait Islander peoples, those who identify as LGBTIQ+ and those from different cultural backgrounds. They viewed the overall language as clinical or pathologising and complex, requiring a level of literacy and digital literacy that may exclude some users, including people from non-English speaking backgrounds or with disabilities.

Some lived experience participants thought the volume of information was overwhelming, but at the same time, they felt that some issues and specific apps were not described well enough. This reduced the site's effectiveness as they struggled to navigate what was needed, and then found the site did not have enough depth to the information on the topics in which they were interested.

KEQ 2: Who are the current users of the Head to Health website?

Data describing the users of Head to Health are not routinely collected. However, secondary data from the Department administered survey provide some insight into the characteristics of survey respondents.

Secondary survey data

Of the 258 respondents who completed the survey, most were female (73%) and of mixed age groups, most commonly 18-50 years (62%) followed by 51-65 years (18%) and under 18 years (17%). Survey respondents represented all states and territories and a range of hard-to-reach minority subpopulations. Survey respondents most commonly heard about Head to Health through an internet search or a friend/co-worker/family member.

Interestingly, of the 16 lived experience participants we recruited for the community conversations, 44% had heard of Head to Health, and 25% had used it.

KEQ 3: What are the experiences of users of the website?

Data from Head to Health google analytics, the Department survey and community conversations with lived experience participants address KEQ 3.

Google analytics data

Google analytics data provide insights into how users engage with the Head to Health website.

On average, only 1-2 pages are viewed per session, and the average session duration is 2.5 minutes. Overall, engagement with Head to Health has declined over time, irrespective of campaigns. One in 10 Head to Health sessions results in a conversion (e.g., completing a desired action including search completions, chatbot completions, and emailing or printing resources). The Head to Health conversion rate is somewhat lower than that of mindhealthconnect at 13%,[2] but the absolute number of conversions has increased over time.

A relatively small number of users provide data on whether or not they perceive the pages they use to be helpful. Pages relating to COVID-19 support, Health professionals, Meaningful life, Mental health difficulties, Supporting someone else and Supporting yourself are more often rated as helpful than not (~60-80%).

Secondary survey data

Just under two-thirds of respondents of the Department administered survey reported that the website was easy or very easy to use, most (88%) reported moderate to high trust in the content, and around 60% reported a good or great user experience. Around two-thirds indicated a relatively high likelihood (≥ 7/10) of recommending Head to Health.

Community conversations

Based on demonstration of its functionality during the community conversations, lived experience participants' positive feedback related to experiencing the site as warm, user-friendly and easy to use. They particularly appreciated the comprehensive menu system that allowed drilling down to specific information, the ability to bookmark important parts, and that the site is mobile friendly. They commented that it is "not a typical government website" and were impressed by the comprehensive information presented on a very broad range of issues, including specific disorders and COVID-19.

The negative feedback from lived experience participants related to lack of user friendliness, particularly the nature of the content, its organisation and the overall feel. Some felt that the site was too broad and overwhelming to navigate. Some content, particularly regarding LGBTIQ+ populations, was reported to be outdated, and other areas too focused on self-help and information rather than providing a true gateway to mental health services. The cartoon characters were particularly unpopular and made it feel like the site did not take mental health seriously.

The other major area lived experience participants viewed as a barrier was accessibility. Some expressed concern that Head to Health may systematically exclude some of the most vulnerable, For example, people without reliable technology, people with vision impairment, and people from different cultural backgrounds, including Aboriginal and Torres Strait Islander peoples.

Importantly, some lived experience participants reported that the crisis resources were not easy to find and were too superficial.

KEQ 4: What are the needs of current users of the website? Are these being met? What needs should be met by the planned national mental health platform?

Data from the Department's survey and the community conversations contribute to addressing KEQ 4.

Secondary survey data

The most commonly used features of the Head to Health website according to respondents of the Department administered survey are the topic and content pages and the search resources (58% and 57%, respectively). More than half (61%) of survey respondents reported that the resources were relevant or extremely relevant. This suggests that these are features that are performing relatively well and should be retained in the planned national mental health platform.

Survey respondents suggested that some features could be improved including:

- providing more information/content/resources (e.g., specific disorders or subpopulations; and information about accessing face-to-face services, particularly based on location; costs and other requirements for entry into suggested services; and including with lived experience views, for example in providing user ratings of services);
- updating outdated information;
- further refining both chatbot and search functionality and to ensure that suggestions are tailored to the individual; and
- website design (e.g., look and feel, and ease of navigation of the website, as well as its speed).

Community conversations

Community conversation participants echoed several of the suggestions made by survey respondents in addition to offering other characteristics of an ideal mental health gateway including:

- a visually appealing site with use of calming colours, and that is less childish-looking;
- comprehensive information (on all mental health issues, not just the most common), organised in a way that is not overwhelming and assists users to find the depth they need;

- the site being accessible to everyone, so easy to read and compatible with screen readers for example;
- removal of medical jargon and complex language, replaced with plain language and recovery-oriented information;
- better information that normalises mental health issues and recovery, and connects to options beyond mainstream mental health approaches, such as peer services;
- input from peers in design and navigation;
- links to physical (real world) services such as mental health professionals, support groups and non-digital tools; and
- addition of live chat or interaction with a real person rather than a robot to help people in distress find what they need.

KEQ 5: How effective is Head to Health in achieving its objectives?

This section lists each of the objectives of Head to Health and indicates whether it has been achieved based on the data sources used to inform the current report. However, we will be better placed to answer how effective Head to Health is in achieving its objectives when we have completed our consultations with consumers, providers, health professionals and other key mental health sector stakeholders.

6. Give Australians the tools and information they need to understand when everyday distress requires additional support and to successfully navigate the mental health system and make informed choices about their care.

None of the available data sources provide information about the first part of this objective (i.e., when everyday distress requires additional support). As far as we can tell, Head to Health provides Australians with tools and information to navigate digital mental health services but not necessarily the mental health system in it entirety, which will be a focus of the new national mental health platform. As reported in response to KEQs 1 and 3, community conversation participants and survey respondents indicated that there is a desire for more comprensive mental health system options (e.g., face-to-face and peer support services; and services for all mental health problems, minority groups and people with complex needs).

7. Improve access by bringing together, streamlining, and providing access to evidence-based information, advice, and digital mental health treatments through a centralised portal.

As mentioned in response to KEQ 1, the trend has been for the overall uptake of Head to Health to increase over time. However, it is not the only source of visits to the websites of key Australian digital mental health services (referring only 1% of visitors).

8. Provide people needing additional support a range of options, including practical tips and advice on how to connect with support.

The available data sources did not directly assess this objective. However, as mentioned in response to the first objective, users expressed a desire for a more comprehensive gateway to mental health services, not just digital mental health services and mainstream majority population services.

As reported in response to KEQ 4, survey respondents and community conversation participants also suggested that the range of support options could be improved either by further refining both chatbot and search functionality to ensure that suggestions are individually tailored, or through the addition of complementary live chat or interaction with a real person rather than a chatbot to help people in distress find what they need.

9. Make it easy to access a range of clinically effective Australian digital mental health services that are often free or low cost, accessible from anywhere/anytime, and offer an effective alternative or complement to face to face services.

As reported in response to KEQ 3, just under two-thirds of respondents of the Department administered survey reported that the website was easy or very easy to use. The community conversation participants appreciated the comprehensive menu system and the broad content; but also felt that navigating the website was overwhelming and criticised the lack of user-friendliness and content targeting minority groups. However, these findings do not directly inform the ease of accessing services themselves.

10. **Foster a sense of trust and confidence in using digital services listed on Head to Health by ensuring they meet an agreed minimum quality standard.**

As mentioned in response to KEQ 3, 88% of survey respondents reported moderate to high trust in the content of Head to Health. This was corroborated by the lived experience community conversation participants' view that the site was a trustworthy starting point for seeking information and links to professionals for mental health issues.

KEQ 6: How efficiently and effectively has Australian Government funding for Head to Health been used?

KEQ 6 was addressed using Head to Health google analytics data and expenditure reports provided by the Department of Health.

For most outcomes, the cost per unit has decreased over time, with the costs in 2020-21 per visit, unique visitor, new user, and conversion being $2.91, $3.57, $3.74 and $35.57. Based on the current data available to us, there is evidence to suggest efficiency of resource use from the allocated budget. However, further evaluation is necessary to determine the cost-effectiveness of Head to Health.

Conclusions

A significant number of people use Head to Health each month, many of whom interact with the website in a meaningful way and go on to access digital mental health services. However, on average users only spend 2.5 minutes per session on the website, suggesting that people either quickly find what they need or are unable to find what they need and leave the website. The latter interpretation is supported by data indicating that only one in 10 people complete a key or desired action. In its current form, although a high proportion of users report high trust in the content, only some users experience Head to health as easy to use, and report a good experience. Stakeholders report mixed views about the design, look and feel of the Head to Health website. Our consultations with lived experience participants indicated that the website is simultaneously overwhelming in its current volume of information, and there are gaps in the information provided. Thus, the challenge for developing the new mental health platform will be to strike a balance between providing comprehensive information for navigating the mental health system (more broadly than digital mental health services) while not overwhelming users. Our planned consultations with consumers, providers, health professionals and other key mental health sector stakeholders may shed further light on who the current users of Head to Health are, whether Head to Health is effective in achieving its objectives, and whether it is cost effective.

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Appendix 1: Evaluation questions

IMPLEMENTATION

KEQ 1: How effective has Head to Health been to date and what can we learn from it?

- What is the overall level of awareness and use of the Head to Health website amongst the population(s)?
- Are the content and resources available on Head to Health fit for purpose, appropriately targeted, and accessible for the target audiences? Including consumers, carers and health professionals?
- Are there gaps or duplication in the content and resources offered on the website?
- Have timely and appropriate updates (content and technology) to Head to Health been delivered?

APPROPRIATENESS

KEQ 2: Who are the current users of the Head to Health website?

- Who are the current users of the website?
- Are there any segments of the population who do not appear to be using the website? How might these needs be met in the future?

KEQ 3: What are the experiences of users of the website?

- How do people currently use website? Are there differences in how different groups of people use the website? Is it easy to navigate and find what users are looking for? Map and describe typical user experiences of the website
- Can consumers be connected in a timely way to the appropriate resources and/or support?
- Map and describe the current services and resources offered or linked through the website, highlighting the most used and least used areas of the website
- How satisfied are users with their experience of the website? Can this be improved?

KEQ 4: What are the needs of current users of the website? Are these being met? What needs should be met by the planned national mental health platform?

- What are the needs of current users' of the website? Consider at a minimum, consumers, carers and health service providers
- Are these needs consistent with the objectives and policy intent of Head to Health?
- Are users current needs being met? What improvements can be made in the short-term? What improvements should be included in the national mental health platform beta site and ultimate state?
- What content or design features of the current website are particularly effective and should be retained in any future state platform?
- What content or design features of the current website are failing to meet user's needs and should be redesigned, categorised into high, medium and low priority?

EFFECTIVENESS

KEQ 5: How effective is Head to Health in achieving its objectives?

- To what extent does Head to Health
- provide users with the tools and information they need to understand when everyday distress requires additional support?
- assist users to successfully navigate the mental health system?
- assist users to make informed choices about their care?
- Refer users to appropriate information, resources, support and treatment according to relevant clinical guidelines?
- Assist health professionals to choose the products and services that can best support a person's mental health and wellbeing

- Are there differences in outcomes for different sub-populations? If so, why?
- To what extent does Head to Health met the needs of hard to reach or high risk populations, including Aboriginal and Torres Strait Islander peoples, men, young people, people with more serious mental illness?
- Has Head to Health provided an effective gateway to digital mental health services for mental health consumers?
- Has Head to Health improved access to evidence-based mental health information, advice, support and treatment services?
- Has Head to Head improved service choice for consumers?
- Has Head to Health made it easier for those who need it to access a range of clinically effective Australian digital mental health services that are free or low cost, accessible from anywhere/anytime, and offer an effective alternative or complement to face to face services?
- Has Head to Health increased access to high quality services?
- What is the level of trust in the information and services provided to consumers on the Head to Health website?
- Has Head to Health led to increased confidence and trust in the services and resources on the website amongst consumers?

EFFICIENCY

KEQ 6: How efficiently and effectively has Australian Government funding for Head to Health be used?

- How cost-effective is Head to Health?
- Are there opportunities to improve the cost-effectiveness of Head to Health?
- What are the implications of free versus low cost versus higher costs to consumers and/or health professionals to access the resources and services provided or linked to on Head to Health?
- Have there been unintended outcomes/consequences from the implementation of Head to Health? If so, explain
- What impact has Head to Health had on adoption of digital mental health in Australia?
- What impact has Head to Health had on mental health information, support and treatment services in Australia?
- What impact has Head to Health had on mental health organisations in Australia?

Appendix 2: Additional methods and analysis for google analytics

Raw data

Raw google analytics data were provided in a series of comma separated variable files (csv). Summarised monthly data were constructed in R and compared against the Excel summary for validation and understanding.

Raw data were in five sets: users' data (1 file), landing page data (8 files), website event data (15 files), page views data (10 files) and goals data (4 files). Using the R programming software, the data was appended by set, yielding five files (one for each data type; e.g., one user file, one landing page file etc.). Each data set had some overlapping and some unique information (some metrics could be obtained from more than one file).

Table A1 shows a concordance between key metrics we analysed and their source file.

Table A1. Concordance between key metrics and source data file

Metric	Source of data
N users	Users file
N new users	Users file
N sessions	Landing file
Bounce rate	Landing file
N page views	Landing fille
Pages per session	Landing file
Mean session duration	Landing file
N conversions	Goals file
Conversion rate	Goals file and Landing file
N SAM, email, print, topic, search, homepage	Goals file

N, number.

Campaign dates

The raw data provided by Liquid Interactive indicated that campaigns were run in:

- 2021: January, February
- 2020: March-June, August, November, December
- 2019: January, February
- 2018: January, October, December
- 2017: November, December

Plotting trend lines

A lowess (Locally Weighted Scatterplot Smoothing) smoothed line was included on these plots to assess both short-term and long-term trends. Lowess is a non-parametric regression technique in which simple linear regression models are fitted to overlapping subsets of the data, and the results are combined to form a smooth curve through the complete set of data points. It is very flexible and makes few assumptions about the distribution of data or the shape of the changes in the outcome over time.

Head to Health uptake plots with trend lines

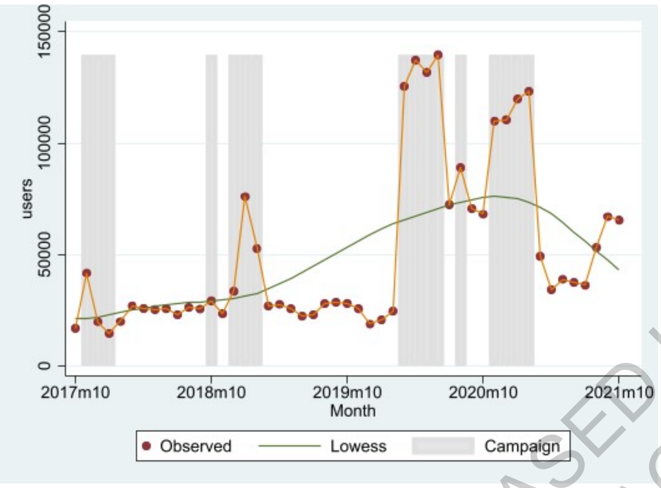


Figure A1. Monthly number of users, October 2017 to October 2021

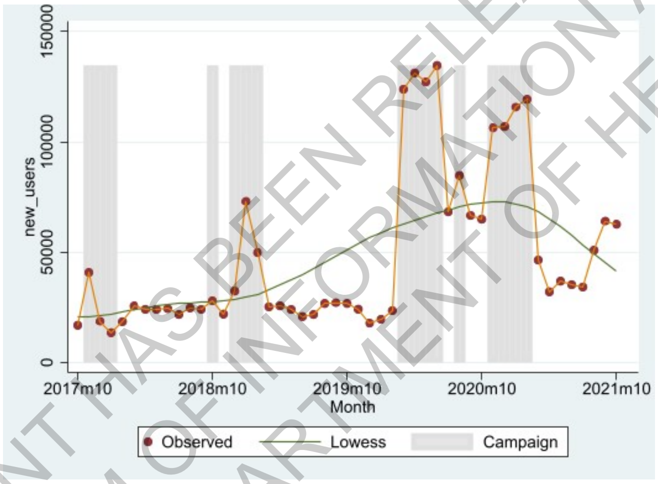


Figure A2. Monthly number of new users, October 2017 to October 2021

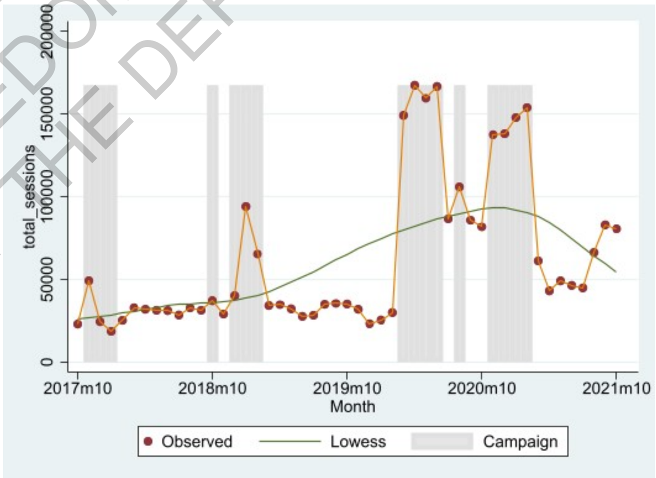


Figure A3. Monthly number of sessions, October 2017 to October 2021

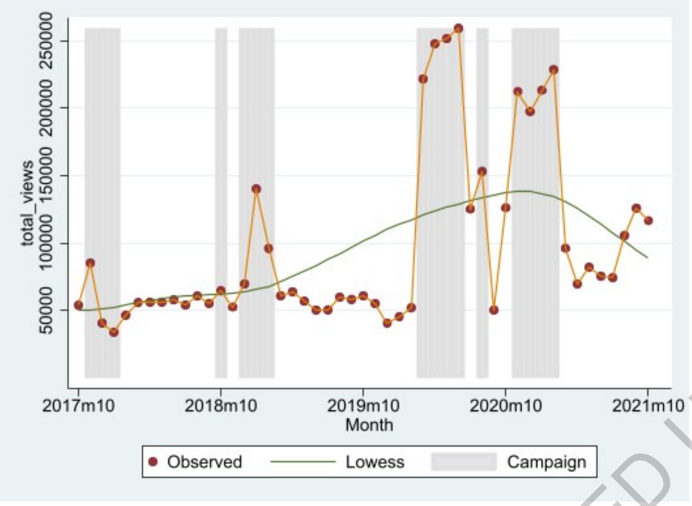


Figure A4. Monthly number of views, October 2017 to October 2021

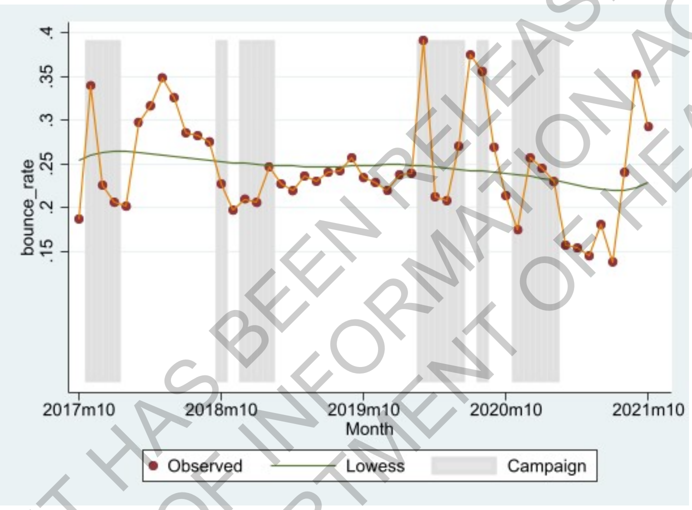


Figure A5. Monthly bounce rate, October 2017 to October 2021

Head to Health engagement plots

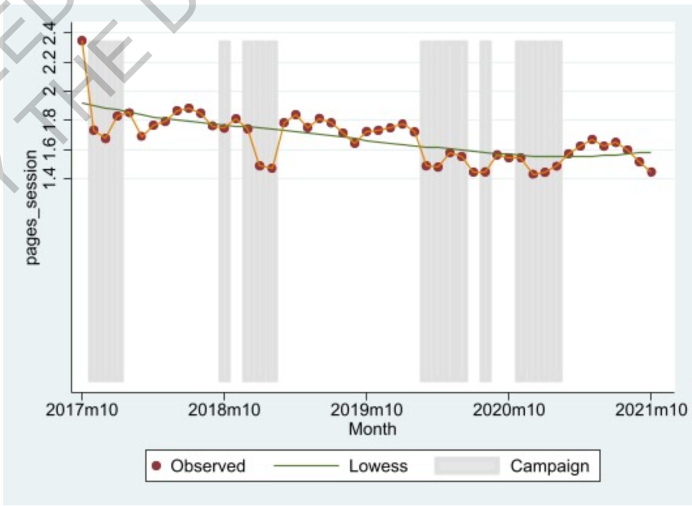


Figure A6. Monthly number of pages per session, October 2017 to October 2021

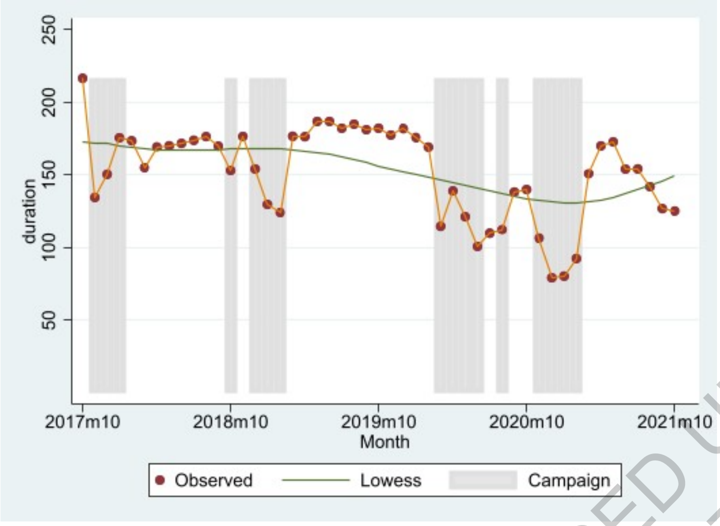


Figure A7. Monthly duration in seconds on website, October 2017 to October 2021

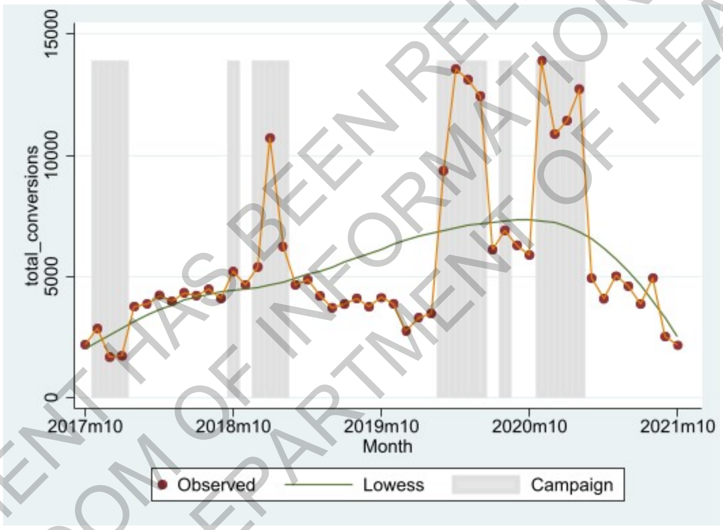


Figure A8. Monthly number of conversions, October 2017 to October 2021

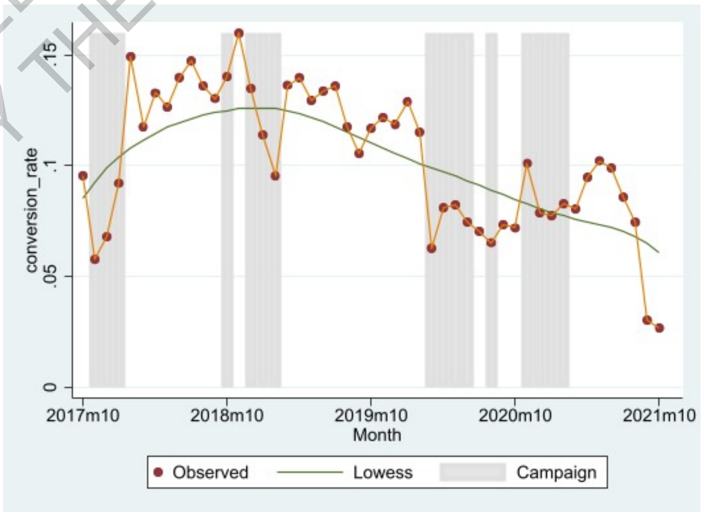


Figure A9. Monthly conversion rate, October 2017 to October 2021

Page helpfulness

At the bottom of every webpage on the Head to Health website, there is an option to indicate whether that page was helpful or not by answering the question, ‘Was this information helpful?’ This page helpfulness data is in the raw data Events file. Each time someone answers the question about whether a page was helpful or not, this is recorded as an event and is given a row of data. The Events file includes other information on each row that can be used to classify the pages specifically rated for helpfulness (e.g., a COVID-19 topic page, or a Meaningful life topic page and so on). The number of times the page was rated as helpful was calculated by summing a column called ‘Unique.events’ in the Events file for rows where a given page page was considered helpful (indicated in the data by a ‘yes’ in the ‘Event.label’ field). The number of times the page was rated as unhelpful was likewise calculated by summing Unique.events for rows where a given page was considered unhelpful (Event.label = ‘no’). From here, the percentage of helpful ratings was calculated. Using notes found in Liquid Interactive’s summary Excel file, helpfulness data was restricted to English rating answers (i.e., ‘yes’ and ‘no’). It is perhaps relevant to note that although ‘yes’ is an English word, ‘no’ is used in several other languages, but this noise was ignored for our purpose.

Appendix 3: Detailed methods and analysis of community conversations

Methods

Community conversations were conducted using the World Café method.[4] The World Café is a powerful way of facilitating group discussions. It is particularly useful for gathering multiple views on an issue to generate collective solutions, where you have all the experts already in the "room", and creative thinking is helpful to generate ideas. It typically involves bringing together small groups of people at tables to discuss a particular issue, shuffling people to new tables with new issues, and then repeating the process several times. The World Café method is therefore easily adapted to be used online for conversations about Head to Health and digital mental health services.

Recruitment was conducted in four main ways:

- An email sent to the ACACIA register, a database of more than 130 consumers, carers and lived experience organisations interested in participation or active involvement in lived experience research;
- A post to the ACACIA Facebook page, which was also shared by Lived Experience Australia and several ACACIA members;
- A paid ad through the ACACIA Facebook account, which ran from 10-23 November, targeting all Australians over 16 years of age. The ad reached 21,411 people, had engagement from 243 people and resulted in 99 clicks through to the Expression of Interest form;
- Tweets from A/Prof Banfield's account on 10 and 18 November, which were retweeted more than 30 times, including by consumer and researcher networks.

People who were interested in taking part clicked a link in the ad/post to complete a brief expression of interest survey on Qualtrics. A member of the research team responded by email, providing the information sheet and consent form, which also collected demographics and information about knowledge of the Head to Health website. Consent was requested prior to the group, but for a small number of participants, it was completed at the time of the conversation, prior to the commencement of discussions. A reminder email was sent the week before the conversations containing the Zoom links for the three conversations and a prompt to return the consent form.

The community conversations ran for 2.5 hours including breaks, and consisted of four sessions: three rounds of small group discussions to discuss strengths, barriers and effectiveness, and one final group discussion to bring the previous discussions together in optimal features. The full World Cafe method included the creation of small group "tables" using the breakout room feature, with one researcher assigned to each room as facilitator, assisted by an observer/note taker. Due to low attendance, only one conversation was run in this way; the other two were conducted as single group discussions for all four questions.

Many participants were not familiar with the Head to Health website prior to the community conversations, so facilitators accessed the website and shared their screens to facilitate exploration in real time, and discussion of observations about strengths and weaknesses and perceived effectiveness.

Note takers and participants entered ideas and issues into the Slido app (https://www.sli.do/). Slido is a web-based, interactive Q&A and polling app that encourages participation in virtual events. There are no downloads or personal information required from participants. They simply follow a link, which was provided live in the Zoom chat, and entered the unique event ID to access the interactive tools for the community conversation. Participants were asked to enter words and phrases in response to the questions to create a "word cloud." They were able to enter words already present in the cloud to increase their emphasis, or enter further words to expand the cloud. Facilitators encouraged discussion about topics emerging in response to the emphasis suggested by the cloud at several points in each session. A fresh Slido event was created for each of the three sessions, allowing the groups to develop their own ideas.

Discussion about each question lasted for 20 minutes. In the conversation run using the World Cafe method, when participants moved between rooms, the facilitator for that room shared the word cloud developed to that point, and asked for comments and additions to the question for that room. This allowed both reinforcement of key issues already raised and the opportunity to add novel areas in an accessible visual format. This was not necessary in the conversations run as single group discussions, as all participants had the opportunity to build the word clouds together at the same time.

For the final discussions, the word clouds developed for strengths, barriers and effectiveness were displayed via shared screen to facilitate discussion on the features of an optimal digital gateway. Participants were invited to reflect on their prior discussions and think about how an ideal website would look, feel and act. They were then invited to enter the most and least important features they thought the website should have.

After the conclusion of the discussion, participants were emailed a $50 e-gift card as a reimbursement for their time.

Analysis

The lists of ideas entered into Slido for all three conversations were downloaded for preliminary thematic analysis using Nvivo qualitative analysis software. An initial list of codes was developed line-by-line, interrogating the data for common issues. These issues were then combined into larger thematic areas, given descriptive titles to demonstrate the major areas of strength, barriers and effectiveness. A summary of these preliminary themes is provided in the preliminary findings section of the report, alongside discussion of the most and least important features for a redeveloped Head to Health website. The full word clouds and survey results are available below in ths appendix. Full thematic analysis, including additional notes taken by notetakers, will be undertaken for the final evaluation report.

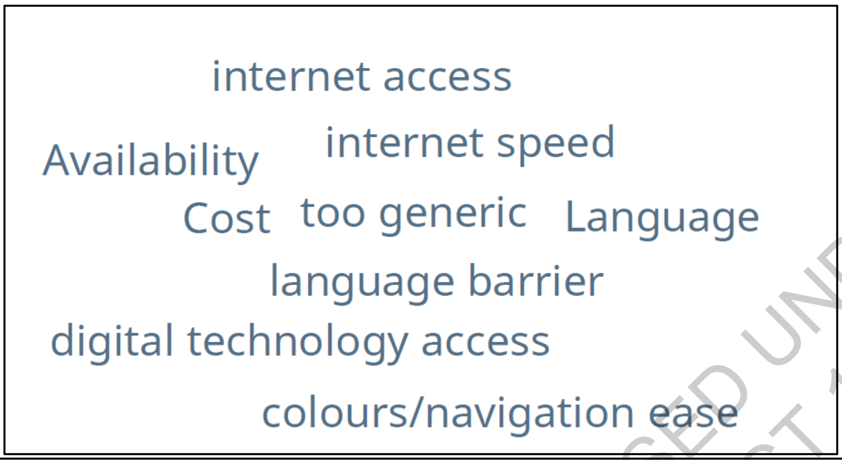
Strengths of Head to Health word clouds

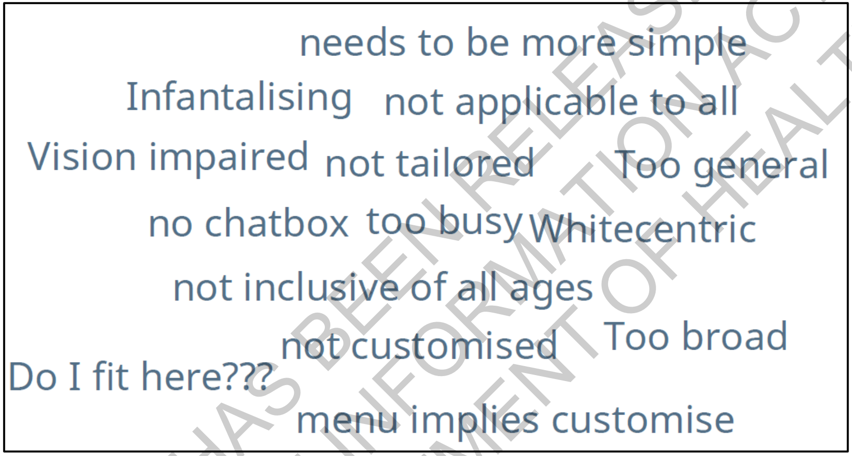
Link to specialists
Can access variety
Outsourced to other place
Informative
Phobia
Trustworthy
Feels warm
Well categorised
Major resource
User friendly
Looks different
Accessible
Starting point
General advice
Needs to be simple
Liked COVID-19 content

Language choices
Looks friendly welcoming
Lots of info quantity
Sam AI + or - ?
Not typical govt website
Looks user friendly
Is 3 choices Sam enough
Can bookmark favourites

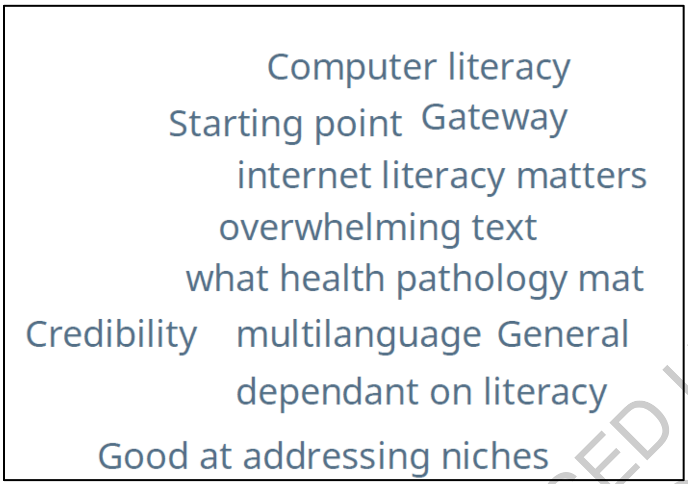
Peer Group Services
friendly colours
menu
drill
easy
specifics
mobile friendly
deficit based
Speaks to young people

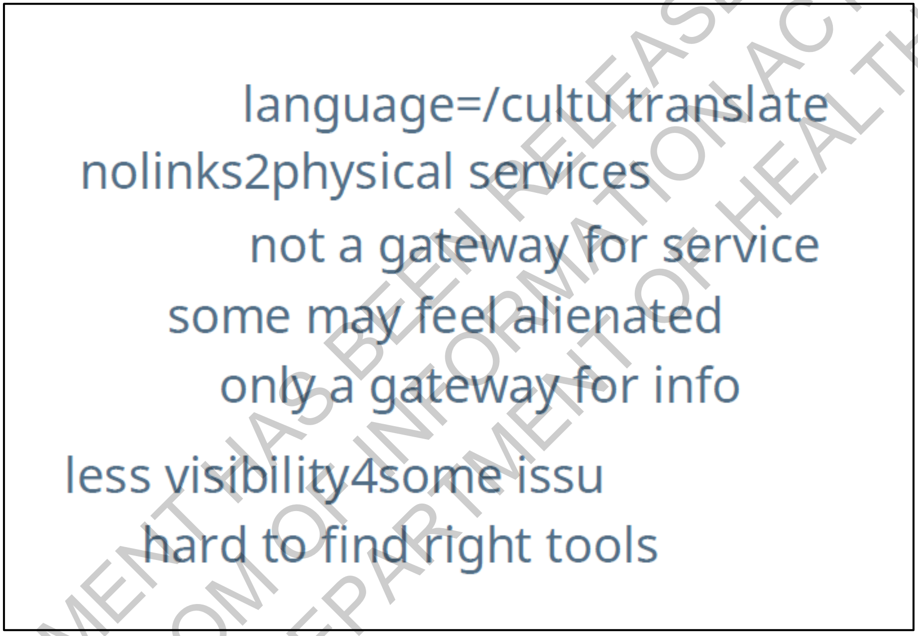
Weaknesses of Head to Health word clouds





Effectiveness of Head to Health word clouds





Most and least important features of Head to Health

Most important

Tailored links

An easy to understand interface

Visually appealing but not excessive use of colours

easy to understand

Engaging not over-whelming

Some live chat, real time interaction

Visually calming and accessible

Way to Narrow info down to me so less overwhelming

Accessibility

Comprehensive without being too overwhelming

Design - a bit childish looking

Link to real people and services - it won’t replace specialists

Don’t think this replaces specialists and access especially rural

Link to support groups too

Has the information you need/want

Links to further discussion or tools or physical services

being able to rate the relevance/effectiveness of resources,

accessibility

wide variety of resources

Need way through via HOPE, recovery

Focus on recovery

empowering people to update an engaged info space

don’t just connect back to mainstream models that don’t connect back too community.

Opportunity to normalise to reduce stigma and self stigma and promote help finding…

need to mention that it is normal that a significant number of people experience.
A lot of transformative stuff is peer base, grass roots, non govt, so it would be great to make those resources available to a wider audience and updating and remaining in touch with the peer spaces

We need redesign for people with substantial and enduring distress.
Normalise mental health issues

Least important

Jargon

Formal language

Very long paragraphs

all relevant

Bloody awful cartoon figures

Chatbots

Referral to Beyond Blue or Lifeline

Need less basic info and address more complex needs

THE UNIVERSITY OF
MELBOURNE

Independent evaluation of the Head to Health Digital Mental Health Gateway

Interim report

Bridget Bassilios, Maria Ftanou, Leo Roberts, Katrina Scurrah,
Michelle Banfield, Andrew Tan, Anna Machlin,
Shaminka Mangelsdorf, Long Le, Matthew Spittal,
Cathy Mihalopoulos, Jane Pirkis

25 February 2022

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Executive summary

Background

In October 2017, the Australian Government launched the Head to Health National Digital Mental Health Gateway (www.headtohealth.gov.au) to improve access to, and navigation of, digital mental health services. It provides a directory of 693 government-funded clinically effective Australian digital mental health resources, including apps, online programs, online forums, phone services and digital information resources.[1]

The objectives of Head to Health are to:

- Give Australians the tools and information they need to understand when everyday distress requires additional support and to successfully navigate the mental health system and make informed choices about their care;
- Improve access by bringing together, streamlining, and providing access to evidence-based information, advice, and digital mental health treatments through a centralised portal;
- Provide people needing additional support a range of options, including practical tips and advice on how to connect with support;
- Make it easy to access a range of clinically effective Australian digital mental health services that are often free or low cost, accessible from anywhere/at anytime, and offer an effective alternative or complement to face to face services; and
- Foster a sense of trust and confidence in using digital services listed on Head to Health by ensuring they meet an agreed minimum quality standard.

Head to Health replaced mindhealthconnect, an e-Mental health web portal that provided access to trusted online mental health resources and programs.[2] mindhealthconnect was operational from July 2012 to 13 November 2017; and managed by Healthdirect Australia, on behalf of the Australian Government.[2]

In response to recommendations of the 2020 Productivity Commission Mental Health Inquiry Report,[3] the Australian Government is in the process of transforming Head to Health into a new national mental health platform. This transformation aims to develop Head to Health into a comprehensive national mental health platform that will provide Australians with greater choice in accessing the treatment and services they need, and more seamless connections across the broader health and mental health system.

Evaluation aims

The Centre for Mental Health at the University of Melbourne has been commissioned by the Department of Health to undertake the independent evaluation of the Head to Health website's appropriateness, effectiveness, and efficiency. The purpose of the evaluation is to inform the development of the national mental health platform and the Australian Government's consideration of digital mental health services and infrastructure.

The evaluation is guided by the six key evaluation questions (KEQs) including:

- **KEQ 1:** How effective has Head to Health been to date and what can we learn from it?
- **KEQ 2:** Who are the current users of the Head to Health website?
- **KEQ 3:** What are the experiences of users of the website?
- **KEQ 4:** What are the needs of current users of the website? Are these being met? What needs should be met by the planned national mental health platform?
- **KEQ 5:** How effective is Head to Health in achieving its objectives?
- **KEQ6:** How efficiently and effectively has Australian Government funding for Head to Health been used?

Data sources

We are using a mixed-methods evaluation approach, involving collecting and analysing data from a range of primary and secondary quantitative and qualitative data sources, which are briefly described below.

Existing data

We will utilise existing data provided to us by:

- The Department of Health (financial data, including development and maintenance costs; and data from a previous Head to Health survey of 258 users, conducted by the Department of Health in 2019);
- Liquid Interactive, the Head to Health website developer (Head to Health google analytics and user feedback data); and
- Three key Australian digital mental health services (DMHS) providers (Mental Health Online, MindSpot and THIS WAY UP) (DMHS website analytics data).

Consultations with key stakeholders

We are in the process of conducting consultations with a broad range of stakeholders who are familiar with Head to Health, including:

- Users of the Head to Health website with lived experience of mental health problems via survey (and optional interview);
- Health professional provider users of the Head to Health website via survey;
- Additional health professionals (with or without experience using Head to Health) such as GPs and mental health professionals (e.g., psychologists, mental health nurses, psychiatrists, social workers, occupational therapists) via survey through professional associations; and
- Other key stakeholders via survey (or interview), e.g., Head to Health (and the new national mental health platform) website developers, management staff from the DMHSs, funders, partners, and others in the mental health sector (e.g., representatives from relevant health professions and peak bodies for people with lived experience).

We have conducted consultations with additional people with lived experience via three community conversations using a modified World Café method.[4]

Interim findings

Interim findings are based on existing data (provided by the Department of Health, Liquid Interactive and three key Australian DMHSs), including google analytics and user feedback data, financial data, website visits to DMHSs and secondary survey data. We also present selected preliminary findings from our in-progress consumer and provider user surveys involving 45 consumers and seven providers, and three online community conversations involving 16 people with lived experience. Findings from consultations with additional health professionals and other key stakeholders are not included in this report because these consultations are not yet completed.

Findings from these data sources are summarised according to the six KEQs. Note that KEQs are addressed by different combinations of, and not necessarily all, data sources.

KEQ 1: How effective has Head to Health been to date and what can we learn from it?

Data from Head to Health google analytics, website analytics from three key digital mental health services and community conversations with lived experience participants contribute to addressing KEQ 1.

Google analytics data

From October 2017 to October 2021, the mean number of unique users per month was 50,694, and almost all appeared to be new users (mean = 48,509). The mean number of sessions was 62,357, and the mean number of views per month was 97,235. This suggests that the monthly mean uptake has halved compared with equivalent monthly average data for mindhealthconnect from February to June 2017 (e.g., 103,136 unique users; 185,140 page views).[2] Although uptake figures were higher during campaign periods (e.g., 84,620 unique users; 151,162 page views), these were still below the mindhealthconnect equivalent monthly averages from February to June 2017.[2]

However, the Head to Health average monthly bounce rate over its life is much better than that of mindhealthconnect from February to June 2015 (25% cf 75%),[2] which means proportionally less sessions involved users not interacting with the website before leaving.

Furthermore, despite the lower than expected monthly average uptake, the trend from October 2017 to October 2021 has been for the overall uptake of Head to Health to increase over time.

A range of devices are being used to access Head to Health. In 2021, 49% of sessions were accessed via desktop, 47% via mobile and 4% tablet devices. Search engine results are the main source of traffic to Head to Health, and most referrals come via Facebook.

Website analytics from digital mental health services

In a 3.75 year period (October 2017 to June 2021), Head to Health referred almost double the number of visitors to three digital mental health services websites as mindhealthconnect in a 3.25 year period (July 2014 to September 2017; 69,595 cf 36,455). However, because the overall number of visitors to the websites of these services more than tripled, proportionally there were fewer referrals from Head to Health than from mindhealthconnect (1% cf 2%). These findings suggest that although more people have continued to become aware of Head to Health over time, people are also increasingly becoming aware of digital mental health services through pathways other than through Head to Health.

Community conversations

Lived experience community conversation participants described the website as a broad and credible gateway suited to family members or those new to mental health. However, they reported insufficient tailoring for those with complex needs, who frequently miss out in "one-size-fits-all" approaches and may need their own section or website to cover information and programs relevant only to people with severe illness and complex needs.

Lived experience participants also expressed concern that the website does not include specific groups such as Aboriginal and Torres Strait Islander peoples, those who identify as LGBTQIA+ and those from different cultural backgrounds. They viewed the overall language as clinical or pathologising and complex, requiring a level of literacy and digital literacy that may exclude some users, including people from non-English speaking backgrounds or with disabilities.

Some lived experience participants thought the volume of information was overwhelming, but at the same time, they felt that some issues and specific apps were not described well enough. This reduced the website's effectiveness as they struggled to navigate what was needed, and then found the website did not have enough depth to the information on the topics in which they were interested.

KEQ 2: Who are the current users of the Head to Health website?

Data describing the users of Head to Health are not routinely collected. However, secondary data from the Department administered survey, and our in-progress consumer and provider user surveys, provide some insight into the characteristics of survey respondents.

Secondary survey data

Of the 258 respondents who completed the survey, most were female (73%) and of mixed age groups, most commonly 18-50 years (62%) followed by 51-65 years (18%) and under 18 years (17%). Survey respondents represented all states and territories and a range of hard-to-reach minority subpopulations. Survey respondents most commonly heard about Head to Health through an internet search or from a friend/co-worker/family member.

Survey data

Our in-progress user survey data from 45 consumers shows that these participants had a similar profile to that reported from the secondary survey data. Around two-thirds were female and aged 20-49 years, but 20% were aged 60-69 years. Just over half of these consumers were aware of the Head to Health website and around half had never used it. By comparison, of the 16 lived experience participants we recruited for the community conversations, 44% had heard of Head to Health, and 25% had used it.

Only seven providers have completed the survey so far. Of these, six were female, and three were aged 20-29 and two 60-69 years. They included GPs, social workers and psychologists among other professions, three of whom had over 20 years' experience, who mainly used the website to access information for themselves or their clients.

KEQ 3: What are the experiences of users of the website?

Data from Head to Health google analytics including user feedback, the Department survey, our in-progress user survey and community conversations with lived experience participants address KEQ 3.

Google analytics data

Google analytics data provide insights into how users engage with the Head to Health website.

On average, only 1-2 pages are viewed per session, and the average session duration is 2.5 minutes. Overall, engagement with Head to Health has declined over time, irrespective of campaigns. One in 10 Head to Health sessions results in a conversion (i.e., completing a desired action including search completions, chatbot completions, and emailing or printing resources). The Head to Health conversion rate is somewhat lower than that of mindhealthconnect at 13%,[2] but the absolute number of conversions has increased over time.

A relatively small number of users provide data on whether or not they perceive the pages they use to be helpful. Pages relating to COVID-19 support, Health professionals, Meaningful life, Mental health difficulties, Supporting someone else and Supporting yourself are more often rated as helpful than not (~60-80%).

Similarly, a relatively small number of users provide feedback about their experience of the Head to Health website overall and its specific pages. Only half of these users' responses report positive (good or great) experiences of the overall website and less than half (~40%) do so for the homepage and other content pages. Consistent with these ratings, less than half of these user responses indicate that they would recommend (≥ 7/10) the website and even fewer would recommend specific website content and the chatbot.

Secondary survey data

Just under two-thirds of respondents of the Department administered survey reported that the website was easy or very easy to use, most (88%) reported moderate to high trust in the content, and around 60% reported a good or great user experience. Around two-thirds indicated a relatively high likelihood (≥ 7/10) of recommending Head to Health.

Survey data

Our in-progress user survey data shows that of the 20 consumers who had used Head to Health, only 30% had used it more than once and most spent less than 20 minutes on the website. The most commonly reported reasons for using the website were struggles with coping, wanting to access information for family and friends, and needing professional help. Overall, only 20% of consumers reported that they were 'satisfied' or 'very satisfied' with the website, and only 35% would recommend it to others.

The seven providers who have completed our in-progress survey reported finding out about the Head to Health website through a variety of sources including online searches, workplace recommendations, flyers, eMHPrac and other continuing professional development activities. Providers varied in their frequency of using the website, ranging from having used it on a single occasion to over 11 times. Most providers spent under 20 minutes engaging with the website. Most commonly, providers used the website to access information and resources for themselves or their clients. Overall, 57% of providers reported that they were 'satisfied' or 'very satisfied' with the Head to Health website and 70% occasionally or frequently recommend it to clients. Sixty percent of providers reported that the website has benefited clients under their care and none reported negative impacts for clients. The most commonly reported client benefits were reduced costs associated with care, improved access to information, improved convenience of care and improved mental health and wellbeing.

Community conversations

Based on demonstration of its functionality during the community conversations, lived experience participants' positive feedback related to experiencing the website as warm, user-friendly and easy to use. They particularly appreciated the comprehensive menu system that allowed drilling down to specific information, the ability to bookmark important parts, and that the website is mobile friendly. They commented that it is "not a typical government website" and were impressed by the comprehensive information presented on a very broad range of issues, including specific disorders and COVID-19.

The negative feedback from lived experience participants related to lack of user friendliness, particularly the nature of the content, its organisation and the overall feel. Some felt that the website was too broad and overwhelming to navigate. Some content, particularly regarding LGBTQIA+ populations, was reported to be outdated, and other areas too focused on self-help and information rather than providing a true gateway to mental health services. The cartoon characters were particularly unpopular and some participants suggested that it made it feel like the website did not take mental health seriously.

The other major area lived experience participants viewed as a barrier was accessibility. Some expressed concern that Head to Health may systematically exclude some of the most vulnerable people, for example, people without reliable technology, people with vision impairment, and people from different cultural backgrounds, including Aboriginal and Torres Strait Islander peoples.

Importantly, some lived experience participants reported that the crisis resources were not easy to find and were too superficial.

KEQ 4: What are the needs of current users of the website? Are these being met? What needs should be met by the planned national mental health platform?

Data from the Department's survey and the community conversations contribute to addressing KEQ 4.

Secondary survey data

The most commonly used features of the Head to Health website according to respondents of the Department administered survey are the topic and content pages and the search resources (58% and 57%, respectively). More than half (61%) of survey respondents reported that the resources were relevant or extremely relevant. This suggests that these are features that are performing relatively well and should be retained in the planned national mental health platform.

Survey respondents suggested that some features could be improved including:

- Providing more information/content/resources (e.g., specific disorders or subpopulations; and information about accessing face-to-face services, particularly based on location; costs and other requirements for entry into suggested services; and including lived experience views, for example in providing user ratings of services);
- Updating outdated information;
- Further refining both chatbot and search functionality and to ensure that suggestions are tailored to the individual; and
- Website design (e.g., look and feel, and ease of navigation of the website, as well as its speed).

Community conversations

Community conversation participants echoed several of the suggestions made by Department survey respondents in addition to offering other characteristics of an ideal mental health gateway including:

- A visually appealing website with use of calming colours, and that is less childish-looking;
- Comprehensive information (on all mental health issues, not just the most common), organised in a way that is not overwhelming and assists users to find the depth they need;
- The website being accessible to everyone, so easy to read and compatible with screen readers for example;
- Removal of medical jargon and complex language, replaced with plain language and recovery-oriented information;
- Better information that normalises mental health issues and recovery, and connects to options beyond mainstream mental health approaches, such as peer services;
- Input from peers in design and navigation;
- Links to physical (real world) services such as mental health professionals, support groups and non-digital tools; and
- The addition of live chat or interaction with a real person rather than a robot to help people in distress find what they need.

KEQ 5: How effective is Head to Health in achieving its objectives?

This section lists each of the objectives of Head to Health and indicates whether it has been achieved based on the data sources used to inform the current report. However, we will be better placed to answer how effective Head to Health is in achieving its objectives when we have completed our consultations with consumers, providers, health professionals and other key mental health sector stakeholders.

1. **Give Australians the tools and information they need to understand when everyday distress requires additional support and to successfully navigate the mental health system and make informed choices about their care.**

None of the available data sources provide information about the first part of this objective (i.e., when everyday distress requires additional support). As far as we can tell, Head to Health provides Australians with tools and information to navigate digital mental health services but not necessarily the mental health system in its entirety, which will be a focus of the new national mental health platform. As reported in response to KEQs 1 and 3, community conversation participants and survey respondents indicated that there is a desire for more comprehensive mental health system options (e.g., face-to-face and peer support services; and services for all mental health problems, minority groups and people with complex needs).

2. **Improve access by bringing together, streamlining, and providing access to evidence-based information, advice, and digital mental health treatments through a centralised portal.**

As mentioned in response to KEQ 1, the trend has been for the overall uptake of Head to Health to increase over time. However, it is not the only source of visits to the websites of key Australian digital mental health services (referring only 1% of visitors).

3. **Provide people needing additional support a range of options, including practical tips and advice on how to connect with support.**

The available data sources did not directly assess this objective. However, as mentioned in response to the first objective, users expressed a desire for a more comprehensive gateway to mental health services, not just digital mental health services and mainstream majority population services.

As reported in response to KEQ 4, survey respondents and community conversation participants also suggested that the range of support options could be improved either by further refining both chatbot and search functionality to ensure that suggestions are individually tailored, or through the addition of complementary live chat or interaction with a real person rather than a chatbot to help people in distress find what they need.

4. **Make it easy to access a range of clinically effective Australian digital mental health services that are often free or low cost, accessible from anywhere/anytime, and offer an effective alternative or complement to face to face services.**

As reported in response to KEQ 3, just under two-thirds of respondents of the Department administered survey reported that the website was easy or very easy to use. Of the 20 consumers who have participated in our in-progress user survey, only 20% reported that they were 'satisfied' or 'very satisfied' with the website, and only 35% would recommend it to others. The community conversation participants appreciated the comprehensive menu system and the broad content; but also felt that navigating the website was overwhelming and criticised the lack of user-friendliness and content targeting minority groups. However, these findings do not directly inform the ease of accessing services themselves and in any case, as noted in response to KEQ 1, Head to Health only accounts for 1% of visitors to websites of key Australian digital mental health services.

5. **Foster a sense of trust and confidence in using digital services listed on Head to Health by ensuring they meet an agreed minimum quality standard.**

As mentioned in response to KEQ 3, 88% of Department survey respondents reported moderate to high trust in the content of Head to Health. This was corroborated by the lived experience community conversation participants' view that the website was a trustworthy starting point for seeking information and links to professionals for mental health issues.

KEQ 6: How efficiently and effectively has Australian Government funding for Head to Health been used?

KEQ 6 was addressed using Head to Health google analytics data and expenditure reports provided by the Department of Health.

For most outcomes, the cost per unit has decreased over time, with the costs in 2020-21 per visit, unique visitor, new user, and conversion being $2.91, $3.57, $3.74 and $35.57. Based on the current data available to us, there is evidence to suggest efficiency of resource use from the allocated budget. However, we are undertaking further evaluation to determine the cost-effectiveness of Head to Health.

Conclusions

A significant number of people use Head to Health each month, many of whom interact with the website in a meaningful way and go on to access digital mental health services. However, on average users only spend 2.5 minutes per session on the website, suggesting that people either quickly find what they need or are unable to find what they need and leave the website. The latter interpretation is supported by data indicating that only one in 10 people complete a key or desired action. In its current form, although a high proportion of users report high trust in the content, only some users experience Head to Health as easy to use, and report a good experience. Stakeholders report mixed views about the design, look and feel of the Head to Health website. Our consultations with lived experience participants indicated that the website is simultaneously overwhelming in its current volume of information, and there are gaps in the information provided. Thus, the challenge for developing the new mental health platform will be to strike a balance between providing comprehensive information for navigating the mental health system (more broadly than digital mental health services) while not overwhelming users. Our continuing consultations with consumers, providers, health professionals and other key mental health sector stakeholders may shed further light on who the current users of Head to Health are, whether Head to Health is effective in achieving its objectives, and whether it is cost effective.

Background

A major review (Review) of Australia's mental health programs and services conducted in 2014 by the National Mental Health Commission, highlighted poor integration of existing digital mental health services amongst other findings calling for reform of the mental health system.[5] As part of its response,[6] the Australian Government funded the digital mental health gateway, Head to Health (www.headtohealth.gov.au). Head to Health provides a directory of 693 government-funded clinically effective Australian digital mental health resources, including apps, online programs, online forums, phone services and digital information resources.[1] Launched in October 2017, this gateway website, aims to improve access to, and navigation of, digital mental health services by:

- Enabling people and professionals to choose the products and services that can best support a person's mental health and wellbeing;
- Connecting people with resources and support, conveniently, safely, and securely; and
- Complementing and enhancing, not competing with, existing digital mental health services.

The objectives of Head to Health are to:

- Give Australians the tools and information they need to understand when everyday distress requires additional support and to successfully navigate the mental health system and make informed choices about their care;
- Improve access by bringing together, streamlining, and providing access to evidence-based information, advice, and digital mental health treatments through a centralised portal;
- Provide people needing additional support a range of options, including practical tips and advice on how to connect with support;
- Make it easy to access a range of clinically effective Australian digital mental health services that are often free or low cost, accessible from anywhere/at anytime, and offer an effective alternative or complement to face-to-face services; and
- Foster a sense of trust and confidence in using digital services listed on Head to Health by ensuring they meet an agreed minimum quality standard.

Head to Health replaced mindhealthconnect, an e-Mental health web portal that provided access to trusted online mental health resources and programs.[2] mindhealthconnect was operational from July 2012 to 13 November 2017; and managed by Healthdirect Australia, on behalf of the Australian Government.[2]

More recently, the 2020 Productivity Commission Mental Health Inquiry Report noted the potential benefits of digital mental health services.[3] It recommended that the Australian Government continue developing and improving Head to Health and using it to inform the development of a new National Mental Health Platform.[3] In response, the Government is transforming Head to Health into a new national mental health platform. This transformation aims to develop Head to Health into a comprehensive national mental health platform that will provide Australians with greater choice in accessing the treatment and services they need, and more seamless connections across the broader health and mental health system.

Transformation of Head to Health is timely in the context of COVID-19 pandemic related lockdowns, restrictions and social distancing, all of which are worsening the population's mental health and increasing demand for mental health services.[7] Evidence based digital mental health services can play a greater role in the mental health system to help meet this demand; and a single national mental health platform has the potential to help improve access to both digital and face-to-face services.

Evaluation aims

The Centre for Mental Health at the University of Melbourne has been commissioned by the Department of Health to undertake the independent evaluation of the Head to Health website's appropriateness, effectiveness, and efficiency. The purpose of the evaluation is to inform the development of the national mental health platform and the Australian Government's consideration of digital mental health services and infrastructure.

The evaluation is guided by the six key evaluation questions (KEQs) and associated sub-questions outlined in the Request for Quote (RFQ) including:

- **KEQ 1:** How effective has Head to Health been to date and what can we learn from it?
- **KEQ 2:** Who are the current users of the Head to Health website?
- **KEQ 3:** What are the experiences of users of the website?
- **KEQ 4:** What are the needs of current users of the website? Are these being met? What needs should be met by the planned national mental health platform?
- **KEQ 5:** How effective is Head to Health in achieving its objectives?
- **KEQ6:** How efficiently and effectively has Australian Government funding for Head to Health been used?

Sub-questions associated with the six KEQs are shown in Appendix 1.

Evaluation method

Our evaluation will be guided by the program logic for Head to Health shown in Table 1.

We are using a mixed-methods approach, involving collecting and analysing data from a range of primary and secondary quantitative and qualitative data sources, which are briefly described below.

Existing data

We have used existing data provided to us by the Department of Health, Liquid Interactive (the Head to Health website developer) and three key Australian digital mental health services (DMHS) providers (Mental Health Online, MindSpot and THIS WAY UP) including:

- Head to Health google analytics and user feedback data;
- DMHS website analytics data;
- Financial data, including development and maintenance costs; and
- Data from a previous Head to Health user survey conducted by the Department of Health.

Consultations with key stakeholders

We are in the process of conducting consultations with a broad range of stakeholders who are familiar with Head to Health, including:

- Users of the Head to Health website with lived experience of mental health problems via survey (and optional interview);
- Health professional users of the Head to Health website via survey (and optional interview);
- Other key stakeholders via survey (or interview), e.g., Head to Health (and the new national mental health platform) website developers, management staff from the DMHSs, funders, partners, and others in the mental health sector (e.g., representatives from relevant health professions and peak bodies for people with lived experience);
- Additional people with lived experience via three community conversations using a modified World Café method;[4]
- Additional health professionals (with or without experience using Head to Health) such as GPs and mental health professionals (e.g., psychologists, mental health nurses, psychiatrists, social workers, occupational therapists) via survey through professional associations.

Purpose of this report

This report provides an update on our progress described in the report dated 24 December 2021. Additionally, it provides preliminary findings based on existing data (provided by the Department of Health, Liquid Interactive and three key Australian DMHSs), including google analytics and user feedback data, financial data, website visits to DMHSs and secondary survey data. We also present selected preliminary findings from our in-progress consumer and provider user surveys, and online group conversations with people with lived experience.

Table 1. Program logic for Head to Health

Program Objective: To improve access to, and navigation of, digital mental health services						
PROBLEM STATEMENT	**INPUTS**	**OUTPUTS: ACTIVITIES**	**OUTPUTS: PARTICIPATION**	**SHORT-TERM OUTCOMES**	**MEDIUM-TERM OUTCOMES**	**LONG-TERM OUTCOMES**
Almost one in five Australians experiences mental ill-health, and many more experience mental health problems in a given year. Many do not receive the treatment and support they need, which results in preventable distress; disruptions in education, employment and relationships; stigma, and loss of life satisfaction and opportunities.[3]	**Funding** **Management and governance** policies, guidelines, standards **Key stakeholder staff** digital mental health service providers, partners, referrers, gateway website developers **Community and consumer stakeholders** **Technology** **Research and evaluation expertise** **Head to Health - specific resources**	**Head to Health planning and development** **Client (consumer and provider) needs identification** **Stakeholder education and support** e.g., promoting Head to Health/educating potential providers, referrers and consumers	**Head to Health gateway developed and maintained** **Head to Health gateway evaluated**	**Increase in number of appropriate users (referrers, consumers, providers) of Head to Health gateway** **Improved navigation of digital mental health services**	**Improved access to mental health information and digital services** **Head to Health gateway meets consumer needs** **Consumers satisfied with Head to Health gateway**	**Increase in number of consumers using appropriate digital mental health services** **Improved adherence to digital mental health services** **Improved mental health outcomes** **Cost-effective Head to Health gateway website**
Assumptions: Head to Health complements and enhances existing digital mental health services; the community and particularly people with mental ill-health (or problems) and those providing them with mental health care are aware of, will use and engage with, and benefit from Head to Health; Head to Health connects people with resources and support, conveniently, safely, and securely; Head to Health enables people and professionals to choose the products and services that can best support a person's mental health and wellbeing.				**External Factors:** Funding and contracts, other mental health directories and services available to consumers, research and evidence on Head to Health gateway and digital mental health services, COVID-19 related quarantine, restrictions and lockdowns, other disasters or crises.		

Note. Stakeholders include people with lived experience of mental health problems, providers delivering digital and other mental health services, partners, referrers, others in the (mental) health sector, website gateway developers, funders.

Progress to date

Progress is reported in five areas – ethics approval, data collection and analysis, stakeholder engagement, challenges, and next steps.

Ethics approval

Approval for the evaluation was sought from The University of Melbourne's Human Research Ethics Committee (Greater than Low Risk – Science, Technology, Engineering, Mathematics and Medicine [STEMM]; Reference Number: 2021-22702-24169-5).

The application was submitted on 27 August, and approval was obtained on 18 October 2021.

Since then, we have submitted two amendments to:
1) Combine consultations with several stakeholder groups (additional people with lived experiences, additional health professionals and other key stakeholders) for the Head to Health evaluation with the complementary evaluation of supported DMHSs; and
2) Clarify that identifying information provided in the consent process will be separated from survey/interview responses prior to analysis and extend the user survey period from one week to three months.

The first amendment was submitted on 4 November, approved 10 November, and ratified on 3 December. The second amendment was submitted on 7 December, approved on 10 December 2021 and ratified on 28 January 2022.

Data collection (and analysis)

Existing data

Routinely collected administrative service use data from digital mental health services

We have collected and analysed data from multiple data sources including:
- Head to Health google analytics and user feedback data (provided by Liquid Interactive);
- DMHS website analytics data (provided by Mental Health Online, MindSpot and THIS WAY UP);
- Financial data including development and maintenance costs (provided by the Department of Health);
- Campaign dates and costs (provided by Liquid Interactive and the Department of Health, respectively); and
- Previous Head to Health user survey conducted by the Department of Health (provided by the Department of Health).

Findings based on these data sources are reported in the preliminary findings section of this report.

Consultations with key stakeholders

Users of the Head to Health website

The survey for consumers and providers who use the Head to Health website went live on the Head to Health website on 8 December 2021 and is still open for completion now. The survey can be accessed on the homepage and via the news and announcements tab.

These user surveys have been widely promoted with support from the Department of Health and eMHPrac.

Specifically, the Department of Health has promoted the user surveys via:
- Their internal newsletter that reached 3,885 staff members on 16 December 2021;

- The Head to Health newsletter that was sent to 5,021 subscribers on 16 December 2021; and
- Their websites and social media (LinkedIn, Facebook, Twitter, and Instagram) throughout December 2021, and January and February 2022.

The Department of Health's social media posts and schedule are included in Appendix 2.

eMHPrac has promoted the user surveys via:

- Their newsletter, which has 2,314 subscribers, on 17 December 2021;
- Their Brief Edition newsletter reaching 2,289 subscribers and through the Menzies School of Health newsletter reaching another 1,182 subscribers – both on 2 February 2022;
- Their social media platforms (Facebook, Instagram, Twitter and LinkedIn), reaching up to 1,931 followers on 5 January and 2 February 2022; and,
- The WellMob Facebook page, which specifically targets Indigenous providers and consumers, on 3 February 2022.

eMHPrac's schedule of advertisements is included in Appendix 2.

On 18 February 2022, the Black Dog Institute sent out the advertisement and link to 5,000 mental health professional members of their Mental Health Community of Practice.

On 10 February 2022, the survey was also advertised on both the University of Melbourne Centre for Mental Health and the Melbourne School of Population Health news and events websites.

Despite extensive promotion, only a small number of users have completed the survey to date. As of 22 February 2022, 45 consumers and seven providers have completed the survey. Selected survey findings are reported in the preliminary findings section of this report. Three consumers have also agreed to take part in an interview, and one has completed the interview.

Additional people with lived experience

We conducted three community conversations with people with lived experience of mental illness using a modified World Café method.[4] Further details about our methods and findings are reported in the corresponding preliminary findings section of this report.

Additional health professionals

We have contacted the Royal Australian College of GPs (RACGP), Australian Psychological Society (APS), Australian Clinical Psychology Association (ACPA), Royal Australian and New Zealand College of Psychiatrists (RANZCP), Australian College of Mental Health Nurses (ACMHN), Australian Association of Social Workers (AASW), and Occupational Therapists Australia (OTA).

The survey was advertised on 8 December 2021 via the ACMHN's newsletter, College Connections (approximately 2600 readers) with a follow up post on social media in January. The AASW's website advertised the survey on 8 December 2021 with a follow up notice on social media in January (greater than 15000 members). The RANZCP featured a notice about the survey in their January newsletter with a follow up notice expected to run in the 28 February edition of their newsletter (approximately 5200 Australian members). OT Australia advertised the survey in their 25 January newsletter (greater than 11000 members). RACGP sent out an email notice to the members of the Psychological Medicine Specific Group (n=859) on 14 February.

The APS declined our request to invite their members to participate in the evaluation survey, instead opting to provide an organisational perspective (as described below under Other key stakeholders). We have begun discussions with ACPA, who are going to assist us with reaching their members: clinical psychologists.

As of 15 February 2022, we have had 52 participants complete the survey.

Other key stakeholders

This stakeholder group includes Head to Health (and the new national mental health platform) website developers, management staff from the digital mental health services, funders, partners, and others in the mental health sector (e.g., representatives from relevant health professions and peak bodies for people with lived experience).

As of 22 February 2022, we have approached 84 individuals from 52 organisations. The list of organisations that were approached includes:

- Australian Indigenous Psychologists Association (AIPA)
- Australian Psychological Society (APS)
- BeyondBlue
- Black Dog
- Butterfly Foundation
- Carer Lived Experience Workforce Network
- Department of Health/Head to Health
- eMental Health International Collaborative, New Zealand
- eMental Health in Practice (eMHPrac)
- Gayaa Dhuwi (Proud Spirit) Australia
- Headspace
- Helping Minds WA
- Indigenous Allied Health Australia
- Lifeline
- Liquid/Speedwell
- Lived Experience Australia
- Mental Health Australia
- Mental Health Carers Australia, VIC
- Mental Health Carers NSW
- Mental Health Families & Friends Tasmania
- Mental Health Online
- Mental Illness Fellowship of Australia (NT)
- Mental Wheels Foundation
- MH@Work
- Mind Australia, Vic
- MindSpot
- National Mental Health Commission
- Orygen Digital
- PHNs (Brisbane South PHN, Central and Eastern Sydney PHN, Country SA PHN, Northern Territory PHN, Primary Health Tasmania, South Eastern Melbourne PHN, WA PHN)
- ReachOut
- SANE
- Selected academics
- Smiling Mind
- Tandem
- The Aboriginal and Torres Strait Islander Lived Experience Centre
- The Northern Territory Mental Health Coalition
- THIS WAY UP/CRUfAD/St Vincent's Hospital

These organisations were approached for this evaluation of Head to Health, as well as the concurrent evaluation of digital mental health services. Therefore, our original list of mental health organisations and peak bodies was enhanced with recommendations from the Department, the three services involved in the digital mental health service evaluation (MindSpot, THIS WAY UP and Mental Health Online), as well as recommendations from representatives of organisations that were contacted. Some contacted representatives held positions within multiple organisations and some organisations chose more than one representative to participate.

Between 7 December 2021 and 22 February 2022, 52 individuals from 34 organisations have consented - 26 representatives have completed the survey, 5 started the survey but did not complete it (2 of these nominated other representatives in their organisation instead), 11 interviews (with 18 individuals as some were group interviews) have been completed across January and February, with 2 more interviews scheduled in the coming weeks and 3 more organisations who have expressed interest in interviews.

Organisations/individuals that did not respond were contacted at least 3 times before recruitment efforts ceased. A small number declined due to being too busy (2 academics).

Stakeholder engagement

We have engaged with stakeholders as described above (Consultations with stakeholders).

Additionally, we are in very regular contact with the Department of Health (by Webex, email and phone) to provide updates, request information, and solve any issues as they arise.

We are in video or email contact with the Head to Health web team (Liquid Interactive) on an as needs basis.

We are in regular email, phone and video, contact with the three supported DMHSs.

Our evaluation team meets weekly, set goals, reviews progress and milestones and responds quickly to any issues as they arise.

All stakeholders have been responsive and engaged in the evaluation of Head to Health.

Challenges

We noted a few challenges relating to stakeholder engagement and the google analytics data in our previous report, dated 24 December 2021. These have now been largely been resolved.

The main challenge we face now is that recruitment rates for stakeholder consultations involving individual consumers, providers and additional health professionals has been lower than expected. However, this is countered by the following:

1. Our recruitment of other key mental health stakeholders representing a range of consumer, peak body and mental health services has been much higher than expected;
2. We have not yet completed the data collection phase which will continue through to March 2022, during which the number of individual stakeholders may improve; and
3. The information we are obtaining by triangulating the various data sources seems to be largely consistent.

Next steps

The next steps are to:

- Collect and analyse data from the following stakeholder groups: users of the Head to Health website (consumers and health professionals), additional health professionals via their professional bodies and additional key stakeholders;
- Synthesise and interpret data from all sources; and

- Draw conclusions about the Head to Health website and make recommendations for the new national mental health platform.

Including this report, we have provided seven of nine deliverables to the Department of Health. The remaining deliverables are:

- **Deliverable 8: Final Reports.** We will prepare a Final Stakeholder Report containing the outcome of consultations with key stakeholders throughout the evaluation. We will also prepare a Final evaluation report(s) providing conclusions on how well Head to Health has been implemented to date; the appropriateness of its design and the extent to which it meets users' needs; conclusions on Head to Health's effectiveness in achieving its intended outcomes; findings on its value for money; and key learnings and recommendations to inform the national mental health platform's ultimate state. This deliverable will be submitted on 29 July 2022.
- **Deliverable 9: Presentation of findings.** We will verbally present the findings of the evaluation to the Department and other relevant stakeholders in July 2022.

Table 2 shows the remaining milestones and deliverables for the evaluation.

Table 2. Timeline for remaining milestones and deliverables

Milestone	2022					
	F	M	A	M	J	J
Evaluation administration activities						
Reporting meetings	▨	▨	▨	▨	▨	▨
Tasks						
Stakeholder consultations	▨	▨				
Consultations with users of Head to Health (people with lived experience of mental illness and health professionals)	▨	▨				
Consultation with additional health professionals (and additional people with lived experience, if needed)	▨	▨				
Consultation with other key informants (e.g., website developers, digital mental health services)	▨	▨				
Quantitative and qualitative data analysis (including economic evaluation)	▨	▨	▨	▨		
Data synthesis and interpretation				▨	▨	▨
Deliverables and reporting						
Final report(s)						▨
Presentation of findings						▨

Preliminary findings: Google analytics and service data

Google analytics data

Our approach

We used raw google analytics, including user feedback, data from October 2017 to October 2021 provided by Liquid Interactive. Liquid Interactive also provided some summary data (a multi-tab Excel file) and example monthly reports, which were useful to cross-check with the raw data. Summarised monthly data were analysed using STATA v16.1.

The relationships between monthly counts of all uptake measures (users, new users, total sessions, total views, bounce rate) were estimated using Pearson's correlation coefficients. Plots showing the counts for each month over time with trend lines were also produced (details in Appendix 3). These analyses were repeated for four measures of engagement: pages per session, duration, total conversions, and conversion rate.

We conducted descriptive analyses of other google analytics data including device use, referral source and user feedback; by calendar year and overall.

Our methods are elaborated in Appendix 3.

Findings

Uptake

Head to Health website uptake (usage) data were available for 49 months in total, 16 months during which campaigns were running, and 33 months without campaigns. Campaign dates are listed in Appendix 3.

Table 3 provides the mean and standard deviation (SD) per month for Head to Health uptake measures – overall and for campaign and non-campaign periods. The mean number of unique users per month was 50,694, and almost all appeared to be new users (mean=48,509). The mean number of sessions was 62,357, and the mean number of views per month was 97,235. In about 25% of sessions, users did not make any recorded interactions on the website before leaving.

Appendix 3 displays plots for each Head to Health uptake measure over time, including trend lines, from October 2017 to October 2021 (Figures A1-A5). These plots show that the numbers of users, new users, total sessions and total views have increased over time, and tended to be higher during campaigns, especially during the two most recent campaigns (which ran in 2020 and until February 2021). The bounce rate varied over time, but the mean did not appear to change (systematically) over time or between campaign and non-campaign periods.

There was very high correlation (> 0.98) between users, new users, total sessions and total views, which was expected.

Table 3. Head to Health monthly uptake overall, and during non-campaign and campaign periods, October 2017 to October 2021

		Overall				Non-campaign		Campaign	
Measure	Description	mean	sd	min	max	mean	sd	mean	sd
Users	An estimate of the number of unique people who have visited the website.	50,694	37,569	14,603	139,783	34,244	16,684	84,620	45,823
New users	A 'new user' is counted when a visitor to the website does not have an existing browser cookie from Head to Health.	48,509	36,445	13,583	134,749	32,453	15,869	81,624	44,455
Total sessions	The number of groups of user interactions (hits) that have occurred within a discrete time frame.	62,357	45,591	18,574	167,628	42,421	20,094	103,474	55,787
Total views	The total number of times pages on the website were viewed (total number of views for each page, summed).	97,235	65,136	33,971	258,851	68,180	24,818	157,162	81,084
Bounce rate	[Bounces] / [Sessions] – the proportion of sessions which bounced (i.e., did not make recorded interactions on the website before leaving)	0.246	0.0595	0.138	0.392	0.244	0.0596	0.250	0.0611

Device use and referral source

Figure 1 shows that there has been a small decline in the use of desktop devices to access Head to Health from 52% in 2017 to 49% in 2021. The use of tablets has also halved from 8% in 2017 to 4% in 2021. Correspondingly, there has been an increase in the use of mobile devices from 40% in 2017 to 47% in 2021.

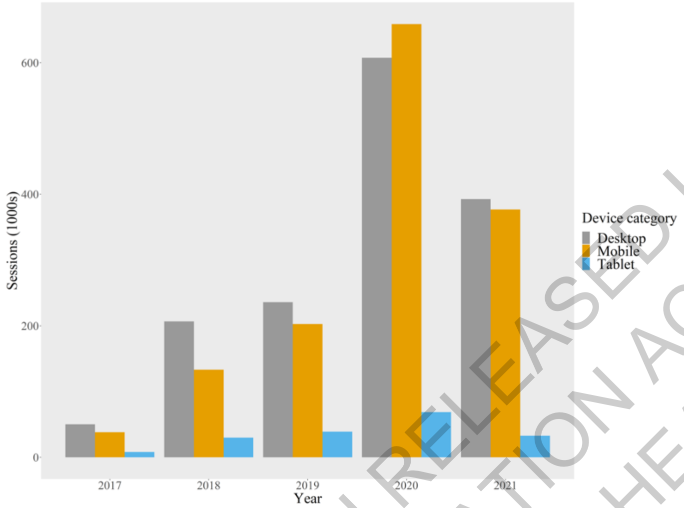

Figure 1. Device types over time, October 2017 to October 2021

Figure 2 shows the top five traffic sources to Head to Health by year from 2017 to 2021. It shows that organic searches (search engine results that were not paid ads) have accounted for the majority of traffic from 2018 to 2021. As of 2021, this is followed by directly typing the Head to Health URL in the web browser address bar or using a bookmark, and then referrals (from hyperlinks on external websites excluding ads), paid searches, and social media.

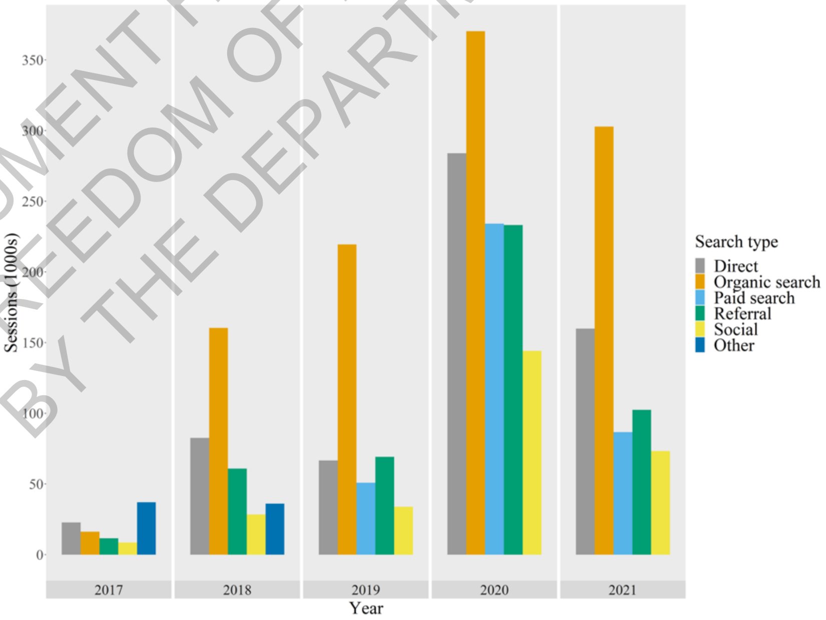

Figure 2. Top five traffic sources over time, October 2017 to October 2021

Figure 3 displays the top 5 referral sources to Head to Health by year from 2017 to 2021. A referral source refers to a web location that directed a Head to Health visitor to the website. It shows that in all years, the majority of referrals came from Facebook. In 2020, this was followed by referrals from the Department of Health website.

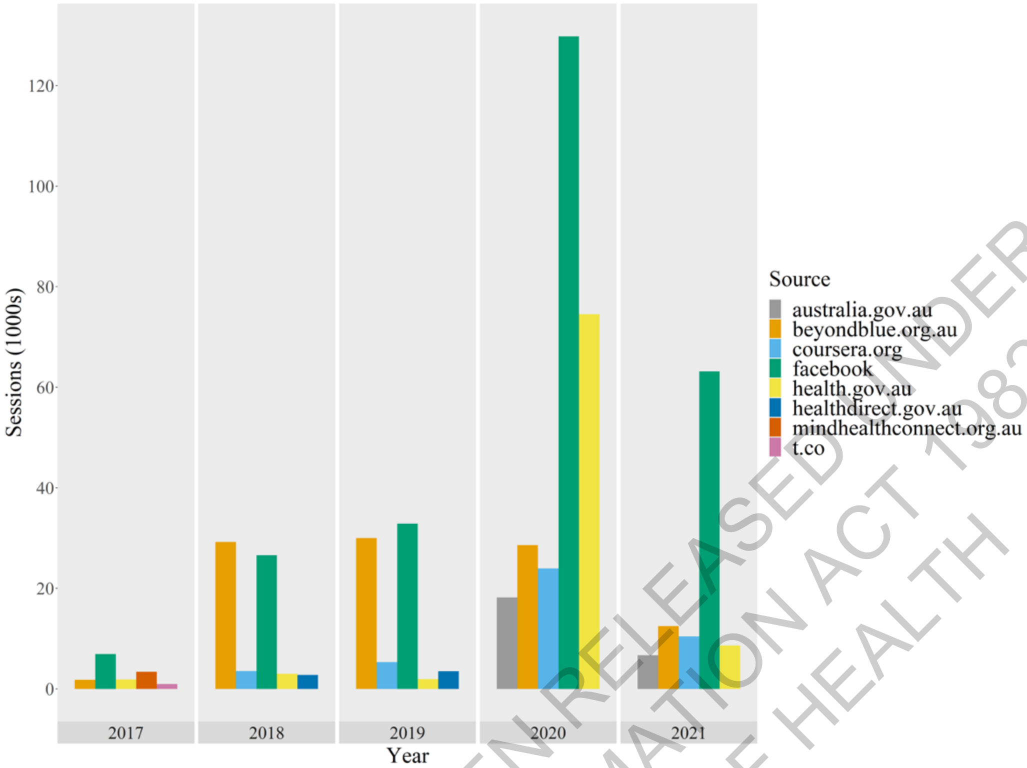

Figure 3. Top five referral sources over time, October 2017 to October 2021

Engagement

Measures of engagement provide information about how users engage with the Head to Health website. These include the number of pages viewed per session, the average length of time spent on the website per session and the number of conversions. A conversion is the completion of a key or desired action, including search completions, SAM (chatbot) completions, emailing resources, and printing resources. Table 4 displays the Head to Health monthly engagement overall, and during non-campaign and campaign periods, from October 2017 to October 2021.

The overall mean number of pages viewed per session was quite low (1-2). The average time spent on the website per session was about 2.5 minutes. A relatively small number and proportion of sessions included a conversion (~ 10%).

Figures A6 to A9 in Appendix 3 display the monthly engagement with Head to Health, and include trend lines, from October 2017 to October 2021. These figures show that the number of pages per session, duration, and conversion rate have decreased over time, during both campaign and non-campaign periods.

The number of conversions has increased over time (until early 2021), with peaks during the 2020-2021 campaigns, which is overall a very similar trend to those observed for users, new users, total sessions and total views. The total number of conversions was higher in campaign than non-campaign periods.

There was a high negative correlation between number of users and duration (-0.83).

Table 4. Head to Health monthly engagement overall, and during non-campaign and campaign periods, October 2017 to October 2021

		Overall				Non-campaign		Campaign	
Measure	Description	mean	sd	min	max	mean	sd	mean	sd
Pages per session	Average number of pages viewed per session	1.673	0.168	1.430	2.346	1.723	0.163	1.570	0.131
Duration	Average length of time (seconds) spent on the website per session	152.4	31.16	79.25	216.5	166.7	21.44	123.1	27.61
Total conversions	Number of sessions in which key or desired actions are completed	5,609	3,322	1,654	13,912	4,142	955.4	8,635	4,345
Conversion rate	Proportion of sessions which include a conversion	0.103	0.0314	0.0267	0.160	0.110	0.0322	0.0880	0.0242

Note. Each conversion is counted only once per session – i.e. unique count of conversions. Thus, a user who makes 2 “search completions” and 2 “email resources” will be counted as having made two conversions only.

User feedback

Head to Health website users can give feedback on the utility and quality of the website overall and the individual pages within it. Two sets of questions are offered to users; one set relates to the Head to Health website overall, and the other set relates to the specific page/content being accessed. These questions can be accessed by users by clicking the ‘Feedback’ tab in the lower right section on each page of the website. Within both sets of feedback items are the following ‘overall’ questions that allow an overall website/page appraisal from users including:

1. How do you rate your overall experience on Head to Health? (website feedback item);
2. How do you rate the home page overall? (page feedback item for the home page);
3. How do you rate this page overall? (page feedback item for content/topic pages within the website (e.g., ‘Covid 19 Support’, ‘What helps us thrive?’);
4. How do you rate the search page overall? (page feedback item for the search page);
5. How do you rate Sam the Chatbot overall? (page feedback item for the chatbot).

From July 2021, the overall items have been rated on the following scale: ‘terrible’, ‘bad’, ‘okay’, ‘good’, ‘great’. Before this time, the overall items were rated as either ‘could be much better’, ‘could be better’, ‘okay’, ‘good’ or ‘great’. In our analysis, all ‘could be much better’ and ‘could be better’ responses were relabelled as ‘terrible’ and ‘bad’, respectively.

Relative to the tens of thousands of Head to Health website users and sessions each month, only a very small number of feedback responses (less than 1000) have been provided over the life of the website.

Figure 4 displays the percentage of ratings for each point of the scale by the type of overall feedback item, for all years combined (2017-2021). Only data for the first three feedback items listed above are displayed (because less than 10 users per year on average gave feedback on the search page and chatbot). Around 50% of overall Head to Health website ratings were positive (i.e., ‘good’ or ‘great’). Around 40% of ratings were positive for the home page and website content pages.

Figure 4. Head to Health website user feedback – overall, home page and content pages, October 2017 to October 2021

The feedback questionnaires also include some items that allow users to record if they would recommend the website or pages within the website to others as follows:

1. Would you recommend us to someone else? (website feedback item);
2. Would you recommend this page to someone else?' (page feedback item for content/topic pages within the website);
3. Would you recommend Sam the chatbot to someone else? (page feedback item for chatbot?).

Responses to these items are rated on a scale of ‘0 – Not at All’ to ’10 – Absolutely!’. For the purposes of analysis, a rating of seven or more was considered a ‘recommendation’, allowing the percentage of responses that were recommendations to be calculated.

Figure 5 displays the percentage of responses recommending the Head to Health website – overall, specific pages and the chatbot over the life of the website (2017-2021). The frequency (n) of recommendation responses are also provided. Overall, 46% of responses recommended the website, 28% recommended specific webpage topics/content and 28% recommended the chatbot.

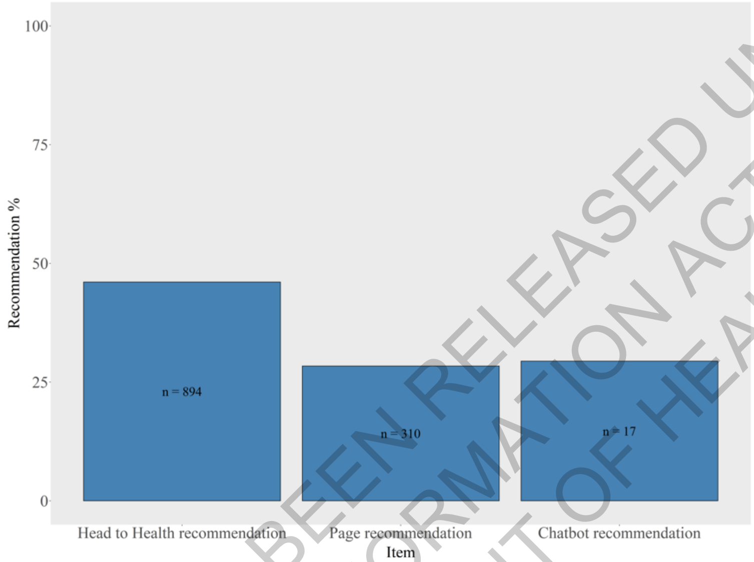

Figure 5. Percentage of responses recommending the Head to Health website – overall, specific page and chatbot, October 2017 to October 2021

Figure 6 displays the percentage of responses recommending the Head to Health website (N = 985) and specific pages (N = 385) by year. The percentage of responses recommending the Head to Health website gently fluctuates around 50% from year to year. Slightly lower recommendation percentages are evident for webpage topics/content. Chatbot data are not represented due to small numbers.

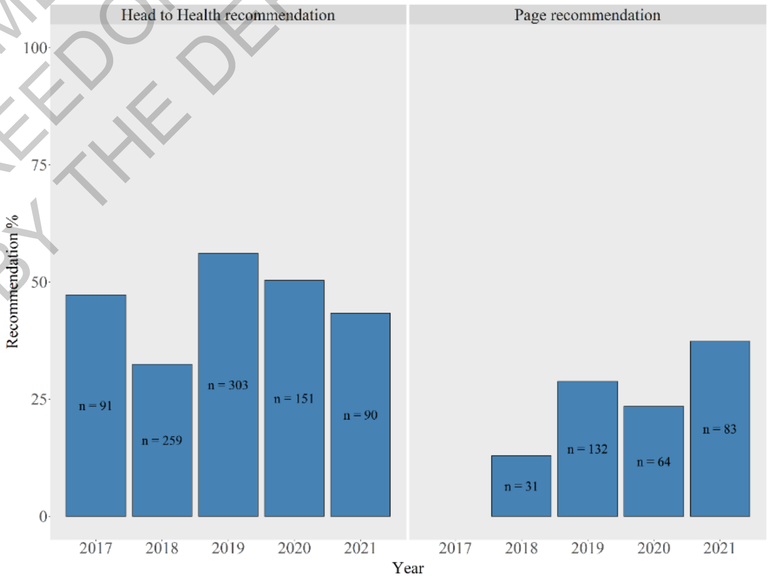

Figure 6. Percentage of responses recommending the Head to Health website and specific page by year, October 2017 to October 2021

Page helpfulness

Appendix 3 provides details on the source of data on page helpfulness that is the focus of this section. As with the user feedback data, only a very small number of helpfulness responses have been provided over the life of the Head to Health website.

Figure 7 shows the percentage of responses in which the page was endorsed as helpful by year (2017-2021). Page helpfulness was steady over time at around 75%.

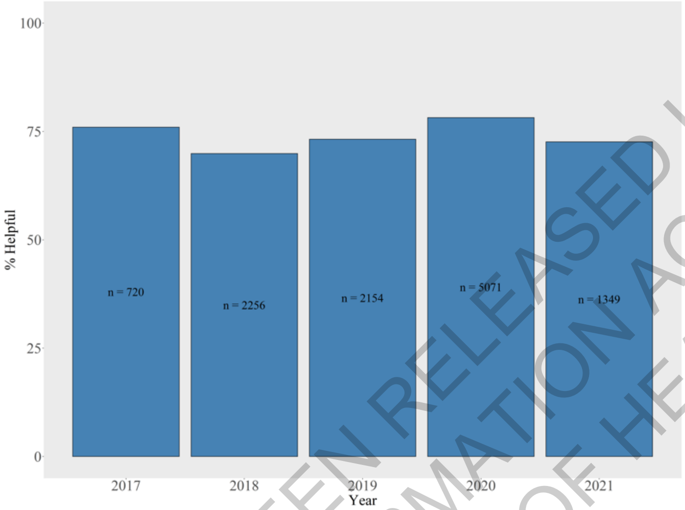

Figure 7. Percentage of responses endorsing a Head to Health website page as helpful by year, October 2017 to October 2021

Figure 8 displays the percentage of webpage ratings that were helpful by webpage topic category over the life of the Head to Health website, excluding any topic categories with <10 responses. The N in the figure below (the denominator) is the number of occasions that the pages under these topic headings were rated for helpfulness (i.e., the number of rating events). The Y axis is the percentage of all ratings that were helpful (i.e., 100 * (helpful ratings/total ratings). It can be seen that the *Meaningful life* topic was the most rated (N = 4844) and, excluding topics with <10 responses, the *For health professionals* topic was the least rated (N = 77) in terms of helpfulness. Each topic was more likely to be rated as helpful than not helpful, with each topic endorsed as helpful in around 60-80% of occasions.

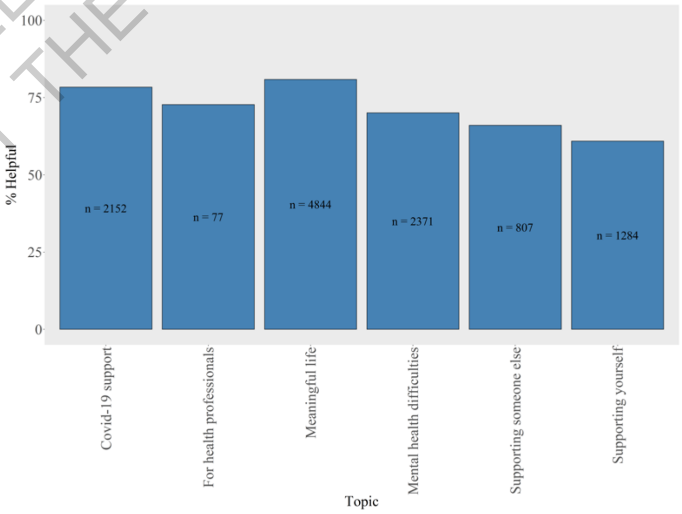

Figure 8. Proportion of webpages endorsed as helpful by topic, October 2017 to October 2021

Figure 9 displays the percentage of webpage ratings that were endorsed as helpful by webpage subtopic category over the life of the Head to Health website, excluding any subtopic categories with <10 responses. It shows that the subtopics most frequently (> 75%) rated as helpful were: What helps us thrive (Meaningful life), Chatstarter (COVID-19 support), Find support that works for you (COVID-19 support), Domestic violence (Supporting yourself) and Self-harm (Mental health difficulties). It should, however, be noted that for four of these five subtopics the total number of ratings in either direction was only $n \leq 66$; whereas the total number of ratings for What helps us thrive (Meaningful life) was more substantial at 2027. The three subtopic pages least endorsed as helpful (in < 50% of ratings) were Impacts on everyday life (COVID-19 support), COVID-19 support (Mental health difficulties) and Seeking support (Supporting yourself). However, these subtopics were rated on a relatively small number of occasions (n = 19, 76 and 110, respectively).

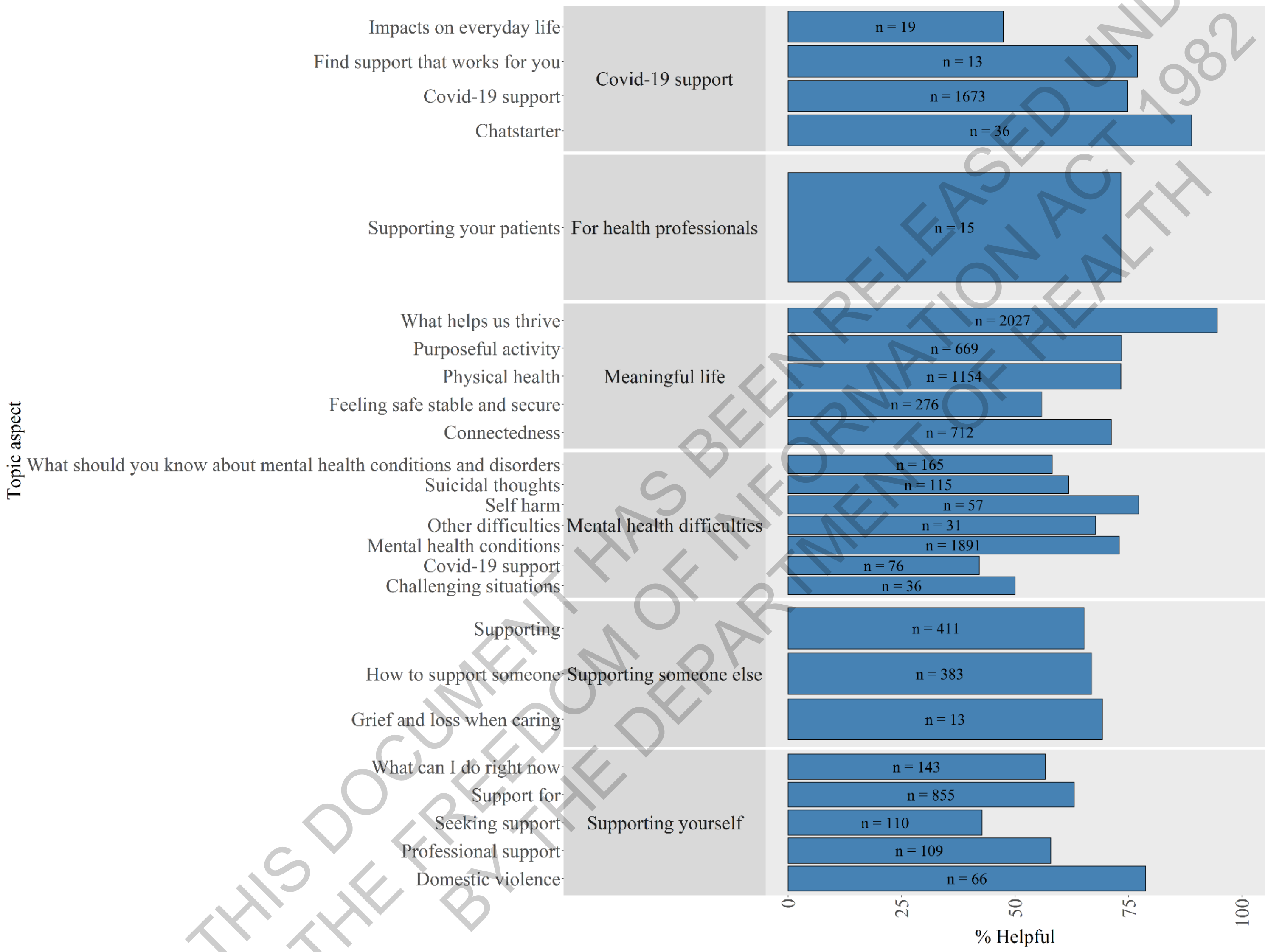

Figure 9. Proportion of webpages endorsed as helpful by subtopic, October 2017 to October 2021

Service data

Our approach

We requested monthly data from July 2014 to June 2021 on total number of unique website visitors and number of unique website visitors via Head to Health (October 2017-June 2021), and its predecessor mindhealthconnect (July 2014-September 2017), from three key Australian digital mental health services (DMHSs)– MindSpot, ThisWayUp and Mental Health Online. Mental Health Online provided data on ‘total’ and ‘new’ rather than unique visitors, and we chose to use ‘new’ users as the equivalent of ‘unique’ users for our analyses.

We calculated the proportion of website visitors via Head to Health and mindhealthconnect. We also produced plots showing the counts for each month over time and included a trend line to assess both short-term and long-term trends.

Findings

Overall service uptake and referrals from Health to Health

Table 5 provides data on the total number of visitors to each of the three DMHSs from July 2014 to June 2021 and the number of referrals from mindhealthconnect and/or Head to Health. It shows that, in the 3.75 year period (October 2017 to June 2021), Head to Health referred almost double the number of visitors to the websites of three key digital mental health services as mindhealthconnect in a 3.25 year period (July 2014 to September 2017; 69,595 cf 36,455). However, because the overall number of visitors to the websites of these services more than tripled, proportionally, there were fewer referrals from Head to Health than from mindhealthconnect (1% cf 2%).

Proportionally, the impact of mindhealthconnect and Head to Health has been the same for MindSpot (1.2% for both). By comparison, there was a decrease in the percentage of referrals to ThisWayUp and an increase in the percentage of referrals to Mental Health Online from Head to Health compared with mindhealthconnect (3.1% cf 0.5% and 7.0% cf 8.0%, respectively).

Table 5. Total visitors, and referrals from Head to Health/mindhealthconnect, to DMHSs, July 2014 to June 2021

	MindSpot	ThisWayUp	Mental Health Online	Total
Jul 2014-Sept 2017 (3.25 years)				
Total number of visitors	1,021,566	563,619	101,905	1,687,090
Number of referrals from MHC	11,767	17,461	7,227	36,455
Percentage of referrals from MHC	1.15%	3.10%	7.09%	2.16%
Oct 2017-Jun 2021 (3.75 years)				
Total number of visitors	1,787,745	5,343,793	238,572	5,363,235
Number of referrals from H2H	21,620	28,760	19,215	69,595
Percentage of referrals from H2H	1.21%.	0.54%	8.05%	1.30%
Jul 2014-Jun 2021 (7 years)				
Total number of visitors	2,809,311	5,907,412	340,477	8,427,933
Number of referrals from MHC/H2H	33,387	46,221	26,442	100,161
Percentage of referrals from MHC/H2H	1.19%.	0.78%	5.64%	1.19%

H2H, Head to Health; MHC, mindhealthconnect.

Trends over time in monthly service uptake and referrals from Head to Health

Table 6 provides the mean monthly uptake of the three DMHSs and the mean monthly proportions referred via Head to Health/mindhealthconnect.

Like the data on total numbers of visits, the mean monthly proportions show that for:

- MindSpot the mean monthly proportion of referrals from mindhealthconnect and Head to Health were about the same (1.3% cf 1.2%);
- ThisWayUp the mean monthly proportion of referrals from Head to Health was smaller than that attributable to mindhealthconnect (5.1% cf 0.8%);
- Mental Health Online the mean monthly proportion of referrals from Head to Health was somewhat larger than that attributable to mindhealthconnect (8.9% cf 8.4%); and
- All three services combined the mean monthly proportion of referrals from Head to Health was smaller than that attributable to mindhealthconnect (4.9% cf 3.6%).

Figures 10-12 display the monthly proportion of website visitors referred via Head to Health or mindhealthconnect from July 2014 to June 2021, and include a trend line.

For MindSpot, the trend line suggests that the proportion of referrals appeared to increase over the Head to Health time period (from October 2017 until June 2021), with a maximum monthly proportion of 3%. The trend for This Way Up was less clear but the trend line suggests that the proportion of referrals over the Head to Health time period appeared to initially decrease (October 2017 until July 2018), then remain steady for some time (until around November 2020) when there was a sharp increase for 4 months (to 3%), before dropping back to the previous steady proportion of about 1%. For MHO, the trend line suggests that the proportion of referrals appeared to be relatively stable for the initial Head to Health time period (from October 2017 until about April 2021), and then decrease, although there was considerable fluctuation during the entire Head to Health period with minimum monthly proportion of 3% and a maximum of 18%.

Table 6. Mean monthly uptake of digital mental health services, overall and via Head to Health/mindhealthconnect, July 2014 – June 2021.

	MindSpot		ThisWayUp		MHO*		All	
	mean	sd	mean	sd	mean	sd	mean	SD
Jul 2014-Sept 2017 (3.25 years)								
Number of unique website visitors during MHC period	26,194	8,186	14,452	11,971	2,613	853.4	14,420	12,752
Number of unique website visitors referred from MHC	301.7	143.0	447.7	96.43	0	0	249.8	211.7
Proportion of unique website visitors referred from MHC	0.0132	0.00814	0.0507	0.0293	0.0841	0.0694	0.0493	0.0522
Oct 2017-Jun 2021 (3.75 years)								
Number of unique website visitors during H2H period	39,728	8,540	118,751	52,842	5,302	2,179	54,593	56,699
Number of unique website visitors referred from H2H	480.4	262.1	639.1	359.4	427	151.0	515.5	283.9
Proportion of unique website visitors referred from H2H	0.0121	0.00560	0.00756	0.00760	0.0893	0.0330	0.0363	0.0425
Jul 2014-Jun 2021 (7 years)								
Total number of unique visitors	33,444	10,745	70,326	65,453	4,053	2,161	35,941	46,845
Number of unique website visitors referred from MHC/H2H	397.5	232.0	550.3	286.3	314.8	174.2	420.8	253.9
Proportion of unique website visitors referred from MHC/H2H	0.0126	0.00687	0.0276	0.0298	0.0869	0.0528	0.0424	0.0476

H2H, Head to Health; MHC, mindhealthconnect; MHO, Mental Health Online
*Data from MHO are counts of new website visitors (not unique website visitors).

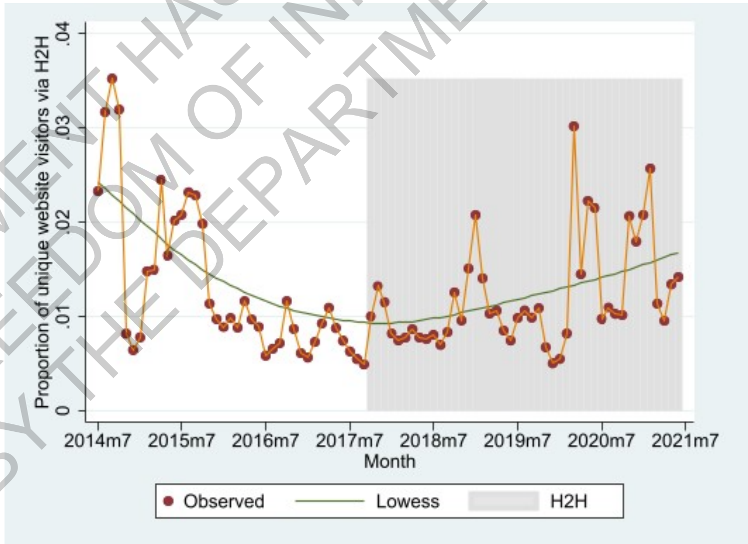

Figure 10. Monthly proportion of MindSpot unique visitors referred from mindhealthconnect or Head to Health, July 2014 to June 2021

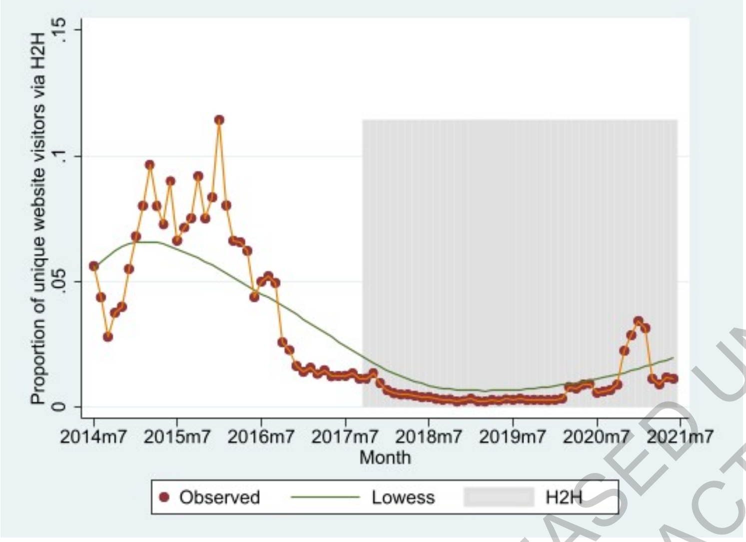

Figure 11. Monthly proportion of ThisWayUp unique visitors referred from mindhealthconnect or Head to Health, July 2014 to June 2021

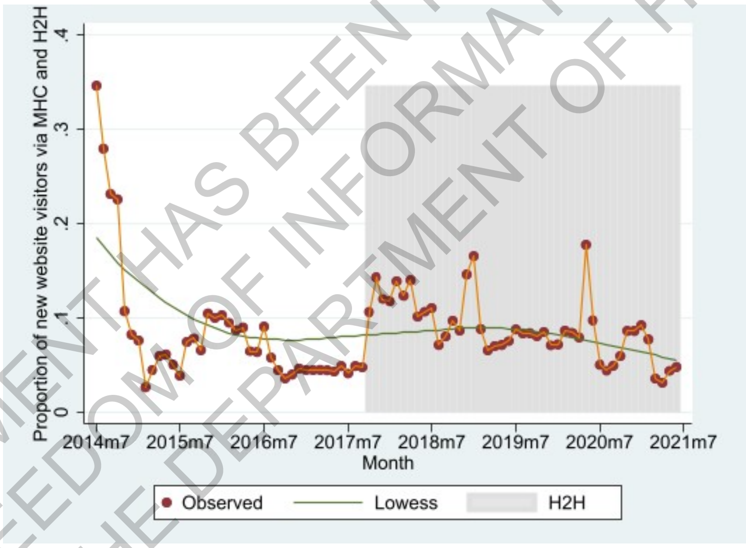

Figure 12. Monthly proportion of Mental Health Online unique (new) visitors referred from mindhealthconnect or Head to Health, July 2014 to June 2021

Preliminary findings: Cost-outcome

Our approach

We examined both the costs and outcomes of Head to Health. The costs associated with delivering Head to Health were based on internal financial and budgeting documents obtained from the Department of Health. These costs were separated into six categories – operations (includes staffing), technology and infrastructure, marketing, governance, capital purchases and COVID-19 enhancements – and aggregated by financial year from 2017-18 to 2020-21. The outcomes used in this cost-outcome description were number of visits to the Head to Health Gateway, unique visitors, conversions, completion rate, search rate and bounce rate. We used monthly data totalled and averaged for each financial year to enable meaningful comparisons between costs and outcomes, including cost per unit of outcome.

Findings

Costs by financial year, 2017-18 to 2020-2021

Table 7 presents the costs associated with Head to Health by financial year. The majority of the costs were related to technology and infrastructure expenditure, primarily from the engagement of an external website delivery partner (Speedwell/Liquid). Operations expenditure, including staffing, was on a general decline from 2017-18 onwards until a significant increase in 2020/21. Expenditure related to enhancing the Head to Health website with COVID-19 materials formed 9-10% of the total costs in the last two financial years. Since its inception, the total costs of delivering Head to Health amounted to approximately $17 million, with the highest annual cost incurred in 2017-18 at $8.2 million.

Outcomes by financial year, 2017-18 to 2020-2021

Table 8 presents selected outcomes from Head to Health by financial year. It should be noted that data were not available for July, August and September in the financial year 2017-18 because Head to Health was not yet operational then. The numbers of visits, unique visitors, new users and conversion have grown over time, with the highest year-on-year growth occurring between 2017-18 and 2018-19, ranging from 80 to 118 percent. On the other hand, the pages sessions, duration and service finder search rate declined from 1.84, 168.60 and 0.06 in 2017-18 to 1.53, 125.65 and 0.04 in 2021-21, respectively. The completion rate improved between 2017-18 and 2018-19 but has declined slightly since then. The bounce rate generally decreased from 2017-18 to 2020-21.

Cost-outcome by financial year, 2017-18 to 2020-2021

The cost per unit for the majority of outcomes decreased between 2017-18 and 2020-21, indicating efficient usage of budget in the delivery of Head to Health. Figure 13 presents the cost per unit of visit, unique visitor, new users and conversion during the study period. In 2017-18, the cost per visit, per unique visitor and per new user were $30.82, $38.07 and $39.91, respectively, while the cost per conversion was $288.70. All three metrics experienced a significant decline by 2020-21, with the cost per visit, per unique visitor and per new user dropping by approximately 90% to $2.91, $3.57 and $3.74, respectively, while the cost per conversion dropped by 88% to $35.57. Based on the current data available to the evaluation team, there is evidence to suggest efficiency of resource use from the allocated budget. However, further evaluation is necessary to determine the cost-effectiveness of Head to Health.

Table 7. Costs of delivering the Head to Health from 2017-18 to 2020-21

Category	2017-18		2018-19		2019-20		2020-21	
	$	%	$	%	$	%	$	%
Technology & Infrastructure	5,205,416	63	1,417,923	43	1,500,000	74	1,900,000	58
Operations	701,139	9	388,783	12	300,000	15	600,000	18
Governance	703,694	9	.	0	.	0	.	0
Marketing	276,691	3	376,710	11	4,000	0	500,000	15
Capital Purchases	1,354,775	16	1,104,901	34	.	0	.	0
COVID-19 Enhancements	.	0	.	0	210,113	10	300,000	9
Total	8,241,715	100	3,288,317	100	2,014,113	100	3,300,000	100

Table 8. Selected outcomes of Head to Health from 2017-18 to 2020-21

Outcomes	2017-18		2018-19		2019-20		2020-21	
	Total	Monthly average	Total	Monthly average	Total	Monthly average	Total	Monthly average
Visits	267,392	29,710	487,371	40,614	888,086	74,007	1,137,632	94,803
Unique visitors	216,515	24,057	391,538	32,628	731,215	60,935	923,188	76,932
New users	206,501	22,945	371,341	30,945	704,171	58,681	883,197	73,600
Conversion	28,548	3,172	62,341	5,195	77,734	6,478	92,763	7,730
Completion rate	.	0.11	.	0.13	.	0.11	.	0.08
Service finder search rate	.	0.06	.	0.05	.	0.04	.	0.04
Bounce rate	.	0.27	.	0.24	.	0.25	.	0.23
Pages sessions	.	1.84	.	1.74	.	1.66	.	1.53
Duration	.	168.60	.	165.43	.	159.26	.	125.65

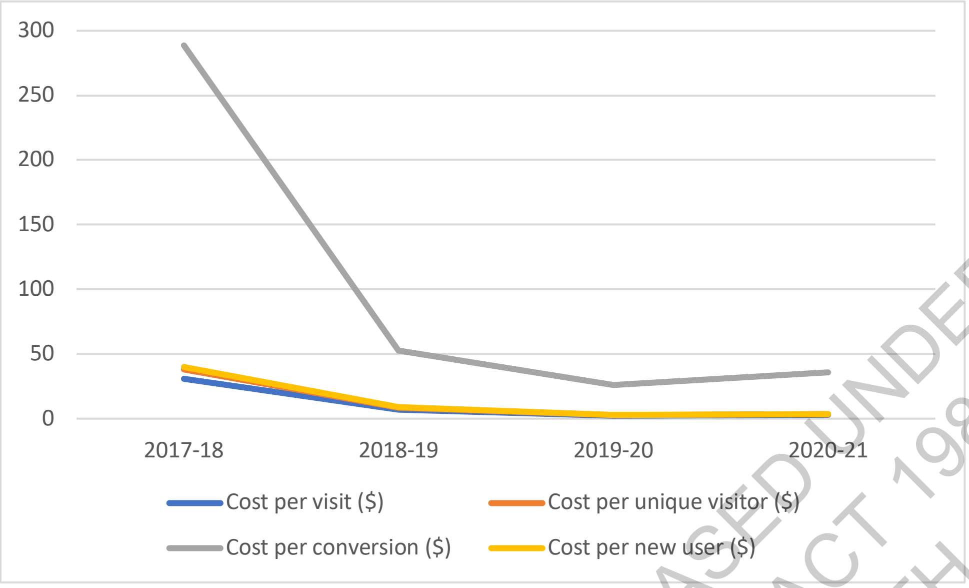

Figure 13. Cost per unit of outcome, 2017-18 to 2020-21

Preliminary findings: Secondary data from user survey

Our approach

We used secondary quantitative and qualitative data from a survey conducted by the Department of Health from 10 July 2019 to 18 November 2019. Visitors to the Head to Health website were invited to participate in an online survey, which included closed and open-ended questions about their demographics, reasons for accessing Head to Health, experience of using Head to Health, and feedback on features, ease of use, relevance and potential improvements of the website. A total of 258 individuals responded to the survey.

Findings

Socio-demographic characteristics of survey respondents

Table 9 shows the demographic characteristics of survey respondents. The majority of respondents were female (73%) and half were aged 35 years or younger. Over one quarter (27%) of respondents resided in NSW and 24 % in Victoria. Close to 20% resided in a rural or remote location. Forty-six percent of respondents had lived experience of mental illness. Twenty percent of respondents identified as LGBTIQ.

Table 9. Characteristics of survey respondents (N = 258)

Characteristic	Frequency	%
Gender		
Female	187	72.5
Male	60	23.3
Prefer not to answer	2	0.8
Self-described	9	3.5
Not answered	0	0
Age range		
Under 18 years	43	16.7
18-35 years	86	33.3
36-50 years	73	28.3
51-65 years	46	17.8
66-79 years	9	3.5
80 years or older	1	0.4
Not answered	0	0
State		
Australian Capital Territory	12	4.7
New South Wales	70	27.1
Northern Territory	3	1.2
Queensland	47	18.2
South Australia	23	8.9
Tasmania	7	2.7
Victoria	61	23.6
Western Australia	32	12.8
Not answered	2	0.8
Population groups identified with[a]		
Aboriginal and Torres Strait Islander	10	3.9
Culturally and linguistically diverse/ main language spoken at home is not English	21	8.1
Living in a rural or remote location	50	19.4
Lesbian, Gay, Bisexual, Transgender, Intersex and Queer people	51	19.8
Person who has personally experienced mental illness (lived experience)	120	46.5
Person with a disability	36	13.9
Person who provides unpaid care/support to family members/friends who have a disability, mental illness, chronic condition, terminal illness, an alcohol or other drug issue or who are frail aged (Carer)	42	16.3
Veteran	5	1.9
Not answered	65	25.2

[a] Multiple responses permitted.

Tables 10 and 11 show how respondents first heard about Head to Health and their reasons for visiting the website, respectively. As shown in Table 10, one third of respondents first heard about Head to Health through an internet search, with 17% hearing about it from a friend, co-worker or family member. Respondents who provided additional information (free text response) and indicated they heard about it elsewhere (n = 60), most commonly indicated they heard about it from their workplace (n = 18), a mental health service (n=10) or their school or educational institution (n = 10). The most commonly cited reason for visiting the website was to find mental health resources for oneself (39%) followed by finding mental health resources for a friend, family member or co-worker; and seeking resources for a client or patient (see Table 11). Of those who indicated they were visiting the website for another reason (n = 64), 20 indicated it was related to their schoolwork, 11 to activities at work and 10 to search for general information.

Table 10. How respondents first heard about Head to Health (N = 258)

Source	Frequency	%
Friend, co-worker or family member	45	17.4
A GP or health professional	20	7.7
Social media	33	12.8
Internet search (e.g., Google)	92	35.7
I don’t remember	11	4.3
Other (please specify)[a]	57	22
Not answered	0	0

[a] Sixty respondents provided additional information in the free text space.

Table 11. Reason for visiting Head to Health (N = 258)

Source	Frequency	%
I’m looking to find mental health resources for myself	100	38.8
I’m looking to find mental health resources for a friend, family member or co-worker	40	15.5
I’m a carer looking to find mental health resources for someone I care for	9	3.5
I’m a health professional or GP looking to find mental health resources for my client/patient	40	15.5
I am a service provider listed on Head to Health	6	2.3
Other[a]	63	24.4
Not answered	0	0

[a] Sixty-four respondents provided additional information in the free text space.

Head to Health user experiences

User experiences of Head to Health were assessed in a series of questions concerning ease of use, rating of the experience and likelihood of recommending the website. As shown in Table 12, 62% of respondents indicated that the website was easy or very easy to use, with less than 10% indicating it was very hard. Forty-three respondents provided further details about ease of use, with 22 of these respondents indicating information was limited and 10 respondents reporting other difficulties.

When asked about the extent to which they trusted the information and resources on Head to Health, 59% of respondents indicated a great deal or a lot of trust, 29% indicated a moderate level of trust and 5% indicated not at all trusting the information or resources (Table 13). Thirty individuals provided additional feedback on trust, 10 of whom cited missing information as inhibiting their trust in the site, and nine respondents provided further positive information that promoted their trust in the website.

Sixty percent of respondents rated their experience of using the Head to Health website as good or great, with around two-thirds reporting a relatively high likelihood (≥ 7/10) of recommending the website (see Tables 14 and 15). Thirty-one respondents provided additional feedback on their rating of the website, 15 of whom provided positive feedback, seven reported difficulties using the website, and four suggested updating or including additional information.

Forty participants responded to the question about recommending Head to Health to a client or patient experiencing mental health concerns. Over half of these respondents (52.5%) had not recommended the website.

Table 12. Ease of using Head to Health (N = 258)[a]

Level of ease	Frequency	%
Very easy	63	24.4
Easy	97	37.6
Neither easy or hard	60	23.3
Hard	14	5.4
Very hard	24	9.3
Not answered	0	0

[a]Forty-three respondents provided additional feedback in the free text space.

Table 13. Extent of trust in information and resources on Head to Health (N = 258)[a]

Level of trust	Frequency	%
A great deal	74	28.7
A lot	79	30.6
A moderate amount	75	29.1
A little	17	6.6
Not at all	13	5.0
Not answered	0	0

[a]Thirty respondents provided additional feedback in the free text space.

Table 14. Rating of experience of using Head to Health (N = 258)[a]

Rating	Frequency	%
Terrible	11	4.3
Bad	18	7.0
Okay	75	29.1
Good	93	36.0
Great	61	23.6
Not answered	0	0

[a]Thirty-one respondents provided additional feedback in the free text space.

Table 15. Likelihood to recommend Head to Health (N = 258)

Likelihood	Frequency	%
0 – not at all	16	6.2
1	5	1.9
2	10	3.9
3	6	2.3
4	12	4.6
5	28	10.8
6	12	4.6
7	23	8.9
8	39	15.1
9	25	9.7
10 – Absolutely	82	31.8
Not answered	0	0

Head to Health user needs

The most commonly used features of the Head to Health website were the topic and content pages (58%) and the search resources (57%) (Table 16). Thirty-seven respondents provided additional feedback on features. This feedback most commonly related to limited information provision (n = 17), poor website design (n = 8) and outdated or inappropriate information (n = 6).

Sixty-one percent of respondents found the resources to be extremely relevant or relevant and 8% indicated the resources were not at all relevant (Table 17). Thirty-three respondents provided additional feedback on resource relevance, with 11 respondents indicating missing information, six identifying gaps in certain digital resources and five mentioning barriers to using the recommended resources.

Table 16. Features used on Head to Health (N = 258)[a, b]

Feature	Frequency	%
Sam the Chatbot	51	19.8
Search resources	154	56.7
Save resources	33	12.8
Topic/content pages (e.g., Anxiety disorders, Depressive disorders, Contentedness, Purposeful activity etc.)	150	58.1
Not answered	41	15.9

[a]Multiple responses permitted.
[b]Thirty-seven respondents provided additional feedback in the free text space.

Table 17. Relevance of resources on Head to Health (N = 258)[a]

Relevance	Frequency	%
Extremely relevant	52	20.2
Relevant	106	41.1
Somewhat relevant	50	19.4
Not very relevant	18	7.0
Not at all relevant	21	8.1
Not answered	11	4.3

[a]Thirty-three respondents provided additional feedback in the free text space.

Twelve percent of respondents (n = 30) had recommended a specific digital mental health resource to a patient or client. Twenty-seven respondents provided further details about the services they recommended. Eight respondents had recommended Beyond Blue, six headspace, four SANE, and three each mentioned Head to Health, Lifeline, moodgym, and Beyond Now (multiple responses permitted). When asked if there were any reasons for, or barriers to, recommending digital mental health resources, five respondents provided further details related to a lack of awareness or experience using digital mental health resources.

Respondents were also asked about additional services, topics, features or other improvements they would like to see. Respondents (n = 133) made specific requests for additional content or resources, including information for specific disorders or subpopulations; and information about accessing face-to-face services, particularly based on location. Comments also included the need to improve the look and feel and ease of navigation of the website and its speed. Some respondents reported that the website was adequate as it was. Others expressed that the gateway needs to outline costs and other requirements for entry into suggested services, as well as including the voices of those with lived experience, for example, in providing user ratings of services. Others also commented on needing to further refine both chatbot and search functionality and to ensure that suggestions are tailored to the individual.

Preliminary findings: Head to Health user surveys

Our approach

We used data from a survey we have been conducting from 8 December 2021 to date. Visitors to the Head to Health website were invited to participate in an online survey, which included closed and open-ended questions about their demographics and experience of using Head to Health. The survey has also been widely promoted by the Department of Health, eMHPrac, the Black Dog Institute and our own University of Melbourne website. Selected findings from these in-progress surveys are reported in this section.

Findings

Consumers

Characteristics of Head to Health consumer survey respondents

In total, 45 consumers have completed the survey to date and Table 18 describes their demographic characteristics and internet access. The majority of consumers were female (64%), under the age of 50 years (69%) and were residing in New South Wales (NSW) (42%). Eighty-five percent of consumers had reliable internet and 73% used the National Broadband Network to access the internet.

Table 18. Consumer survey respondent characteristics (N = 45)

Characteristic	Frequency	%
Gender		
Male	14	31
Female	29	64
Missing	2	4
Age		
16-17 years	1	2
20-29 years	12	27
30-39 years	9	20
40-49 years	9	20
50-59 years	2	4
60-69 years	9	20
70-79 years	2	4
Missing	1	2
State		
Northern Territory	2	4
New South Wales	19	42
Victoria	8	18
Queensland	7	16
South Australia	7	16
Western Australia	1	2
Missing	1	2
Type of internet		
ADSL or ADSL2+	1	2
National Broadband	33	73
Satellite Connection	2	4
Wireless Router	7	16
Mobile Broadband	5	11
Other	3	7
Reliability of internet		
Unreliable all the time	2	4
Unreliable most of the time	3	7
Unreliable/reliable some of the time	1	2
Reliable most of the time	22	49
Reliable all the time	16	36
Missing	1	2

Consumer experiences of the Head to Health website

Consumers were asked about their experiences of using the Head to Health website. Their responses are recorded in Table 19. Fifty-five percent of consumers were aware of the Head to Health website, however, 51% had never used it. Consumers who were aware of the website indicated that they found out about it primarily through an online search.

The 20 consumers who had used the Head to Health website indicated that their use of the website had been infrequent. Sixty percent of consumers were first-time users and 30% had used it between 1 and 5 times. Most commonly, consumers spent less than 20 minutes on the website. The most common reasons for using the website included struggles with coping, wanting to access information for family and friends, and needing professional help.

Overall, 20% of consumers reported that they were 'satisfied' or 'very satisfied' with the Head to Health website, and 35% would recommend it to others (25% 'somewhat agreed' and 10% 'strongly agreed').

Table 19. Consumer experiences of the Head to Health website

Aspect of experience	Frequency	%
Method of finding Head to Health (n = 45)		
Online search	19	42
Health provider recommended	1	2
Heard of Head to Health but not used	5	11
Have not heard of or used Head to Health	18	40
Missing	2	4
Frequency of use of Head to Health (n = 20)		
First time	12	60
Used 1 to 5 times	6	30
Used 6 to 10 times	1	5
Used 11 or more times	1	5
Time spent on Head to Health (n = 20)		
Less than 10 minutes	9	45
10 to 20 minutes	1	5
20 to 30 minutes	4	20
30 to 40 minutes	1	5
Over 40 minutes	1	5
Missing	4	20
Reason(s) for accessing Head to Health (n = 20)[a]		
Was not coping	9	45
To access information for a family member /friend	7	35
Needed professional help	4	20
Symptoms were getting worse	3	15
Experienced a crisis or traumatic event	3	15
Family /friend suggested it	1	5
Health professional referred me	1	5
Other	6	30
Satisfaction with Head to Health (n = 20)		
Not at all satisfied	5	25
Somewhat satisfied	4	20
Satisfied	1	5
Very Satisfied	3	15
Missing	7	35
Would recommend Head to Health to others (n = 20)		
Strongly disagree	1	5
Somewhat disagree	2	10
Neither agree nor disagree	6	30
Somewhat agree	5	25
Strongly agree	2	10
Missing	4	20

[a] Multiple responses permitted.

Providers

Characteristics of Head to Health provider survey respondents

In total, seven Head to Health providers completed the survey. Table 20 describes their demographic and professional characteristics. Most providers were female (86%). Approximately 60% were aged 20-39 years, were from New South Wales (NSW) and had over 10 years of experience. Approximately 60% of providers were either GPs or social workers. Other less common professions included psychologists and nurses. Providers worked in a variety of mental health settings including private practice, not-for-profit community organisations, general practice and public hospitals. Most providers described their internet as reliable and used either the National Broadband Network or a wireless router to access the internet.

Table 20. Provider survey respondent characteristics (N = 7)

Characteristic	Frequency	%
Gender		
Female	6	86
Male	0	0
I do not identify with either term	1	14
Age		
20-29 years	3	43
30-39 years	1	14
60-69 years	0	0
50-59 years	1	14
60-69 years	2	29
Aboriginal or Torres Strait Islander		
Aboriginal	1	14
Torres Strait Islander	0	0
Neither Aboriginal nor Torres Strait Islander	6	86
State		
Northern Territory	2	29
NSW	4	57
Victoria	1	14
Profession		
GP	2	29
Clinical psychologist	1	14
Social worker	2	29
Other (Mid-wife, school nurse)	2	29
Years of experience		
Less than 1 year	1	14
1-5 years	2	29
6-10 years	0	0
11-15 years	1	14
16-20 years	0	0
More than 20 years	3	43
Type of organisation		
Face-to-face mental health service	3	43
Telephone mental health service	3	43
Private practice – mental health	2	29
Not-for-profit community organization	1	14
General practice	1	14
Public hospital	1	14
Other (public school)	1	14
Type of internet		
Wireless router	3	43
National Broadband Network (NBN)	4	57
Mobile broadband	1	14
Reliability of internet		
Reliable most of the time	6	86
Unreliable/reliable some of the time	1	14

Provider experiences of using the Head to Health website

Providers were asked about their experiences of using the Head to Health website. Their responses are recorded in Table 21. Providers found out about the Head to Health website through a variety of sources including online searches, workplace recommendations, flyers, eMHPrac and other continuing professional development (CPD) activities. Providers varied in their frequency of using the website. One provider had used it on a single occasion, three used it between 1 and 10 times and two used it over 11 times. Most commonly, providers used the website to access information and resources for themselves (71%) or their clients (56%). Most providers spent under 20 minutes engaging with the website, with 43% of providers spending under 10 minutes on the website.

Table 21. Provider experiences of using the Head to Health website (N = 7)

Aspect of experience	Frequency	%
Method of finding Head to Health		
Online search	1	14
Recommended by workplace	1	14
Other, please specify (Flyer, eMHPrac Project, CPD)	3	43
Missing	2	29
Previous experience with Head to Health		
This is the first time I have used it	1	14
I have used it between 1 and 5 times	2	29
I have used it between 6 and 10 times	1	14
I have used it more than 11 times	2	29
Missing	1	14
Reasons that prompted you to visit the website[a]		
To find resources for myself as a health professional	5	71
To find information, support or services for a client	4	57
To find information, support or services for a family member or friend	1	14
How long did you spend using the Head to Health?		
Less than 10 minutes	3	43
10 to 20 minutes	3	43
Missing	1	14
Satisfaction with Head to Health		
Not at all	0	0
Somewhat satisfied	1	14
Satisfied	1	14
Very satisfied	3	43
Completely satisfied	0	0
Missing	2	29
Frequency of recommendation of Head to Health		
Never	0	0
Occasionally	2	29
Frequently	3	43
Missing	3	43
Whether Head to Health benefited clients/patients		
Yes	4	57
No	1	14
Missing	2	29

[a] Multiple responses permitted.

Overall, 57% of providers reported that they were satisfied or very satisfied with the Head to Health website. Approximately 70% of providers occasionally or frequently recommend the website to clients. Sixty percent of providers reported that the website has benefited clients under their care and one provider (14%) indicated that it had no benefits. As described in Table 22, the most common benefits for clients include reduced costs associated with care, improved access to information, improved convenience of care and improved mental health and wellbeing. Other less frequently described benefits included improved access to care, privacy, and reduced wait-times for care.

Table 22. Provider perceived benefits of the Head to Health website for clients (N = 7)

Benefit	Frequency	%
Reduced costs associated with care	4	57
Improved access to information	3	43
Improved convenience of care	3	43
Improved mental health and wellbeing	3	43
Improved privacy	2	29
Improved waiting times for services	2	29
Improved access to care	1	14

Providers were also asked if the Head to Health website had had negative impacts for clients under their care. Only five of seven providers answered this question, and all indicated that the website had no negative impacts for clients.

Preliminary findings: Community conversations

Our approach

We conducted three online community conversations using a modified World Café method.[4] Each conversation involved 4-8 people who identified as consumers or carers, and was held during November 2021, using Zoom.

These community conversations were combined with discussion of supported online mental health services to reduce participant burden. The conversations focused on four areas:

1) What are the strengths or enablers for use of the Head to Health website?
2) What are the weaknesses or barriers for use of the Head to Health website?
3) How effective is the Head to Health website, particularly for different groups e.g., symptom severity, cultural diversity, socioeconomic background etc.?
4) What are the:
    a. Most important features to create the optimal Head to Health Digital Gateway;
    b. Least important features to create the optimal Health to Health Digital Gateway?

Methods and analysis details are provided in Appendix 4.

Findings

Participant characteristics

Table 23 presents the demographic characteristics of the 16 participants in the three community conversations. One participant did not provide any demographic or service use data, and one did not provide their age.

The demographics demonstrate participation by a range of people, representing multiple genders and age groups. Four participants were located in regional areas and none in remote locations, and all but two used the NBN to access the internet. None of the participants identified as Aboriginal or Torres Strait Islander, but during discussions, several identified strongly as Culturally and Linguistically Diverse or reported disabilities.

Participants' familiarity with online mental health services was mixed. Only three reported that they had not used digital mental health services, but half reported that they had not heard of the Head to Health website, and only four of the 16 reported ever using it. Therefore, community conversation facilitators accessed the website and shared their screens with participants to facilitate exploration in real time.

Table 23. Demographic characteristics of community conversation participants (N = 15)[a]

Characteristic	Frequency	%
Gender		
Male	7	46.7
Female	5	33.3
Non-binary	3	20.0
Age[b]		
<20	2	13.3
20-29	5	33.3
30-39	3	20.0
40-49	2	13.3
50-59	1	6.7
60-69	1	6.7
Location		
Major cities	11	73.3
Inner regional	2	13.3
Outer regional	2	13.3
Type of internet		
NBN	13	86.7
Wireless	1	6.7
Mobile	1	6.7
Used digital services		
Yes	12	80.0
No	3	13.3
Heard of Head to Health Digital Gateway		
Yes	7	46.7
No	8	53.3
Used Head to Health Digital Gateway		
Yes	4	26.7
No	11	73.3

[a] An additional participant did not provide any demographic information.
[b] One participant did not provide their age.

Strengths of the Head to Health website

Discussions about the strengths of the Head to Health website focused mainly on user friendliness and the scope of content. Since most participants had never used the site, their experience was limited to demonstration of its functionality during the community conversations, with little time to explore its content and functionality in any depth. Many participants commented that the site has a warm, user-friendly feel and is easy to use. They particularly appreciated the comprehensive menu system that allowed drilling down to specific information, the ability to bookmark important parts, and that the site is mobile friendly. They commented that it is "not a typical government website." They were impressed by the comprehensive information presented on a very broad range of issues, including specific disorders and COVID-19, and thought that the site was a trustworthy starting point for people seeking information and links to professionals for mental health issues. The full word clouds created in each conversation are contained in Appendix 4.

Weaknesses of the Head to Health website

The weaknesses of the website and barriers to its use tended to mirror the strengths. The largest focus of discussion was on user friendliness, and in particular the nature of the content, its organisation and the overall feel. Although some users had found the breadth and depth of content a strength, others felt that the website was too broad and overwhelming to navigate. Some content, particularly regarding LGBTIQ+ populations was reported to be outdated, and other areas too focused on self-help and information rather than providing a true gateway to mental health services. The cartoon characters were particularly unpopular, described as "Humpty Dumpty people" that infantilised or patronised people with mental health problems and made it feel like the website did not take these issues seriously.

The other major area considered to be a barrier was accessibility. There were concerns about the Head to Health Digital Gateway being the major way of gaining information and referral within the system when there were people without access to technology such as smartphones and the internet. As a gateway, people were uncertain whether the Head to Health website was meant to be a primary point of entry to the entire system, and were thus concerned that it may systematically exclude some of the most vulnerable who did not have reliable technology. Likewise, the accessibility of the design was questioned for people with vision impairment. Finally, the diversity of appeal and accessibility to people from different cultural backgrounds was questioned due to the complexity of the English used, and the limited translations available. The figure holding the tiny Aboriginal and Torres Strait Island flags was commented on as "tokenistic."

One group focussed on the crisis and suicide resources on the website, which is a critical area of any mental health resource. They commented that the crisis resources were not as easy to find as possible and were too superficial. This group also thought that the website would benefit from involving peers in co-designing the platform.

Appendix 4 contains the word clouds for barriers.

Effectiveness of the Head to Health website

In the third session, participants were asked to consider the effectiveness of the Head to Health website, especially for different groups such as those from different cultural backgrounds or with different levels of mental health problem severity. Consistent with the discussions about strengths and weaknesses, the breadth of the website was viewed as a double-edged sword. Participants described the website as a broad and credible gateway that was particularly well-suited to providing general introductory information and may appeal to family members or those new to mental health who were seeking this type of information. However, they observed that there was not sufficient tailoring for those with complex needs, who frequently miss out in "one-size-fits-all" approaches and may need their own section or even website to cover information and programs relevant only to people with severe illness and complex needs. Further, there was concern that specific groups such as Aboriginal and Torres Strait Islander peoples, those who identify as LGBTIQ+ and those from different cultural backgrounds may feel "alienated" by the website due to the relative lack of information specific to these groups.

Some participants thought the volume of information was overwhelming, but at the same time felt that some issues and specific apps were not described well enough. This reduced the website's effectiveness as they struggled to navigate to what was needed, then the website did not have enough depth to the information on the topics in which they were interested. They suggested it would be helpful to add further layers of detail to drill down on all mental health issues, not just the most common, again to reduce the sense of being excluded if not in a majority group. They also suggested it would increase the website's effectiveness and profile as a gateway if the information also included referrals or searchable databases of physical services rather than just digital services, and had a section on peer services.

The other major area of focus was on accessibility. As for the weaknesses, there was concern that the literacy and digital literacy required to use the website may exclude some users. Participants described the overall language as quite clinical or pathologising, with both complex language and an approach to mental health that many with lived experience do not favour. Some also found navigation difficult, and were unsure they were getting the information they needed. Further, there were concerns that people from non-English speaking backgrounds or with disabilities may not be able to effectively interact with the website due to its complex language and setup.

The word clouds containing all the suggestions for effectiveness are included in Appendix 4.

What would an optimal Head to Health website look like?

In the final session, participants were provided with the word clouds produced in the strengths, weaknesses and effectiveness discussions and asked to consider what they thought an optimal Head to Health website would include. They were informed that the website was under redevelopment and encouraged to consider the features that would be useful to include in an ideal world, along with those they would like to see removed.

Interest for the most important features focused primarily on design and navigation. Participants wanted a visually appealing website with use of calming colours, and that is less childish-looking. They wanted information to be comprehensive but organised in a way that is not overwhelming and assists them to find the depth they need. Some suggested that addition of live chat or interaction with a real person rather than a robot would assist with this. They also stated that an ideal website should be accessible to everyone, so easy to read (e.g., compatible with screen readers).

The second major area that was described as most important was the overall focus of the website. Participants described the Head to Health Digital Gateway as an "opportunity to normalise, to reduce stigma and self-stigma, and promote help-finding," but thought it was largely missing this opportunity by using a deficit-based, medical approach. They wanted to see better information that normalises mental health issues and recovery, and connects to options beyond mainstream mental health approaches, such as peer services.

The final area on the wish list of most important features was links to physical (real world) services such as mental health professionals, support groups and non-digital tools. Participants were unsure of the scope of the digital gateway, but thought that describing it as a "gateway" implied that there was more than just basic digital health links to be found.

Discussion of the least important features was more limited, and focused on the few issues about which participants felt most strongly. They suggested that the medical jargon and complex language needed to be removed, replaced with plain language and recovery-oriented information that deals with topics in sufficient depth. They also wanted the cartoon figures replaced with something less childish and with broader appeal. One group also disliked the chatbot, suggesting that interacting with a robot when in distress was not useful.

The full lists of most and least important features are included in Appendix 4.

Interim summary and conclusions

Summary

This section summarises findings from all the data sources used in this interim report according to the six KEQs. Note that KEQs are addressed by different combinations of, and not necessarily all, data sources.

KEQ 1: How effective has Head to Health been to date and what can we learn from it?

Data from Head to Health google analytics, website analytics from three key digital mental health services and community conversations with lived experience participants contribute to addressing KEQ 1.

Google analytics data

From October 2017 to October 2021, the mean number of unique users per month was 50,694, and almost all appeared to be new users (mean = 48,509). The mean number of sessions was 62,357, and the mean number of views per month was 97,235. This suggests that the monthly mean uptake has halved compared with equivalent monthly average data for mindhealthconnect from February to June 2017 (e.g., 103,136 unique users; 185,140 page views).[2] Although uptake figures were higher during campaign periods (e.g., 84,620 unique users; 151,162 page views), these were still below the mindhealthconnect equivalent monthly averages from February to June 2017.[2]

However, the Head to Health average monthly bounce rate over its life is much better than that of mindhealthconnect from February to June 2015 (25% cf 75%),[2] which means proportionally less sessions involved users not interacting with the website before leaving.

Furthermore, despite the lower than expected monthly average uptake, the trend from October 2017 to October 2021 has been for the overall uptake of Head to Health to increase over time.

A range of devices are being used to access Head to Health. In 2021, 49% of sessions were accessed via desktop, 47% via mobile and 4% tablet devices. Search engine results are the main source of traffic to Head to Health, and most referrals come via Facebook.

Website analytics from digital mental health services

In a 3.75 year period (October 2017 to June 2021), Head to Health referred almost double the number of visitors to three digital mental health services websites as mindhealthconnect in a 3.25 year period (July 2014 to September 2017; 69,595 cf 36,455). However, because the overall number of visitors to the websites of these services more than tripled, proportionally there were fewer referrals from Head to Health than from mindhealthconnect (1% cf 2%). These findings suggest that although more people have continued to become aware of Head to Health over time, people are also increasingly becoming aware of digital mental health services through pathways other than through Head to Health.

Community conversations

Lived experience community conversation participants described the website as a broad and credible gateway suited to family members or those new to mental health. However, they reported insufficient tailoring for those with complex needs, who frequently miss out in “one-size-fits-all” approaches and may need their own section or website to cover information and programs relevant only to people with severe illness and complex needs.

Lived experience participants also expressed concern that the website does not include specific groups such as Aboriginal and Torres Strait Islander peoples, those who identify as LGBTQIA+ and those from different cultural backgrounds. They viewed the overall language as clinical or pathologising and complex, requiring a level of literacy and digital literacy that may exclude some users, including people from non-English speaking backgrounds or with disabilities.

Some lived experience participants thought the volume of information was overwhelming, but at the same time, they felt that some issues and specific apps were not described well enough. This reduced the website's effectiveness as they struggled to navigate what was needed, and then found the website did not have enough depth to the information on the topics in which they were interested.

KEQ 2: Who are the current users of the Head to Health website?

Data describing the users of Head to Health are not routinely collected. However, secondary data from the Department administered survey, and our in-progress consumer and provider user surveys, provide some insight into the characteristics of survey respondents.

Secondary survey data

Of the 258 respondents who completed the survey, most were female (73%) and of mixed age groups, most commonly 18-50 years (62%) followed by 51-65 years (18%) and under 18 years (17%). Survey respondents represented all states and territories and a range of hard-to-reach minority subpopulations. Survey respondents most commonly heard about Head to Health through an internet search or from a friend/co-worker/family member.

Survey data

Our in-progress user survey data from 45 consumers shows that these participants had a similar profile to that reported from the secondary survey data. Around two-thirds were female and aged 20-49 years, but 20% were aged 60-69 years. Just over half of these consumers were aware of the Head to Health website and around half had never used it. By comparison, of the 16 lived experience participants we recruited for the community conversations, 44% had heard of Head to Health, and 25% had used it.

Only seven providers have completed the survey so far. Of these, six were female, and three were aged 20-29 and two 60-69 years. They included GPs, social workers and psychologists among other professions, three of whom had over 20 years' experience, who mainly used the website to access information for themselves or their clients.

KEQ 3: What are the experiences of users of the website?

Data from Head to Health google analytics including user feedback, the Department survey, our in-progress user survey and community conversations with lived experience participants address KEQ 3.

Google analytics data

Google analytics data provide insights into how users engage with the Head to Health website.

On average, only 1-2 pages are viewed per session, and the average session duration is 2.5 minutes. Overall, engagement with Head to Health has declined over time, irrespective of campaigns. One in 10 Head to Health sessions results in a conversion (i.e., completing a desired action including search completions, chatbot completions, and emailing or printing resources). The Head to Health conversion rate is somewhat lower than that of mindhealthconnect at 13%,[2] but the absolute number of conversions has increased over time.

A relatively small number of users provide data on whether or not they perceive the pages they use to be helpful. Pages relating to COVID-19 support, Health professionals, Meaningful life, Mental health difficulties, Supporting someone else and Supporting yourself are more often rated as helpful than not (~60-80%).

Similarly, a relatively small number of users provide feedback about their experience of the Head to Health website overall and its specific pages. Only half of these users' responses report positive (good or great) experiences of the overall website and less than half (~40%) do so for the homepage and other content pages. Consistent with these ratings, less than half of these user responses indicate that they would recommend (≥ 7/10) the website and even fewer would recommend specific website content and the chatbot.

Secondary survey data

Just under two-thirds of respondents of the Department administered survey reported that the website was easy or very easy to use, most (88%) reported moderate to high trust in the content, and around 60% reported a good or great user experience. Around two-thirds indicated a relatively high likelihood (≥ 7/10) of recommending Head to Health.

Survey data

Our in-progress user survey data shows that of the 20 consumers who had used Head to Health, only 30% had used it more than once and most spent less than 20 minutes on the website. The most commonly reported reasons for using the website were struggles with coping, wanting to access information for family and friends, and needing professional help. Overall, only 20% of consumers reported that they were 'satisfied' or 'very satisfied' with the website, and 35% would recommend it to others.

The seven providers who have completed our in-progress survey reported finding out about the Head to Health website through a variety of sources including online searches, workplace recommendations, flyers, eMHPrac and other continuing professional development activities. Providers varied in their frequency of using the website, ranging from having used it on a single occasion to over 11 times. Most providers spent under 20 minutes engaging with the website. Most commonly, providers used the website to access information and resources for themselves or their clients. Overall, 57% of providers reported that they were 'satisfied' or 'very satisfied' with the Head to Health website and 70% occasionally or frequently recommend it to clients. Sixty percent of providers reported that the website has benefited clients under their care and none reported negative impacts for clients. The most commonly reported client benefits were reduced costs associated with care, improved access to information, improved convenience of care and improved mental health and wellbeing.

Community conversations

Based on demonstration of its functionality during the community conversations, lived experience participants' positive feedback related to experiencing the website as warm, user-friendly and easy to use. They particularly appreciated the comprehensive menu system that allowed drilling down to specific information, the ability to bookmark important parts, and that the website is mobile friendly. They commented that it is "not a typical government website" and were impressed by the comprehensive information presented on a very broad range of issues, including specific disorders and COVID-19.

The negative feedback from lived experience participants related to lack of user friendliness, particularly the nature of the content, its organisation and the overall feel. Some felt that the website was too broad and overwhelming to navigate. Some content, particularly regarding LGBTQIA+ populations, was reported to be outdated, and other areas too focused on self-help and information rather than providing a true gateway to mental health services. The cartoon characters were particularly unpopular and some participants suggested that it made it feel like the website did not take mental health seriously.

The other major area lived experience participants viewed as a barrier was accessibility. Some expressed concern that Head to Health may systematically exclude some of the most vulnerable people, for example, people without reliable technology, people with vision impairment, and people from different cultural backgrounds, including Aboriginal and Torres Strait Islander peoples.

Importantly, some lived experience participants reported that the crisis resources were not easy to find and were too superficial.

KEQ 4: What are the needs of current users of the website? Are these being met? What needs should be met by the planned national mental health platform?

Data from the Department's survey and the community conversations contribute to addressing KEQ 4.

Secondary survey data

The most commonly used features of the Head to Health website according to respondents of the Department administered survey are the topic and content pages and the search resources (58% and 57%, respectively). More than half (61%) of survey respondents reported that the resources were relevant or extremely relevant. This suggests that these are features that are performing relatively well and should be retained in the planned national mental health platform.

Survey respondents suggested that some features could be improved including:

- providing more information/content/resources (e.g., specific disorders or subpopulations; and information about accessing face-to-face services, particularly based on location; costs and other requirements for entry into suggested services; and including lived experience views, for example in providing user ratings of services);
- updating outdated information;
- further refining both chatbot and search functionality and to ensure that suggestions are tailored to the individual; and
- website design (e.g., look and feel, and ease of navigation of the website, as well as its speed).

Community conversations

Community conversation participants echoed several of the suggestions made by Department survey respondents in addition to offering other characteristics of an ideal mental health gateway including:

- a visually appealing website with use of calming colours, and that is less childish-looking;
- comprehensive information (on all mental health issues, not just the most common), organised in a way that is not overwhelming and assists users to find the depth they need;
- the website being accessible to everyone, so easy to read and compatible with screen readers for example;
- removal of medical jargon and complex language, replaced with plain language and recovery-oriented information;
- better information that normalises mental health issues and recovery, and connects to options beyond mainstream mental health approaches, such as peer services;
- input from peers in design and navigation;
- links to physical (real world) services such as mental health professionals, support groups and non-digital tools; and
- the addition of live chat or interaction with a real person rather than a robot to help people in distress find what they need.

KEQ 5: How effective is Head to Health in achieving its objectives?

This section lists each of the objectives of Head to Health and indicates whether it has been achieved based on the data sources used to inform the current report. However, we will be better placed to answer how effective Head to Health is in achieving its objectives when we have completed our consultations with consumers, providers, health professionals and other key mental health sector stakeholders.

1. **Give Australians the tools and information they need to understand when everyday distress requires additional support and to successfully navigate the mental health system and make informed choices about their care.**

None of the available data sources provide information about the first part of this objective (i.e., when everyday distress requires additional support). As far as we can tell, Head to Health provides Australians with tools and information to navigate digital mental health services but not necessarily the mental health system in its entirety, which will be a focus of the new national mental health platform. As reported in response to KEQs 1 and 3, community conversation participants and survey respondents indicated that there is a desire for more comprehensive mental health system options (e.g., face-to-face and peer support services; and services for all mental health problems, minority groups and people with complex needs).

2. **Improve access by bringing together, streamlining, and providing access to evidence-based information, advice, and digital mental health treatments through a centralised portal.**

As mentioned in response to KEQ 1, the trend has been for the overall uptake of Head to Health to increase over time. However, it is not the only source of visits to the websites of key Australian digital mental health services (referring only 1% of visitors).

3. **Provide people needing additional support a range of options, including practical tips and advice on how to connect with support.**

The available data sources did not directly assess this objective. However, as mentioned in response to the first objective, users expressed a desire for a more comprehensive gateway to mental health services, not just digital mental health services and mainstream majority population services.

As reported in response to KEQ 4, survey respondents and community conversation participants also suggested that the range of support options could be improved either by further refining both chatbot and search functionality to ensure that suggestions are individually tailored, or through the addition of complementary live chat or interaction with a real person rather than a chatbot to help people in distress find what they need.

4. **Make it easy to access a range of clinically effective Australian digital mental health services that are often free or low cost, accessible from anywhere/anytime, and offer an effective alternative or complement to face to face services.**

As reported in response to KEQ 3, just under two-thirds of respondents of the Department administered survey reported that the website was easy or very easy to use. Of the 20 consumers who have participated in our in-progress user survey, only 20% reported that they were 'satisfied' or 'very satisfied' with the website, and only 35% would recommend it to others. The community conversation participants appreciated the comprehensive menu system and the broad content; but also felt that navigating the website was overwhelming and criticised the lack of user-friendliness and content targeting minority groups. However, these findings do not directly inform the ease of accessing services themselves and in any case, as noted in response to KEQ 1, Head to Health only accounts for 1% of visitors to websites of key Australian digital mental health services.

5. **Foster a sense of trust and confidence in using digital services listed on Head to Health by ensuring they meet an agreed minimum quality standard.**

As mentioned in response to KEQ 3, 88% of Department survey respondents reported moderate to high trust in the content of Head to Health. This was corroborated by the lived experience community conversation participants' view that the website was a trustworthy starting point for seeking information and links to professionals for mental health issues.

KEQ 6: How efficiently and effectively has Australian Government funding for Head to Health been used?

KEQ 6 was addressed using Head to Health google analytics data and expenditure reports provided by the Department of Health.

For most outcomes, the cost per unit has decreased over time, with the costs in 2020-21 per visit, unique visitor, new user, and conversion being $2.91, $3.57, $3.74 and $35.57. Based on the current data available to us, there is evidence to suggest efficiency of resource use from the allocated budget. However, we are undertaking further evaluation to determine the cost-effectiveness of Head to Health.

Conclusions

A significant number of people use Head to Health each month, many of whom interact with the website in a meaningful way and go on to access digital mental health services. However, on average users only spend 2.5 minutes per session on the website, suggesting that people either quickly find what they need or are unable to find what they need and leave the website. The latter interpretation is supported by data indicating that only one in 10 people complete a key or desired action. In its current form, although a high proportion of users report high trust in the content, only some users experience Head to Health as easy to use, and report a good experience. Stakeholders report mixed views about the design, look and feel of the Head to Health website. Our consultations with lived experience participants indicated that the website is simultaneously overwhelming in its current volume of information, and there are gaps in the information provided. Thus, the challenge for developing the new mental health platform will be to strike a balance between providing comprehensive information for navigating the mental health system (more broadly than digital mental health services) while not overwhelming users. Our continuing consultations with consumers, providers, health professionals and other key mental health sector stakeholders may shed further light on who the current users of Head to Health are, whether Head to Health is effective in achieving its objectives, and whether it is cost effective.

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Appendix 1: Evaluation questions

IMPLEMENTATION

KEQ 1: How effective has Head to Health been to date and what can we learn from it?

- What is the overall level of awareness and use of the Head to Health website amongst the population(s)?
- Are the content and resources available on Head to Health fit for purpose, appropriately targeted, and accessible for the target audiences? Including consumers, carers and health professionals?
- Are there gaps or duplication in the content and resources offered on the website?
- Have timely and appropriate updates (content and technology) to Head to Health been delivered?

APPROPRIATENESS

KEQ 2: Who are the current users of the Head to Health website?

- Who are the current users of the website?
- Are there any segments of the population who do not appear to be using the website? How might these needs be met in the future?

KEQ 3: What are the experiences of users of the website?

- How do people currently use website? Are there differences in how different groups of people use the website? Is it easy to navigate and find what users are looking for? Map and describe typical user experiences of the website
- Can consumers be connected in a timely way to the appropriate resources and/or support?
- Map and describe the current services and resources offered or linked through the website, highlighting the most used and least used areas of the website
- How satisfied are users with their experience of the website? Can this be improved?

KEQ 4: What are the needs of current users of the website? Are these being met? What needs should be met by the planned national mental health platform?

- What are the needs of current users' of the website? Consider at a minimum, consumers, carers and health service providers
- Are these needs consistent with the objectives and policy intent of Head to Health?
- Are users current needs being met? What improvements can be made in the short-term? What improvements should be included in the national mental health platform beta site and ultimate state?
- What content or design features of the current website are particularly effective and should be retained in any future state platform?
- What content or design features of the current website are failing to meet user's needs and should be redesigned, categorised into high, medium and low priority?

EFFECTIVENESS

KEQ 5: How effective is Head to Health in achieving its objectives?

- To what extent does Head to Health
- provide users with the tools and information they need to understand when everyday distress requires additional support?
- assist users to successfully navigate the mental health system?
- assist users to make informed choices about their care?
- Refer users to appropriate information, resources, support and treatment according to relevant clinical guidelines?
- Assist health professionals to choose the products and services that can best support a person's mental health and wellbeing

- Are there differences in outcomes for different sub-populations? If so, why?
- To what extent does Head to Health met the needs of hard to reach or high risk populations, including Aboriginal and Torres Strait Islander peoples, men, young people, people with more serious mental illness?
- Has Head to Health provided an effective gateway to digital mental health services for mental health consumers?
- Has Head to Health improved access to evidence-based mental health information, advice, support and treatment services?
- Has Head to Head improved service choice for consumers?
- Has Head to Health made it easier for those who need it to access a range of clinically effective Australian digital mental health services that are free or low cost, accessible from anywhere/anytime, and offer an effective alternative or complement to face to face services?
- Has Head to Health increased access to high quality services?
- What is the level of trust in the information and services provided to consumers on the Head to Health website?
- Has Head to Health led to increased confidence and trust in the services and resources on the website amongst consumers?

EFFICIENCY

KEQ 6: How efficiently and effectively has Australian Government funding for Head to Health be used?

- How cost-effective is Head to Health?
- Are there opportunities to improve the cost-effectiveness of Head to Health?
- What are the implications of free versus low cost versus higher costs to consumers and/or health professionals to access the resources and services provided or linked to on Head to Health?
- Have there been unintended outcomes/consequences from the implementation of Head to Health? If so, explain
- What impact has Head to Health had on adoption of digital mental health in Australia?
- What impact has Head to Health had on mental health information, support and treatment services in Australia?
- What impact has Head to Health had on mental health organisations in Australia?

Appendix 2: Promotional activity for Head to Health user survey

Department of Health promotion of survey via social media

Survey for people 16+ years	**Copy**	**Image**
Post 1 – published December/January		
Facebook	If you're 16+ we want to hear from you. Help improve the mental health gateway - Head to Health. This website helps users find mental health services from some of 🇦🇺 most trusted organisations. It brings together: 📱apps 🖥online programs 💬online forums, and ☎phone services 📚digital information resources. Have your say. Take part in the survey today at 💻 https://melbourneuni.au1.qualtrics.com/jfe/form/SV_55NxrsCjajxabmS	
Twitter	If you're 16+ we want to hear from you. Help improve the mental health gateway #HeadtoHealth. This helps users find #mentalhealth services from some of 🇦🇺most trusted organisations. Have your 💬say. Take part in this survey at 💻 https://melbourneuni.au1.qualtrics.com/jfe/form/SV_55NxrsCjajxabmS	

Instagram	If you’re 16+ we want to hear from you. Help improve the mental health gateway - Head to Health. This website helps users find digital mental health services from some of 🇦🇺 most trusted organisations. It brings together: 📱 apps 🖥online programs 💬online forums, and ☎phone services 📚digital information resources. Have your say. Take part in the survey today by clicking the link in our bio and selecting ‘Head to Health survey’. #Mentalhealth #HeadtoHealth *https://melbourneuni.au1.qualtrics.com/jfe/form/SV_55NxrsCjajxabmS*	
LinkedIn	If you’re 16+ we want to hear from you. Help improve the mental health gateway -Head to Health. This website helps users find mental health services from some of 🇦🇺 most trusted organisations. It brings together: 📱 apps 🖥online programs 💬online forums, and ☎phone services 📚digital information resources. Have your say. Take part in the survey today at 💻https://melbourneuni.au1.qualtrics.com/jfe/form/SV_55NxrsCjajxabmS #Mentalhealth #HeadtoHealth	

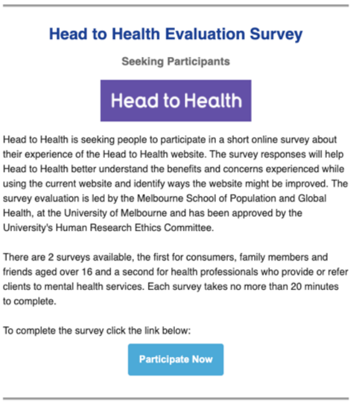
Post 2 – published 17 January		
Facebook	The Head to Health survey is closing ⏰soon. Have you had your say ❓ If you’re 16+ we want to hear 🗣from you. Help improve the mental health gateway today. Take part before 17 February 2022 at 💻 https://melbourneuni.au1.qualtrics.com/jfe/form/SV_55NxrsCjajxabmS	
Twitter	The #HeadtoHealth survey is closing ⏰soon. Have you had your say ❓ If you’re 16+, we want to hear 🗣from you. Help improve the #mentalhealth gateway today. Take part before 17 February 2022 at 💻 https://melbourneuni.au1.qualtrics.com/jfe/form/SV_55NxrsCjajxabmS	
Instagram	The Head to Health survey is closing ⏰soon. Have you had your say ❓ If you’re 16+ we want to hear 🗣from you. Help improve the mental health gateway today. Take part before 17 February 2022 by clicking 🖱 the link in our bio and selecting ‘Head to Health survey’. #Mentalhealth #HeadtoHealth	
LinkedIn	The Head to Health survey is closing ⏰soon. Have you had your say ❓ If you’re 16+ we want to hear 🗣from you. Help improve the mental health gateway today. Take part before 17 February 2022 at 💻 https://melbourneuni.au1.qualtrics.com/jfe/form/SV_55NxrsCjajxabmS #Mentalhealth #HeadtoHealth	

Survey for health professionals	**Copy**	**Image**
Post 1 – published December/January		
LinkedIn	If you’re a health professional 👩‍⚕️ we want to hear from you. Take part in a survey that will help improve the mental health gateway - Head to Health. This website 🖥️ provides your patients 👪 access a range of mental health resources from trusted organisations across 🇦🇺 Digital resources 📄 can be beneficial for people with or at risk of mild to moderate mental health difficulties, or people supporting someone with mental health issues. Have your say at 💻 https://melbourneuni.au1.qualtrics.com/jfe/form/SV_beH6FafiQTd6pRs #Mentalhealth #HeadtoHealth	
Post 2 – published 20 January		
LinkedIn	The Head to Health survey is closing ⏰ soon. Have you had your say ❓ If you’re a health professional 👩‍⚕️ we want to hear from you. Help improve this important mental health gateway. Take part before 📅 February 2022 at 💻 https://melbourneuni.au1.qualtrics.com/jfe/form/SV_beH6FafiQTd6pRs #Mentalhealth #HeadtoHealth	

eMHPrac promotion of survey

Newsletters

eMHPrac Newsletter – Vol. 3, No. 12, December 2021



Head to Health Evaluation Survey

Seeking Participants

Head to Health

Head to Health is seeking people to participate in a short online survey about their experience of the Head to Health website. The survey responses will help Head to Health better understand the benefits and concerns experienced while using the current website and identify ways the website might be improved. The survey evaluation is led by the Melbourne School of Population and Global Health, at the University of Melbourne and has been approved by the University's Human Research Ethics Committee.

There are 2 surveys available, the first for consumers, family members and friends aged over 16 and a second for health professionals who provide or refer clients to mental health services. Each survey takes no more than 20 minutes to complete.

To complete the survey click the link below:

Sent: Friday, 17th December 2021

Recipients: 2,314

Opens: 716
Total Link Clicks: 362
Clicks on Head to Health Evaluation Survey Link: 13 (3.6%)

eMHPrac Brief Edition: ‘Head to Health’ Evaluation Newsletter

CLINICIANS AND CONSUMERS:

An Opportunity to Have Your Say on the Head to Health Website

Head to Health are seeking your help to improve the website experience by inviting you to take part in a short online survey about the usefulness of the Head to Health website.

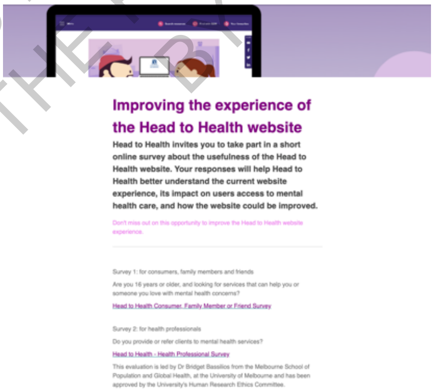
Participants' responses will help the Head to Health team and researchers from the University of Melbourne better understand the benefits and concerns experienced while using the current website, and how the website might be improved for clinicians and consumers.

Sent: Wednesday, 2nd February 2022

Recipients: 2,289

Opens: 526
Total Link Clicks: 74
Clicks on Head to Health Evaluation Consumer, Family Member or Friend Survey Link: 15 (20.3%)
Clicks on Head to Health Evaluation Health Professionals Survey Link: 16 (21.6%)

Menzies School of Health Research – AIMhi Newsletter:



Improving the experience of the Head to Health website

Head to Health invites you to take part in a short online survey about the usefulness of the Head to Health website. Your responses will help Head to Health better understand the current website experience, its impact on users access to mental health care, and how the website could be improved.

Don't miss out on this opportunity to improve the Head to Health website experience.

Survey 1: for consumers, family members and friends

Are you 16 years or older, and looking for services that can help you or someone you love with mental health concerns?

Head to Health Consumer, Family Member or Friend Survey

Survey 2: for health professionals

Do you provide or refer clients to mental health services?

Head to Health - Health Professional Survey

This evaluation is led by Dr Bridget Bassilios from the Melbourne School of Population and Global Health, at the University of Melbourne and has been approved by the University's Human Research Ethics Committee.

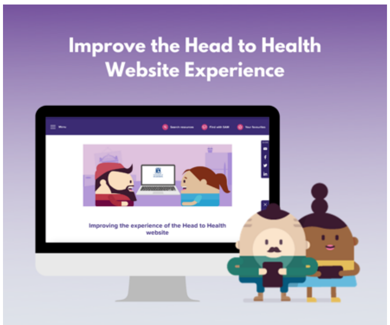
Sent: Wednesday, 2nd February 2022

Recipients: 1,182

Opens: 168
Total Link Clicks: 1,193
Clicks on Head to Health Evaluation Consumer, Family Member or Friend Survey Link: 108 (9.1%)
Clicks on Head to Health Evaluation Health Professionals Survey Link: 112 (9.4%)

Social media promotion

eMHPrac Facebook



Posted: January 5th 2022

Reach: 145
Impressions: 154

Likes, comments and shares: 1

Link Clicks: 0

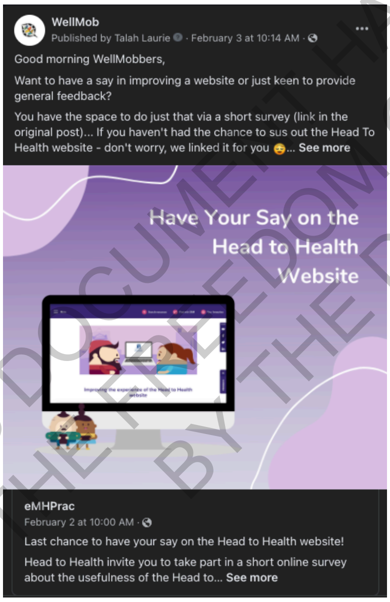
Posted: February 2nd 2022

Reach: 260
Impressions: 280

Likes, comments and shares: 4

Link Clicks: 2

WellMob Facebook


WellMob
Published by Talah Laurie · February 3 at 10:14 AM ·

Good morning WellMobbers,

Want to have a say in improving a website or just keen to provide general feedback?

You have the space to do just that via a short survey (link in the original post)... If you haven't had the chance to sus out the Head To Health website - don't worry, we linked it for you 😌... **See more**

eMHPrac
February 2 at 10:00 AM ·

Last chance to have your say on the Head to Health website!

Head to Health invite you to take part in a short online survey about the usefulness of the Head to... **See more**

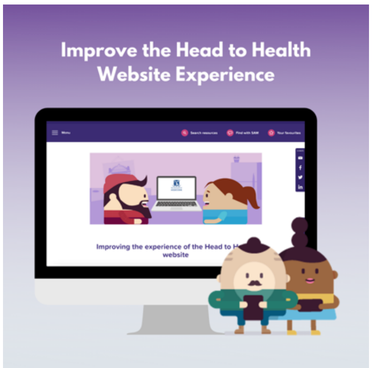
Posted: February 3rd 2022

Reach: 175
Impressions: 187

Likes, comments and shares: 0

Link Clicks: 1

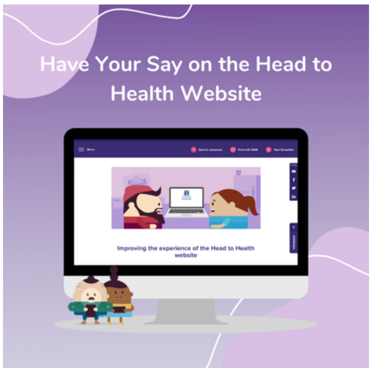
eMHPrac Instagram



Posted: January 5th 2022

Reach: 69
Impressions: 75

Engagements: 8

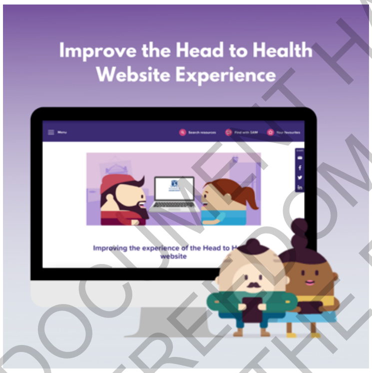


Posted: February 2nd 2022

Reach: 41
Impressions: 44

Engagements: 6

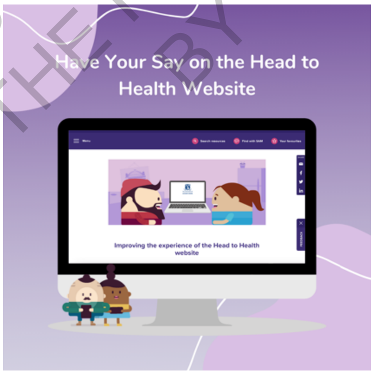
eMHPrac LinkedIn



Posted: January 5th 2022

Impressions: 67

Engagements: 1
Link Clicks: 1

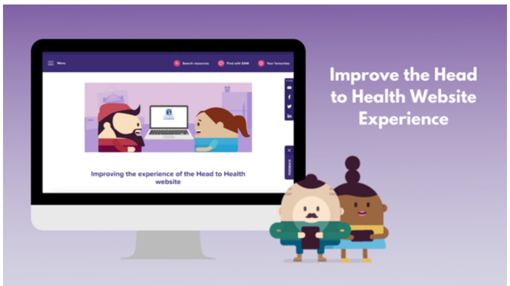


Posted: February 2nd 2022

Impressions: 76

Engagements: 4
Link Clicks: 3

eMHPrac Twitter

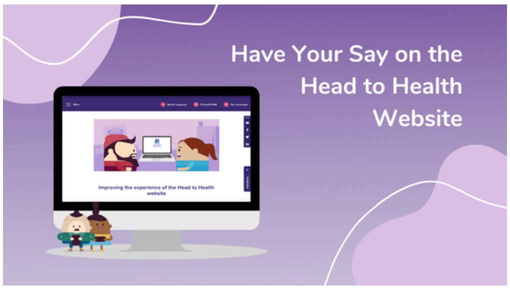


Posted: January 5th 2022

Impressions: 121

Engagements: 2

Link Clicks: 0



Posted: February 2nd 2022

Impressions: 262

Engagements: 13

Link Clicks: 1

Appendix 3: Additional methods and analysis for google analytics

Raw data

Raw google analytics data were provided in a series of comma separated variable files (csv). Summarised monthly data were constructed in R and compared against the Excel summary for validation and understanding.

Raw data were in five sets: users' data (1 file), landing page data (8 files), website event data (15 files), page views data (10 files) and goals data (4 files). Using the R programming software, the data was appended by set, yielding five files (one for each data type; e.g., one user file, one landing page file etc.). Each data set had some overlapping and some unique information (some metrics could be obtained from more than one file).

Table A1 shows a concordance between key metrics we analysed and their source file.

Table A1. Concordance between key metrics and source data file

Metric	Source of data
N users	Users file
N new users	Users file
N sessions	Landing file
Bounce rate	Landing file
N page views	Landing fille
Pages per session	Landing file
Mean session duration	Landing file
N conversions	Goals file
Conversion rate	Goals file and Landing file
N SAM, email, print, topic, search, homepage	Goals file

N, number.

Campaign dates

The raw data provided by Liquid Interactive indicated that campaigns were run in:

- 2021: January, February
- 2020: March-June, August, November, December
- 2019: January, February
- 2018: January, October, December
- 2017: November, December

Plotting trend lines

A lowess (Locally Weighted Scatterplot Smoothing) smoothed line was included on these plots to assess both short-term and long-term trends. Lowess is a non-parametric regression technique in which simple linear regression models are fitted to overlapping subsets of the data, and the results are combined to form a smooth curve through the complete set of data points. It is very flexible and makes few assumptions about the distribution of data or the shape of the changes in the outcome over time.

Head to Health uptake plots with trend lines

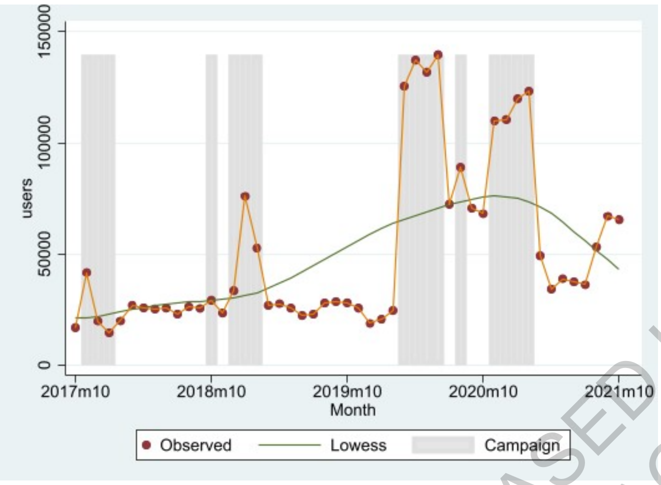


Figure A1. Monthly number of users, October 2017 to October 2021

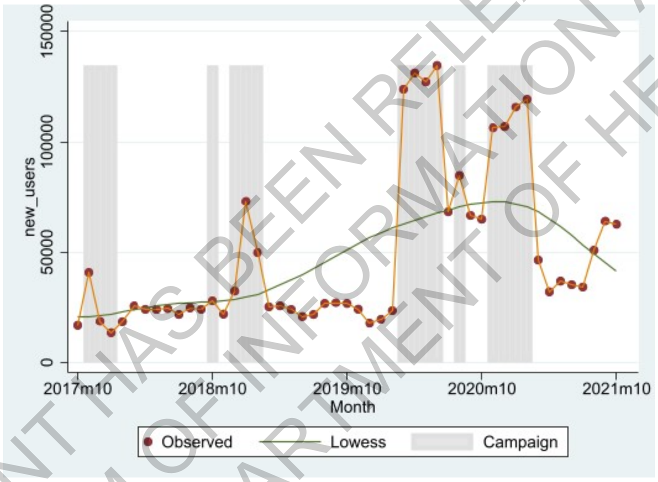


Figure A2. Monthly number of new users, October 2017 to October 2021

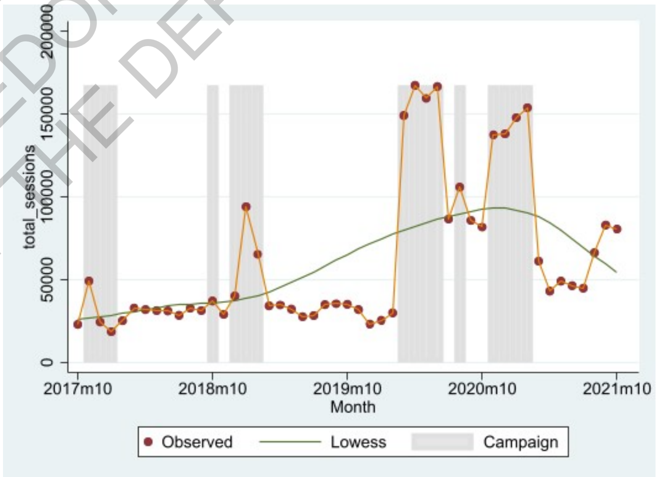


Figure A3. Monthly number of sessions, October 2017 to October 2021

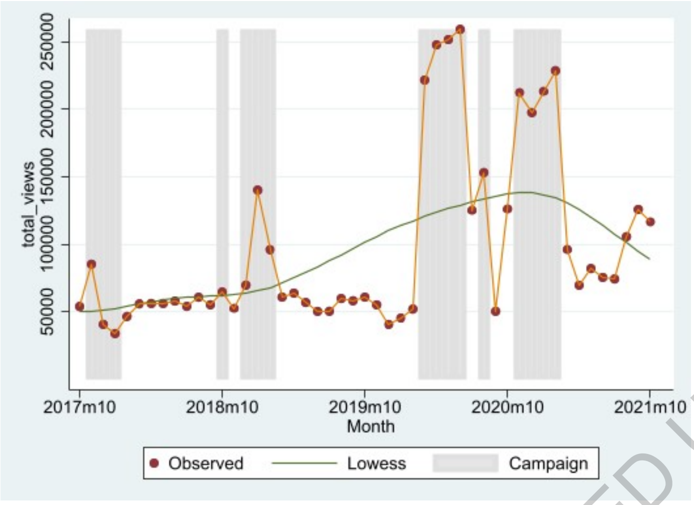


Figure A4. Monthly number of views, October 2017 to October 2021

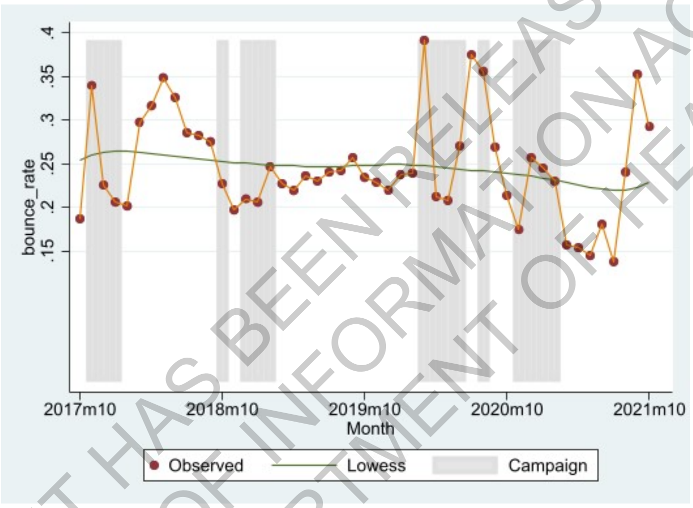


Figure A5. Monthly bounce rate, October 2017 to October 2021

Head to Health engagement plots

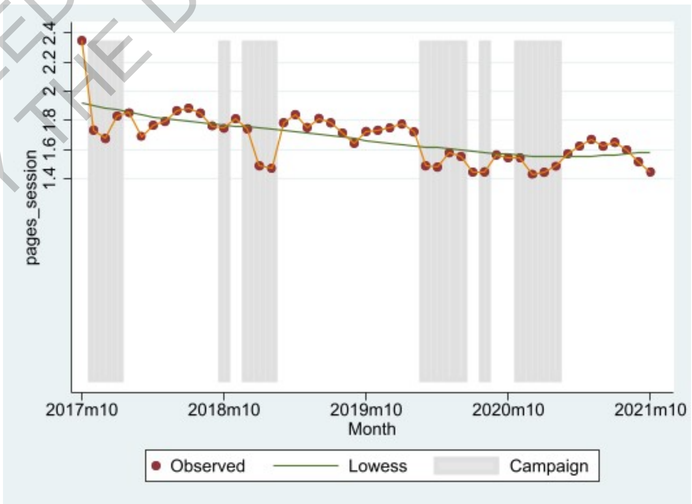


Figure A6. Monthly number of pages per session, October 2017 to October 2021

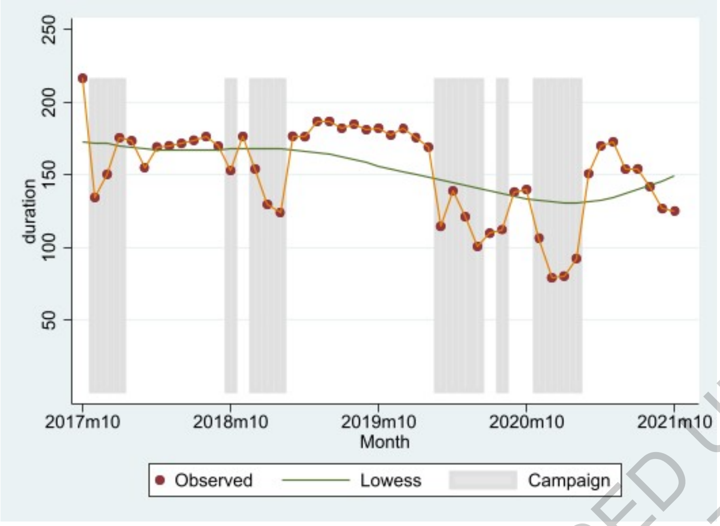


Figure A7. Monthly duration in seconds on website, October 2017 to October 2021

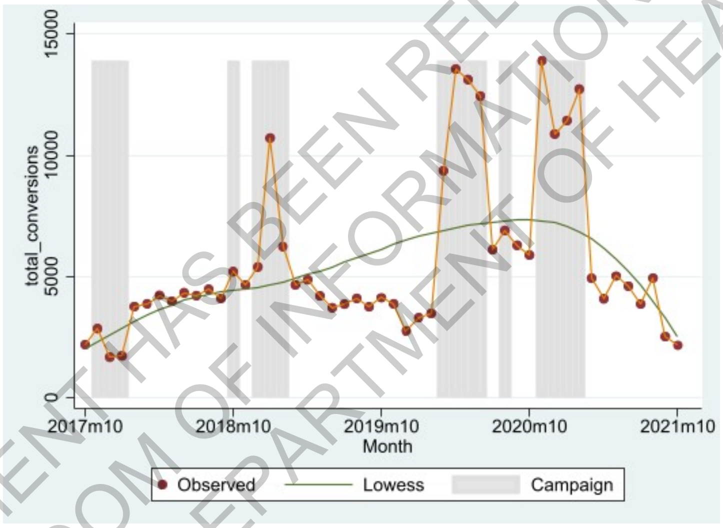


Figure A8. Monthly number of conversions, October 2017 to October 2021

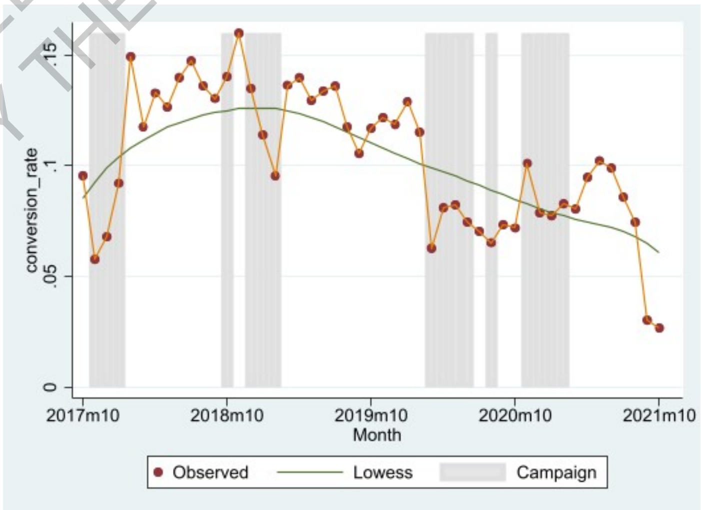


Figure A9. Monthly conversion rate, October 2017 to October 2021

Page helpfulness

At the bottom of every webpage on the Head to Health website, there is an option to indicate whether that page was helpful or not by answering the question, ‘Was this information helpful?’ This page helpfulness data is in the raw data Events file. Each time someone answers the question about whether a page was helpful or not, this is recorded as an event and is given a row of data. The Events file includes other information on each row that can be used to classify the pages specifically rated for helpfulness (e.g., a COVID-19 topic page, or a Meaningful life topic page and so on). The number of times the page was rated as helpful was calculated by summing a column called ‘Unique.events’ in the Events file for rows where a given page was considered helpful (indicated in the data by a ‘yes’ in the ‘Event.label’ field). The number of times the page was rated as unhelpful was likewise calculated by summing Unique.events for rows where a given page was considered unhelpful (Event.label = ‘no’). From here, the percentage of helpful ratings was calculated. Using notes found in Liquid Interactive’s summary Excel file, helpfulness data was restricted to English rating answers (i.e., ‘yes’ and ‘no’). It is perhaps relevant to note that although ‘yes’ is an English word, ‘no’ is used in several other languages, but this noise was ignored for our purpose.

Appendix 4: Detailed methods and analysis of community conversations

Methods

Community conversations were conducted using the World Café method.[4] The World Café is a powerful way of facilitating group discussions. It is particularly useful for gathering multiple views on an issue to generate collective solutions, where you have all the experts already in the "room", and creative thinking is helpful to generate ideas. It typically involves bringing together small groups of people at tables to discuss a particular issue, shuffling people to new tables with new issues, and then repeating the process several times. The World Café method is therefore easily adapted to be used online for conversations about Head to Health and digital mental health services.

Recruitment was conducted in four main ways:

- An email sent to the ACACIA register, a database of more than 130 consumers, carers and lived experience organisations interested in participation or active involvement in lived experience research;
- A post to the ACACIA Facebook page, which was also shared by Lived Experience Australia and several ACACIA members;
- A paid ad through the ACACIA Facebook account, which ran from 10-23 November, targeting all Australians over 16 years of age. The ad reached 21,411 people, had engagement from 243 people and resulted in 99 clicks through to the Expression of Interest form;
- Tweets from A/Prof Banfield's account on 10 and 18 November, which were retweeted more than 30 times, including by consumer and researcher networks.

People who were interested in taking part clicked a link in the ad/post to complete a brief expression of interest survey on Qualtrics. A member of the research team responded by email, providing the information sheet and consent form, which also collected demographics and information about knowledge of the Head to Health website. Consent was requested prior to the group, but for a small number of participants, it was completed at the time of the conversation, prior to the commencement of discussions. A reminder email was sent the week before the conversations containing the Zoom links for the three conversations and a prompt to return the consent form.

The community conversations ran for 2.5 hours including breaks, and consisted of four sessions: three rounds of small group discussions to discuss strengths, barriers and effectiveness, and one final group discussion to bring the previous discussions together in optimal features. The full World Cafe method included the creation of small group "tables" using the breakout room feature, with one researcher assigned to each room as facilitator, assisted by an observer/note taker. Due to low attendance, only one conversation was run in this way; the other two were conducted as single group discussions for all four questions.

Many participants were not familiar with the Head to Health website prior to the community conversations, so facilitators accessed the website and shared their screens to facilitate exploration in real time, and discussion of observations about strengths and weaknesses and perceived effectiveness.

Note takers and participants entered ideas and issues into the Slido app (https://www.sli.do/). Slido is a web-based, interactive Q&A and polling app that encourages participation in virtual events. There are no downloads or personal information required from participants. They simply follow a link, which was provided live in the Zoom chat, and entered the unique event ID to access the interactive tools for the community conversation. Participants were asked to enter words and phrases in response to the questions to create a "word cloud." They were able to enter words already present in the cloud to increase their emphasis, or enter further words to expand the cloud. Facilitators encouraged discussion about topics emerging in response to the emphasis suggested by the cloud at several points in each session. A fresh Slido event was created for each of the three sessions, allowing the groups to develop their own ideas.

Discussion about each question lasted for 20 minutes. In the conversation run using the World Cafe method, when participants moved between rooms, the facilitator for that room shared the word cloud developed to that point, and asked for comments and additions to the question for that room. This allowed both reinforcement of key issues already raised and the opportunity to add novel areas in an accessible visual format. This was not necessary in the conversations run as single group discussions, as all participants had the opportunity to build the word clouds together at the same time.

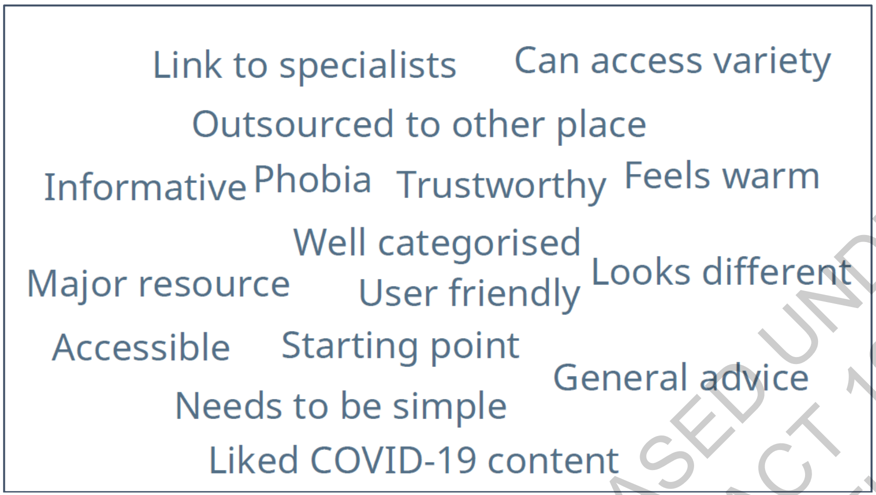
For the final discussions, the word clouds developed for strengths, barriers and effectiveness were displayed via shared screen to facilitate discussion on the features of an optimal digital gateway. Participants were invited to reflect on their prior discussions and think about how an ideal website would look, feel and act. They were then invited to enter the most and least important features they thought the website should have.

After the conclusion of the discussion, participants were emailed a $50 e-gift card as a reimbursement for their time.

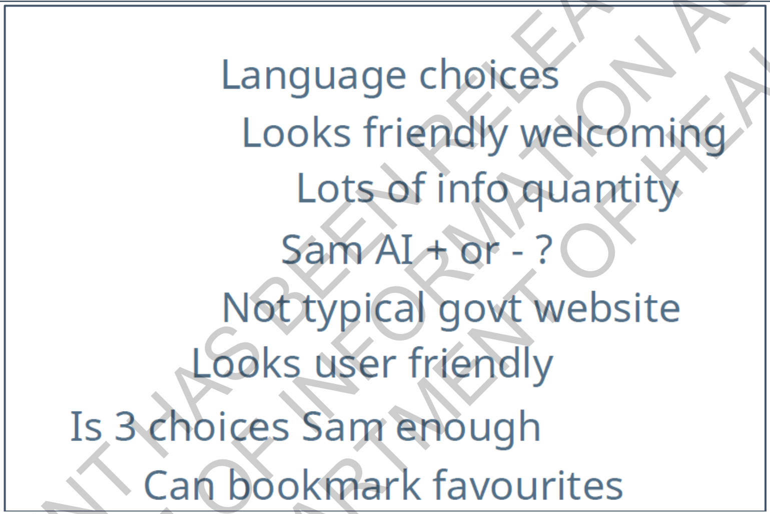
Analysis

The lists of ideas entered into Slido for all three conversations were downloaded for preliminary thematic analysis using Nvivo qualitative analysis software. An initial list of codes was developed line-by-line, interrogating the data for common issues. These issues were then combined into larger thematic areas, given descriptive titles to demonstrate the major areas of strength, barriers and effectiveness. A summary of these preliminary themes is provided in the preliminary findings section of the report, alongside discussion of the most and least important features for a redeveloped Head to Health website. The full word clouds and survey results are available below in the appendix. Full thematic analysis, including additional notes taken by notetakers, will be undertaken for the final evaluation report.

Strengths of Head to Health word clouds



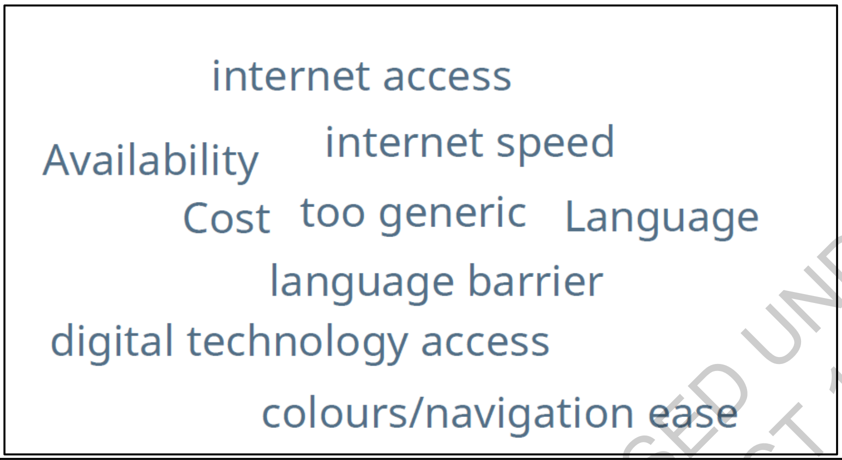
Link to specialists
Can access variety
Outsourced to other place
Informative
Phobia
Trustworthy
Feels warm
Well categorised
Major resource
User friendly
Looks different
Accessible
Starting point
General advice
Needs to be simple
Liked COVID-19 content

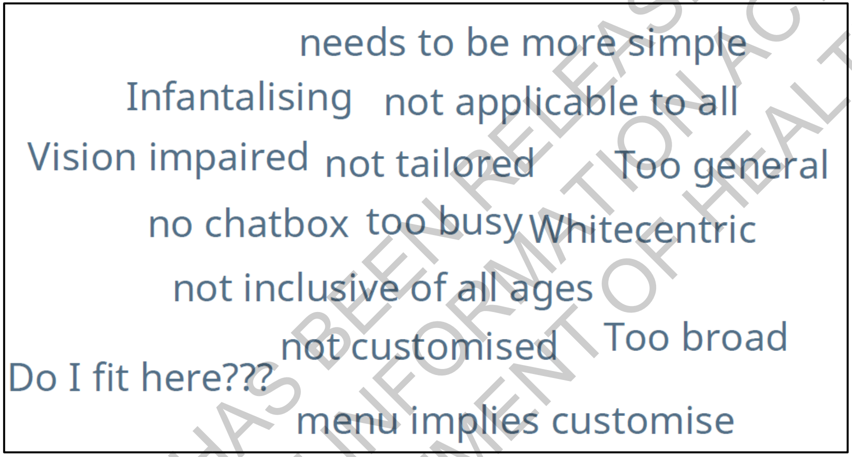


Language choices
Looks friendly welcoming
Lots of info quantity
Sam AI + or - ?
Not typical govt website
Looks user friendly
Is 3 choices Sam enough
Can bookmark favourites

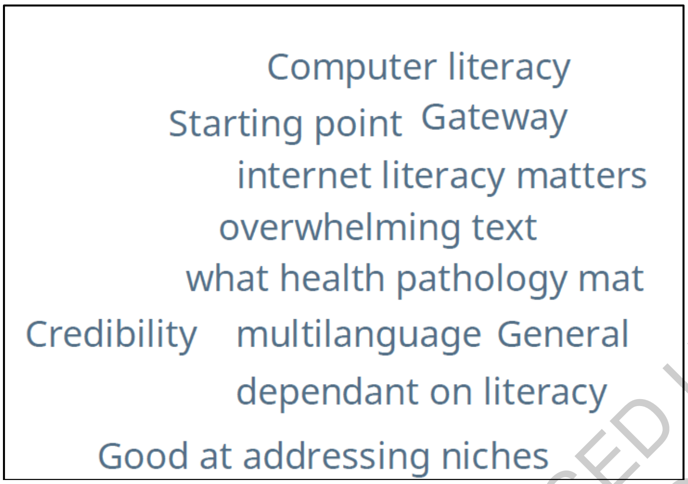
Peer Group Services
friendly colours
menu
drill
easy
specifics
mobile friendly
deficit based
Speaks to young people

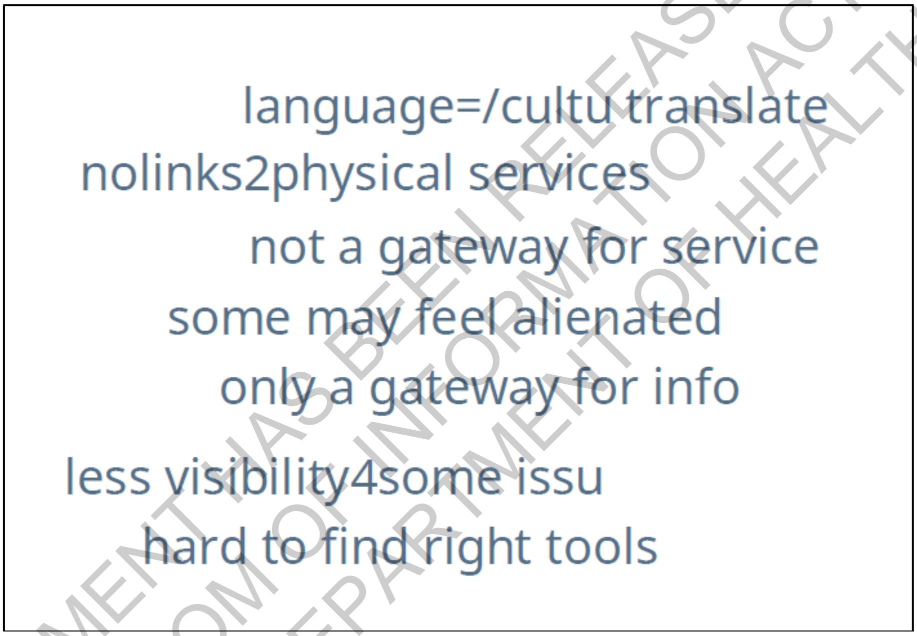
Weaknesses of Head to Health word clouds





Effectiveness of Head to Health word clouds





Most and least important features of Head to Health

Most important
Tailored links

An easy to understand interface

Visually appealing but not excessive use of colours

easy to understand

Engaging not over-whelming

Some live chat, real time interaction

Visually calming and accessible

Way to Narrow info down to me so less overwhelming

Accessibility

Comprehensive without being too overwhelming

Design - a bit childish looking

Link to real people and services - it won't replace specialists

Don't think this replaces specialists and access especially rural

Link to support groups too

Has the information you need/want

Links to further discussion or tools or physical services

being able to rate the relevance/effectiveness of resources,

accessibility

wide variety of resources

Need way through via HOPE, recovery

Focus on recovery

empowering people to update an engaged info space

don't just connect back to mainstream models that don't connect back too community.

Opportunity to normalise to reduce stigma and self stigma and promote help finding…

need to mention that it is normal that a significant number of people experience.
A lot of transformative stuff is peer base, grass roots, non govt, so it would be great to make those resources available to a wider audience and updating and remaining in touch with the peer spaces

We need redesign for people with substantial and enduring distress.
Normalise mental health issues

Least important
Jargon

Formal language

Very long paragraphs

all relevant

Bloody awful cartoon figures

Chatbots

Referral to Beyond Blue or Lifeline

Need less basic info and address more complex needs

AusHSI Australian Centre for Health Services Innovation

QUT

Evaluation of the Program of Assistance for Survivors of Torture and Trauma

Prepared for the Department of Health

Final Report
June 2022

Bringing health innovation to life

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Glossary of terms

Acronym or abbreviation	Full name
ACT	Australian Capital Territory
ASeTTS	Association for Services to Torture and Trauma Survivors
AusHSI	Australian Centre for Health Services Innovation
CEO	Chief Executive Officer
EAP	Employee Assistance Program
FASSTT	Forum of Australian Services for Survivors of Torture and Trauma
FICT	Families In Cultural Transition program
HSP/HP	Humanitarian Support Program
IRCT	International Rehabilitation Council for Torture Victims
KPI	Key Performance Indicator
Melaleuca	Melaleuca Australia
MRC	Migrant Resource Centre
NSMHS	National Standards for Mental Health Services
NSW	New South Wales
NT	Northern Territory
OPICT	Older People In Cultural Transition program
PASTT	Program of Assistance for Survivors of Torture and Trauma
Phoenix	Phoenix Centre
PPE	Personal Protective Equipment
QIP	Quality Improvement Plan
QLD	Queensland
QPASTT	Queensland Program of Assistance to Survivors of Torture and Trauma
QUT	Queensland University of Technology
SA	South Australia
SCHADS	Social, Community, Home Care and Disability Services Industry Award
SGA	Commonwealth Standard Grant Agreement
SHEV	Safe Haven Enterprise Visa

SIS	Specialised and Intensive Support Services
STARTTS	Service for the Treatment and Rehabilitation of Torture and Trauma Survivors
STTARS	Survivors of Torture and Trauma Assistance and Rehabilitation Service
TAS	Tasmania
TSV	Temporary Substantive Visa
UN	United Nations
US	United States
VFST	Victorian Foundation for Survivors of Torture (Foundation House)
VIC	Victoria
WA	Western Australia
WHO-5	World Health Organisation-Five Well-being Index

Executive summary

Background

The Program of Assistance for Survivors of Torture and Trauma (PASTT) is a specialist service available to refugees who settle in Australia and are survivors of pre-migration conflict and human rights abuses including physical and psychological harm. PASTT is funded by the Commonwealth Department of Health and has operated for over 27 years. It is currently administered by eight not-for-profit state and territory-based agencies forming the Forum of Australian Services for Survivors of Torture and Trauma (FASSTT). PASTT is provided Australia-wide including in many regional and rural areas.

The flexible nature of PASTT allows for services to be tailored to clients' needs for short, medium, or long-term support. Services are offered at the individual, family, and community level and include counselling, community capacity development work, and advocacy. FASSTT agencies also engage in research activities and partner with mainstream services to provide care to clients. A key aim of PASTT-funded work is to improve the effectiveness of mainstream health and community organisations to support successful resettlement of refugees by delivering professional development and training activities to mainstream providers.

The Australian Centre for Health Services Innovation (AusHSI) was engaged by the Commonwealth Department of Health to independently evaluate the Program of Assistance for Survivors or Torture and Trauma (PASTT).

This evaluation examines the implementation (appropriateness, acceptability, challenges), outcomes (client, third-party provider, and community), and economic considerations related to PASTT service provision, including in regional and rural areas. The alignment of PASTT (and FASSTT activities) with international standards of evidence, is also considered.

The evaluation employed a mixed-methods approach. Data sources included:

- Quantitative activity data and other program data routinely collected by FASSTT agencies including service delivery activities (e.g., counselling sessions), program referrals, client outcomes and qualitative client feedback
- Quantitative financial data prepared by FASSTT agency staff for the purpose of this evaluation
- Individual and group qualitative interviews with FASSTT agency staff including upper management, clinical/counselling, community capacity building, and administration and corporate services
- Individual qualitative interviews with previous clients of PASTT
- Qualitative interviews with, and survey responses (quantitative and qualitative) from, external stakeholders who work with FASSTT agencies

It is noted that much of the data provided for this evaluation was self-reported by agencies or qualitative in nature, and so may be subject to recall bias, selection bias, or other limitations. To address this, data from multiple sources have been analysed and compared (where appropriate) to inform findings. Relevant academic literature has also been drawn upon.

Key findings

There are, in total, 36 key findings arising from the evaluation. Nine findings relate to implementation appropriateness; eight each to regional and rural service delivery, and outcomes achieved; nine to economic analysis; and two to alignment with best practice.

Appropriateness and acceptability of PASTT	
Finding A1	Culturally appropriate approaches (e.g., community healing) and needs-based support (e.g., helping with schooling, advocacy, settlement) are equally important for improving clients' well-being as therapeutic approaches (e.g., counselling). Mainstream care was not perceived to be appropriate to meet the complex needs of many PASTT clients.
Finding A2	PASTT demonstrates high levels of appropriateness in meeting client needs and improving access and outcomes for refugee communities.
Finding A3	The three defining features of PASTT's appropriateness are: 1. delivery of a specialised culturally responsive and trauma-informed service model; 2. establishment and maintenance of a connection to community; and 3. flexibility in approach regarding how, when, and which services are accessed and delivered. Any future iteration of PASTT should seek to retain these three key features at its core.
Finding A4	There is a continued need for PASTT to build the skills and capacity of mainstream services to respond to and care for refugee clients appropriately.
Finding A5	Building and sustaining a long-term connection with communities is essential if PASTT is to reduce stigma and contribute to early intervention and prevention work.
Finding A6	The Forum of Australian Services for Survivors of Torture and Trauma (FASSTT) is effectively facilitating the funding allocation and service delivery of PASTT. However, to support sustainability consideration should be given to leadership succession planning and maintaining a successful and timely democratic decision-making process.
Finding A7	The flexibility provided in PASTT contracting agreements is a strength of current governance arrangements as it allows individual FASSTT agencies to maintain autonomy, be innovative, and respond to local needs.
Finding A8	Consideration should be given to reviewing current reporting requirements, performance indicators, and evaluation criteria to align with PASTT's underpinning philosophy and adequately capture the range and type of services which may be appropriate for clients' needs.
Finding A9	PASTT is client-centred and satisfactorily meeting the needs of its clients for service delivery within its scope. There may be an opportunity for FASSTT agencies to better communicate with clients regarding services that the agency can and cannot provide them at the outset of engagement.
Regional and rural implementation of PASTT	
Finding R1	Overall, the findings support a need for PASTT delivery in regional and rural communities, however the service delivery models used in metropolitan areas have not been fully realised in regional settings.
Finding R2	Balancing service demand and organisational capacity is a key challenge for regional and rural PASTT delivery. Capacity to respond is impacted by organisational factors (e.g., resourcing, staffing) and the region's geographical context (e.g., higher cost of service delivery, limited workforce, and lack of third-party providers).
Finding R3	Regional and rural communities are not homogenous so a single model to fund or deliver all regional PASTT services is not appropriate. Rather, it is important to support and encourage the development and delivery of locally relevant models of care.
Finding R4	The non-directive, flexible and adaptable nature of the PASTT program and its funding facilitates each FASSTT agency to work effectively in regional and rural areas using models of care appropriate to the local and state-based context.

Finding R5	The three major strategies used by FASSTT agencies to adapt PASTT delivery for regional and rural areas are: 1. establishing local offices to provide direct service delivery; 2. partnering with local third-party organisations to deliver PASTT services; and 3. using digital solutions.
Finding R6	FASSTT agency staff in regional and rural areas are often required to work beyond the scope of practice required in metropolitan areas (e.g., assisting refugee clients with finding suitable housing or applying for work).
Finding R7	There is a need to dedicate time and funding to training and capacity building of mainstream regional service providers and undertaking regional community development work to enable holistic delivery of PASTT in these communities.
Finding R8	PASTT funding could be better allocated or increased to address some of the current challenges in regional service delivery. However, inherent systematic challenges associated with service delivery in regional and rural Australia are likely to remain. Consequently, it may be pertinent to discuss whether the PASTT model of care needs to be re-engineered for regional services.
Outcomes achieved (effectiveness)	
Finding O1	PASTT is effective in achieving its aim of improving the psychosocial health and wellbeing of people who have experienced torture and trauma prior to their arrival in Australia.
Finding O2	PASTT is effective in assisting refugees engage with Australian society including through employment, education, and social avenues.
Finding O3	PASTT is mostly effective in its engagement with a range of third-party providers to enhance their capacity to support refugees who have experienced torture and trauma. However, to enable greater collaboration and sustainability, it will be important to address issues of trust with third-party providers; improve FASSTT involvement in system-level collaboration; and better communicate information about national and state PASTT funding, scope, and priorities to key external stakeholders.
Finding O4	The ongoing demand for training of third-party providers, and high costs of developing and delivering these services, may warrant increased funding allocation for this service activity.
Finding O5	The available evidence indicates that PASTT provides a safe, comfortable space for community healing and contributes to positive changes in refugee communities. Increased social cohesion, improved confidence and self-agency of groups and individuals, increased trust in the health system, and mental health stigma reduction have been reported.
Finding O6	An important individual and system level outcome of PASTT is the employment of former clients within FASSTT agencies and the resulting ability to embed culturally appropriate lived experience in service delivery.
Finding O7	The broad scope of PASTT activities necessitates an evaluation of impact that encompasses measurement at the client, provider, service, community, and society level using both objective and subjective measures of impact. Given this may present challenges, there needs to be nuance into how the impact of PASTT is measured and acknowledged, particularly where it is linked to achieving ongoing funding.
Finding O8	A more clearly defined national framework for classifying and reporting sector development and community engagement activities (including some pre-defined categories) would support ongoing quality improvement and evaluation activities of the PASTT program.
Economic analysis (efficiency)	
Finding E1	Recent policy decisions, including reductions in the Humanitarian Program intake and cessation of the Social and Community Services Workers Wage Supplementation scheme, have resulted in significant disruption to core income streams across FASSTT agencies.
Finding E2	The current PASTT funding model and base funding allocation is not fit for purpose due to: 1. a growing pool of humanitarian entrants accessing services over a relatively long period post settlement; 2. an increasing proportion of clients settling in regional and rural areas; 3. increasing costs of service delivery, especially wage-related costs; and 4. the impact of external stressors like international humanitarian crises and COVID-19.

Finding E3	FASSTT agencies report a relatively low rate of indirect costs, reflecting the prioritisation of crisis-driven service delivery above long term planning and infrastructure investment. This may be indicative of financial vulnerability. Investment in national-level infrastructure for supporting services would likely provide a more efficient use of resources than agencies making investments in silos.
Finding E4	Appropriately classifying and funding interpreter services at the national level should be a high priority in future funding allocations.
Finding E5	At least 46% of humanitarian entrants have been enrolled in PASTT individual counselling services in the 10 to 20 years following their settlement.
Finding E6	There is an increasing level of unmet need within the system as evidenced by growing waiting lists.
Finding E7	There is a need for better resourcing of, and long-term investment in, community capacity building and engagement activities within the program, particularly for successful early intervention work.
Finding E8	The categorisation and reporting of agency expenses as they relate to key activities and services is inconsistent across FASSTT agencies. A consistent national framework with clear definitions for reporting expenditure against pre-defined categories would support ongoing quality improvement and evaluation activities.
Finding E9	Any new PASTT funding model should consider the cumulative eligible population, regional and rural service delivery, adequate and competitive staff salaries, longer funding durations, and balancing base and surge/crisis funding.
Alignment with best international practice	
Finding IP1	PASTT is clearly aligned with key international best practice standards as a specialist service that meets the recovery needs for refugee survivors of torture and trauma.
Finding IP2	Additional opportunities to meet standards identified in international best practice relate to: 1. consistently implementing care for staff (particularly during surges in service demand) 2. better strategic and supported systems advocacy for PASTT services and rehabilitation funding; and 3. improving access to interpreters, particularly in regional and rural areas.

Suggested Citation:
Abell B, Carter H, Davidson K, Rodwell D and Tyack Z. Evaluation of the Program of Assistance for Survivors of Torture and Trauma: Final Report. Brisbane (AU): Australian Centre for Health Service Innovation; 2022.

Report structure

This evaluation report is structured as follows:

- *Chapter 1: Introduction.*
- *Chapter 2: Evaluation methodology.* This chapter outlines the evaluation aim, key evaluation questions guiding the evaluation, evaluation methods, and considerations in evaluating PASTT.
- *Chapter 3: Appropriateness and acceptability of PASTT.* This chapter analyses the implementation of PASTT including 'what has' and 'what has not' worked in terms of the delivery model and governance structures, along with its appropriateness and ability to effectively address client needs.
- *Chapter 4: Regional and rural implementation of PASTT.* This chapter analyses the implementation of PASTT, including 'what has' and 'what has not' worked in terms of providing activities in regional and rural areas, along with how this impacts PASTT's ability to effectively address client needs.
- *Chapter 5: Outcomes achieved.* This chapter examines the extent to which program outcomes are achieved at the client, service-provider, health system, and community levels.
- *Chapter 6: Economic analysis.* This chapter examines the funding arrangements, costs, and financial pressures of PASTT.
- *Chapter 7: Alignment of PASTT with best international practice.* This chapter considers the alignment of PASTT with international best practice for meeting the recovery needs of refugee survivors of torture and trauma.
- *Chapter 8: Findings and conclusion.* This chapter consolidates findings as discussed through the report, including an additional summary of barriers and enablers to PASTT's effectiveness.
- *Appendices.* This includes data collection tools, relevant reports and literature, supplementary data, case studies, and additional quotes from stakeholder consultation.

Chapter 1. Introduction

The Australian Centre for Health Services Innovation (AusHSI) was engaged by the Commonwealth Department of Health (DoH) to conduct an evaluation of the Program of Assistance for Survivors of Torture and Trauma (PASTT).

The purpose of this evaluation was to obtain an independent and evidence-based evaluation of PASTT in contributing to the successful resettlement of refugees of Australia. Specifically, the evaluation sought to assess the appropriateness, effectiveness, and efficiency of PASTT, aligned to key evaluation questions. The evaluation will be used to inform future PASTT planning and improvement.

1.1 The impact of torture and trauma on refugees

Globally, by the end of 2020, more than 82 million people had been forcibly displaced because of persecution, conflict, violence, human rights violations, or events seriously disturbing public order[1]. Among them are over 26 million refugees, with half being under the age of 18[1]. A total of 34,400 refugees were resettled worldwide in 2020 alone[1]. Australia has a long history of assisting displaced peoples, having resettled 920,000 refugees and others in need since the end of the Second World War[2].

The effects of forced displacement are profound. Many refugees have experienced conflict, family separation, and significant torture and trauma prior to arrival in a settlement country[3]. Estimates suggest that as many as 35% of refugees have been physically tortured or psychologically violated worldwide[4]. These experiences may have significant impacts on an individual's immediate and long-term physical and psychological health[5]. For example, research indicates that torture and trauma survivors may suffer from traumatic brain injuries[6], experience neurological symptoms (headaches, vertigo, loss of consciousness, dizziness)[7], and psychological problems including anxiety, phobias, depression, and post-traumatic stress disorder[4,3, 8, 9]. Moreover, torture and trauma can shatter survivors' sense of security, their assumptions about their safety, the predictability of and trust in others, and their sense of self-worth and control[10]. The physical and psychological consequences of torture and trauma can cause disability or restricted functioning, and have damaging effects on survivors' social functioning, health, and well-being[5]. These impacts are often not only experienced by the individual survivors but also by their families and can lead to disruptions in communities and broader society.

1.1.1 Defining torture

Torture can take many forms. It can be physical or psychological and consist of beatings, electric shocks, sexual abuse, solitary detention, mock executions, sensory deprivations, being forced to witness others being torture or killed, and detention in harsh and inhumane conditions[11]. There are no boundaries to torture; children, women, and men, of any age, political, religious, cultural group, or societal class can be targeted.

In Article 1 of the Declaration on the Protection of All Persons from Being Subjected to Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (1975), the United Nations Office of the High Commissioner for Human Rights[12] defines torture as:

> *“1. Any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted by or at the instigation of a public official on a person for such purposes as obtaining from him or a third person information or confession, punishing him for an act he has committed or is suspected of having committed, or intimidating him or other persons. It does not include pain or suffering arising only from, inherent in or incidental to, lawful sanctions. 2. Torture constitutes an aggravated and deliberate form of cruel, inhuman, or degrading treatment or punishment.”*

1.2 Programs for survivors of torture and trauma

Rehabilitation of torture and trauma survivors is complex. It requires an in-depth understanding of torture and trauma and its effects, and expert skills in design and delivery of flexible, creative, adaptable, and responsive services to individuals, groups, and communities[10]. Several interventions focusing on improving the mental health of refugee survivors of torture and trauma have been reviewed in the literature. For example, Shaw and Funk[13] searched academic research databases and selected and analysed 68 social services programs developed for refugees. Programs were grouped into interventions focused on general adaptation, relationships, financial and employment support, or a specific area such as involvement in sport. Using Cochrane review methodology, Patel et al.[5] identified nine Randomised Controlled Trials (RCT) of programs delivering interventions based on psychological treatments such as Narrative Exposure Therapy (NET) and Cognitive Behavioural Therapy (CBT). Murray, Davidson, and Schweitzer[14] reviewed 22 intervention programs to improve refugee mental health after resettlement. These programs focused on interventions including CBT, school-based interventions, music therapy, drama therapy, creative expression workshops, coping skills, a sandplay program for school age children, and family group interventions.

Many programs have been evaluated and while some report positive changes or outcomes the findings are generally mixed[13]. There is also some suggestion in the literature that the findings to date may not be robust and should be treated with some caution. For example, in their review of RCTs, Patel et al.[5], found that the quality of the methodology employed in the studies was low and there was a high risk of bias in the results. In addition, the interventions that have been developed appear to be mostly short-term in nature, offering individual or group treatment to a specific refugee population[5, 13, 14]. While potentially important for individual recovery, it is unlikely that short-term and disconnected interventions provide an opportunity to comprehensively establish safety, trust, and facilitate service providers to build a strong connection with survivors, which are essential to both the commencement of healing and long-lasting rehabilitation[13, 15]. Hence, it is necessary that torture and trauma survivors have access to a range of services offered through a long-term, well-established, and evidence-based rehabilitation program.

1.2.1 International snapshot of programs for survivors of torture and trauma

Programs for survivors of torture and trauma are offered in many countries. A list of over 160 centres from 76 countries is available on the International Rehabilitation Council for Torture Victims (IRCT) website[16]. As this list includes only the IRCT member centres it is possible that more programs are available.

This section in the report focuses on programs available in the countries that, according to the United Nations High Commissioner for Refugees (UNHCR), resettled the largest number of refugees in 2018 (latest official government statistics submitted to the UNHCR)[1]. This included Canada who admitted the largest number of resettled refugees (27,100), followed by the United States of America (US) (22,900), Australia (12,700) and the United Kingdom (UK) (5,800). **Table 1** provides a summary of programs available to refugees resettled in Canada, the US, and the UK. In Section 1.4 the Australian Commonwealth Program of Assistance to Survivors of Torture and Trauma (the focus of this evaluation) is introduced and described including a comparison of this program with those described in **Table 1**. It is noted the information provided below is not exhaustive and was sourced mainly from grey literature (non-academic/non-commercially published), when available, and a search of relevant websites.

Overall, each country provides a range of services to the survivors of torture and trauma. These include individual and group counselling, various therapies, advocacy, legal assistance, practical help such as language development, finding employment, housing or medical care, and training and education to external organisations[17-22]. Community development and capacity building activities are largely missing from the portfolio of services available for torture and trauma survivors internationally.

The reach and funding arrangements of international services varied among the countries. For example, in the US, less than half of states (22 out of 50) offer specialised services for torture and trauma survivors that are funded by the U.S. Department of Health and Human Services [21, 23] and only 20 centres are listed as IRCT members[16]. Torture and trauma survivors who resettle in Canada can access individual and group therapeutic support delivered by three IRCT-member organisations based in Toronto [17], Montreal [19] and Vancouver [22]. Services are free and funded under the government's Interim Federal Health program that offers 'limited, temporary coverage of health-care benefits' [24] or via donations from the public and other funders [17, 19, 22]. In the UK, two IRCT-member charitable organisations offer services to torture and trauma survivors across several centres[18, 20]. These organisations are largely funded by grants, other charities, foundations and donations[18, 20].

Table 1. *Summary of programs for survivors of torture and trauma who resettle in Canada, the US and UK*

Country*	Reach	Centre and/or program and their activities	Funding
Canada	3 cities	The Canadian Centre for Victims of Torture (CCVT) in (Toronto) Vancouver Association for Survivors of Torture (VAST) Fund Rivo Resilience (Montreal) Offer individual and group therapeutic support, counselling, art therapy, crisis intervention, access to professional services, legal aid, employment services, recreational activities, mentoring, peer support, community engagement, public education, language training	Government's Interim Federal Health Program and via donations from public and other funders
US	22/50 states	43 Programs 100% offer social services (health service coordination) 93% offer psychological services (individual therapy, psychosocial support groups, wellness and art, alternative therapies, psychological evaluations) 73% offer medical services (physical therapy, occupational therapy, medical evaluations, medical forensic evaluations) 73% offer legal services 27% offer 'other' services (advocacy, employment services, micro-enterprise development, adult education, childcare)	U.S. Department of Health and Human Services, federal and state grants, the United Nations Voluntary Fund and funding from foundations, individuals, corporations etc.
UK	5 cities and presence in 2 counties	Freedom from Torture (London, Manchester, Newcastle, Glasgow, Birmingham, presence in Yorkshire and Humberside) Room to heal (London) Offer individual and group therapy and practical help (with accessing legal representation, medical care, housing, prepare for employment, education and training), medico-legal reports, training for organisations	Grants, other charities, foundations, and donations

*All centres were contacted to seek further information about their programs, activities, reach, and funding to complement data found via their websites. Details about the US program were provided by HealTorture Logistics and Communication Coordinator via email. All other centres did not respond.
Sources: [17-23]

1.3 Australian Commonwealth Government's Humanitarian Support Program

Australia has a well-established and internationally respected approach to refugee settlement[25]. The Commonwealth Government's Humanitarian Support Program (HSP) assists humanitarian entrants and other eligible visa holders during their initial settlement in the country by offering support via an individualised case management approach[2]. This may include support in terms of airport reception, general orientation, accommodation, referral to mainstream and specialised support services, connections to local community groups and activities, assistance to learn English and access education and training, and/or find employment[2]. Specialised and intensive support services (SIS), which are a component of the Humanitarian Support Program, are provided to clients with complex needs such as disability, severe health needs, mental health issues, homelessness or housing instability, domestic or family violence, child and youth welfare concerns, family and/or relationship breakdown, social isolation, financial hardship, and/or legal issues[26]. While most clients use services under the Humanitarian Support Program for six to eighteen months they can continue accessing HSP services for up to five years after their arrival to Australia[2].

1.4 The Commonwealth Program of Assistance for Survivors of Torture and Trauma

In addition to the Humanitarian Support Program, eligible clients who have pre-migration experiences of conflict and human rights abuses can also access PASTT-funded services. This includes Humanitarian Program (HP) entrants permanently resettled in Australia, and people on Temporary Substantive Visas (TSVs) and Safe Haven Enterprise Visas (SHEVs).

Established in 1995, PASTT is a specialist support service funded by the Commonwealth Department of Health (DoH) that has been offered to refugee survivors of torture and trauma who settle in Australia[27]. Under the PASTT program, survivors can access specialised counselling and related support services with or without a diagnosed mental health illness. Interventions and support are offered at the individual, family, and community level. The flexible and adaptable nature of the PASTT program's model allows for services to be tailored to the clients' needs.

PASTT has been reported as a key complementary referral service for the Humanitarian Support Program to support the successful settlement of humanitarian entrants. Importantly, clients can engage, disengage, and reengage with PASTT at any time after their arrival in Australia as program eligibility is not time dependent on the date of arrival. Clients who access PASTT services can continue to do so after they exit the Humanitarian Support Program. This offers survivors of torture and trauma an opportunity to establish their lives in Australia and seek support from PASTT when they need it most.

1.4.1 Aims and objectives of PASTT

The overarching aim of PASTT is to contribute to the successful settlement of refugees in Australia in the short, medium, and long term[27]. Specific objectives are to:

- Provide survivors of torture and trauma with appropriate counselling and related support services
- Promote the physical health and psycho-social recovery of humanitarian entrants to Australia who have pre-migration experiences of conflict and human rights abuses, which make them vulnerable to developing mental health problems
- Provide services tailored to the needs of clients, whether this involves short, medium, or long-term support

1.4.2 Activities and scope of PASTT

The scope of PASTT encompasses a wide range of activities and services including – but not limited to – psychological assessments, individual psycho-therapeutic interventions, group and family therapy, specialist programs for particularly vulnerable cohorts, natural therapies, and community development. PASTT also provides support to the broader community and health services including professional development and capacity building for service providers (such as workers in the health, housing, education, and settlement fields), networking opportunities, research, volunteer programs, and case consultations.

Current Grant Operating Guidelines[27] define the specific PASTT eligible activities which may be flexibly delivered to meet the needs of local clients and communities. These include:

- Provision of direct counselling services to individuals, families, and groups
- Delivery of community development and capacity building activities
- Provision of education and training to health and other service providers
- Delivery of regional, rural, and remote outreach services
- Development of resources
- Advocacy and referrals to health and other services
- Delivery of community education and systemic advocacy
- Provision of activities that promote the psychological health and wellbeing of survivors of torture and trauma

1.4.3 PASTT delivery and governance

PASTT is administered by eight state and territory-based member agencies forming the Forum of Australian Services for Survivors of Torture and Trauma (FASSTT; see **Figure 1**). All FASSTT members are individual specialist not-for-profit torture and trauma support agencies which are based in each of the capital cities across the country. These agencies are:

- Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS; NSW)
- Victorian Foundation for Survivors of Torture (VFST/Foundation House; VIC)
- Queensland Programme of Assistance to Survivors of Torture and Trauma (QPASTT; QLD)
- Survivors of Torture and Trauma Assistance and Rehabilitation Service (STTARS; SA)
- Association for Services to Torture and Trauma Survivors (ASeTTS; WA)
- Phoenix Centre (TAS)
- Melaleuca Refugee Centre (Melaleuca; NT)
- Companion House (ACT)

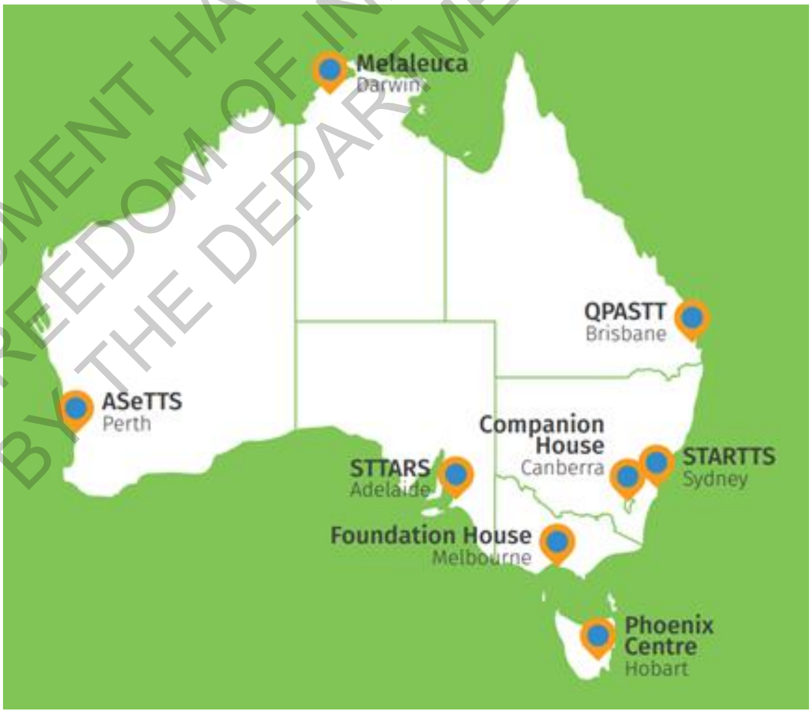

Figure 1. FASSTT member agencies in Australia

PASTT funding is used by the FASSTT agencies to provide direct services to clients, and along with funding provided from a range of other sources, to engage in complementary and supporting activities such as training of mainstream service providers, consultations, community development activities, and development of service infrastructure. However, it is important to note that each member agency of FASSTT operates, at base level, as an independent entity servicing the needs of client populations within the respective states and territories, with each having a separate PASTT Funding Agreement with the Department. However, FASSTT acts as a framework for the agencies to obtain and utilise funding to continue their work, to work collaboratively with each other, to share knowledge and resources, and develop, research, and innovate trauma-informed models of care appropriate and effective for use with refugee survivors of torture and trauma.

The Forum of Australian Services for Survivors of Torture and Trauma

FASSTT is a network of specialist agencies with the mission of providing short, medium, and long-term assistance to refugee survivors of torture and trauma, and to work to improve the capability of mainstream providers in working with clients with these special characteristics and needs[28]. It was established in 1992 and in 1995 was engaged by the Department of Health to establish PASTT to ensure there was nationwide access in Australia to longer-term counselling and interventions, and to improve refugee survivor access to, and utilisation of, mainstream health services[28]. In 2011, a separate short-term torture and trauma program, originally developed as part of the Integrated Humanitarian Settlement Strategy funded by the Commonwealth Department of Immigration and Citizenship, was merged into PASTT[28].

Since 2021, FASSTT has been registered as a not-for profit company limited by guarantee, reinvesting any surplus back into achieving the organisation’s purpose. This also gives FASSTT an enhanced capacity to operate as a single national legal entity where appropriate and facilitates the running of the FASSTT national office. FASSTT employs a National Coordinator who plays an important role in facilitating engagement across the eight member agencies, including their collective collaboration with the Commonwealth Department of Health. Each FASSTT agency CEO or Director is an equal voting member of the FASSTT Board. FASSTT also advises the Department of funding distribution across the member agencies.

There is a symbiotic relationship between PASTT and FASSTT[28]. Namely, FASSTT exists as an entity because of the existence of PASTT, while PASTT could not be delivered effectively without the existence of FASSTT[28]. Consequently, while this evaluation focusses on the implementation and impact of PASTT, in doing so it is important to recognise its interrelationship with the broader work of FASSTT member agencies.

1.4.4 PASTT logic model

At the beginning of the evaluation AusHSI designed a logic model based on our understanding of PASTT from program documents. Throughout the evaluation we have added to and adapted the model based on our discussions with stakeholders and analysis of data. While each FASSTT agency adapts its PASTT-funded activities to suit their local context (see Chapter 3) a broad depiction of key inputs, processes, and outcomes consistent with PASTT logic is presented below in **Figure 2**.

Issue	Response	Participants	Activities and contexts of work	Outcomes	Short-term Impact	Long-term Impact
Arrival of survivors of pre-settlement torture and trauma in Australia, making them vulnerable to developing mental health problems and who may require specialist rehabilitation services to support and improve their health and wellbeing	The Australian Government funds 8 members of the FASSTT network to deliver PASTT in each state and territory	Humanitarian entrants, Temporary Substantive Visa holders, Safe Haven Enterprise Visa holders and their families FASSTT and member agencies Refugee communities Government and relevant government agencies Health and community service providers	Counselling (individual, family, group)	Improved psycho-social wellbeing of clients and their families	Survivors of torture and trauma provided with appropriate counselling and related support services Promotion of the physical health and psycho-social recovery of humanitarian entrants to Australia who have pre-migration experiences of conflict and human rights abuses Provision of services tailored to the needs of clients, including short, medium, or long-term support	Improved health and wellbeing of torture and trauma survivors who access PASTT rehabilitation services preventing longer term dependency on health and social services Support of survivors by local communities contributes to thriving local communities Contribute to successful resettlement of refugees in Australia including social and economic participation
			Education and Training (internal & external)	Increased effectiveness of FASSTT agency workforce Increased effectiveness of 3rd party providers		
			Community development and capacity building	Increased community capacity, capability, and resilience		
			Rural, regional, and remote outreach	Improved equity in access and outcomes for clients in regional and metropolitan locations		
			Resource development	Efficient development and use of effective resources		
			Advocacy, consultation & engagement	Effective advocacy, consultation & engagement at the local, state, and national level		

KEY ACTIONS TO UNDERPIN CONTINUED AND SUSTAINED OUTCOMES OF THE PROGRAM

- Continued provision for local flexibility in use of funding and program delivery
- Continued provision of culturally appropriate approaches and needs-based support through PASTT agencies, and support to external agencies to ensure this support is delivered
- Extending the base funding allocation to reach beyond urgent short-term agency priorities (e.g., counselling) to longer term priorities (e.g., community development)
- Building and sustaining a long-term connection with communities

***Figure 2**. PASTT Logic Model*

Chapter 2. Methodology

The evaluation aim, key evaluation questions guiding the evaluation, evaluation methods, and considerations in evaluating PASTT are discussed in the following chapter.

2.1 Aim of the evaluation

The purpose of the evaluation is to obtain an independent, evidence-based assessment of the appropriateness, effectiveness, and efficiency of PASTT in contributing to the successful resettlement of refugees in Australia. The evaluation also seeks to provide an assessment of what is working well with PASTT, and how the program could be improved in the future.

2.2 Evaluation questions

Key evaluation questions aligned with PASTT objectives were provided by the Department of Health and underpinned the conduct of the evaluation. These questions guided decisions on data collection and analysis. Each of the four key questions and their sub-questions are presented below. **Table 2** outlines the corresponding report chapters for each key evaluation question.

2.2.1 Key question 1: How appropriate is the PASTT model?

a. Does PASTT align with key international best practice characteristics of a specialist service that meets the recovery needs for refugee survivors of torture and trauma?

b. What is the suitability of PASTT governance, funding arrangements, operation cost, and delivery model?

c. Extent to which services are consistent with, and tailored to, achieving the six specific program objectives:

    1. Improve the psychosocial health and wellbeing of people who have experienced torture and trauma prior to their arrival in Australia
    2. Increase the responsiveness of mainstream health and related services to the needs of people who have survived torture and trauma prior to arriving in Australia, through the provision of training and support services
    3. Build the confidence of refugee communities to access mainstream health and related services through capacity building activities
    4. Provide regional, rural, and remote outreach services to enable survivors of torture and trauma to access comparable services outside metropolitan areas
    5. Provision of resources to support and enhance the capacity of specialist counselling and related support services to deliver effective services to survivors of torture and to respond to emerging client needs
    6. Provide community education and advocacy to overcome any barriers to access and equity for the client group

2.2.2 Key question 2: How efficient has PASTT been?

a. How efficiently have resources been used by PASTT providers? Can this be improved?

b. Has the program delivered value for money and cost-effectiveness?

c. To what extent has the program avoided duplicating internal or external functions and services?

d. To what extent has the program has leveraged internal and external resources?

2.2.3 Key question 3: How effective has PASTT been?

a. What is the effectiveness of PASTT and Forum of Australian Services for Survivors of Torture and Trauma (FASSTT) engagement with and of third-party organisations in delivering the six specific program objectives?

b. To what extent are services consistent with, and tailored to, achieving the six specific program objectives?

c. To what extent did the program facilitate early intervention?

d. To what extent are activities evidence-based?

e. What is the capability and effectiveness of PASTT services in addressing client needs?

f. What is the appropriateness of services provided (including but not limited to availability and duration)?

g. What are the changes in client-reported outcomes?

2.2.4 Key question 4: How can the program be developed or refined to best deliver on outcomes?

a. What are the enablers and challenges to the program's effectiveness?

b. What additional opportunities are identified in international best practice?

c. What are the recommendations for annual appropriation and funding mechanisms?

***Table 2**. Alignment of key evaluation questions and report chapters*

Key evaluation question	Chapters
Question 1. How appropriate is the PASTT model?	3,4,6
Question 2. How efficient has PASTT been?	4,6
Question 3. How effective has PASTT been?	3,4,5
Question 4. How can the program be developed or refined to best deliver on outcomes?	6,7,8

2.3 Evaluation methods

The evaluation employed a mixed-methods approach using retrospectively and prospectively collected data. The initial stage of the evaluation involved informal discussions with key PASTT stakeholders from each of the eight FASSTT agencies to gain relevant information about the program and shape evaluation planning. Following ethical approval, AusHSI then collected and analysed both quantitative and qualitative data across four parts of the evaluation: alignment with international practice; evaluation of client, service, and implementation outcomes; cost-effectiveness and funding; and contextual and implementation factors. Data collection processes and data sources are depicted in **Figure 3** and outlined below in Section 2.5 . This triangulation of data from multiple sources, collected by multiple evaluators, helps to mitigate some of the biases involved with single data sources, provides a more holistic perspective on the program, and allows for increased trustworthiness and validity of the findings[29].

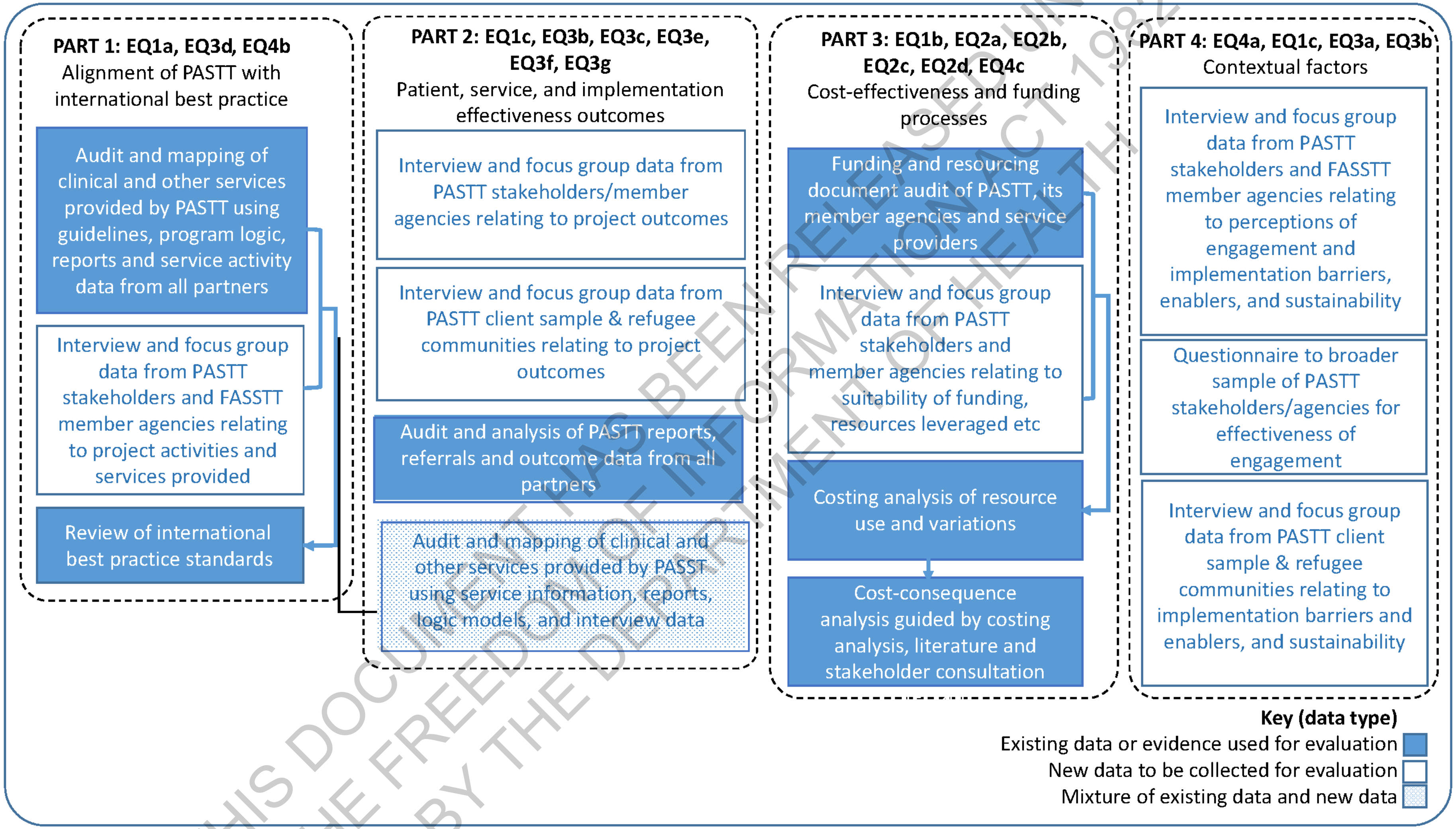

Figure 3. Overview of evaluation methods and data sources, aligned to evaluation questions

2.4 Ethics

Due to the vulnerable nature of PASTT clients and the nature of the activities conducted by FASSTT agencies it was deemed essential to obtain ethical review for the evaluation. To facilitate the efficient collection of data, two separate ethics review submissions were made. The first, granted on 17th February 2022 from Queensland University of Technology Human Research Ethics Committee, allowed commencement of individual and group interviews with key organisational and partner stakeholders (e.g., FASSTT employees) and distribution of an online survey to key external stakeholders and service partners. This ethics application was categorised as Negligible/Low Risk.

The second ethics approval was granted on 3rd June 2022 from Bellberry Ethics Committee (https://bellberry.com.au/), which allowed commencement of interviews with PASTT clients and community stakeholders/leaders. As expected, this application was categorised as 'Greater than Low Risk' due to the vulnerable nature and potential risks to participants in participating in research. This application was approved almost three months after the initial submission (on 11th March 2022) and involved three cycles of feedback during this time frame. Development of this second ethics application was complex and required consideration of potential harms and development of effective harm minimisation strategies. Through this process the AusHSI team developed a flexible plan for data collection from PASTT clients and others. The plan included partnering with individual agencies to ensure processes were acceptable to local stakeholders and likely to gain usable and informative data. The plan enabled data collection to be via individual or group interviews that were facilitated either by an AusHSI team member or a trained local bi-cultural worker/interpreter depending upon participant and organisational preferences and taking into account cultural factors.

2.5 Data collection

Upon request, AusHSI received a number of key documents from each FASSTT agency, the FASSTT national coordinator, and the Commonwealth Department of Health. Data sources are listed in **Table 3** together with the report chapters they inform. AusHSI performed audit, review, and analysis of all key documents listed in Table 3. In addition, as outlined in Section 2.5.1 , a key part of the evaluation consisted of qualitative interviews with key PASTT stakeholders[a].

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[a] Interviews with PASTT clients were delayed due to the ethics review process.

Table 3. *Evaluation data sources and alignment with report chapters*

Data source	Chapters
Quantitative	
FASSTT agencies' Data Table Report including service activities and reach	5,6,7
Client WHO-5 wellbeing index scores	5
Client goal achievement data: QPASTT, STARTTS, VFST	5
Agency-completed evaluation data request comprising 2017-18 to 2021-22 data on: income, expenses, cost profiles, client numbers, waiting list numbers, staff redundancies, award wage rates	6
Previous AusHSI-led report (commissioned by FASSTT): "Cost of service provision for survivors of torture and trauma in rural and regional locations: an environmental scan and costing analysis for FASSTT"	6
National-level humanitarian entrants' data[30]	6
Qualitative	
FASSTT agencies' Performance Reports	3,4,5,7,8
Qualitative interviews with stakeholders internal to FASSTT agencies	3,4,5,6,7,8
Qualitative interviews stakeholders external to FASSTT agencies	3,4,5,7,8
Qualitative interviews with former PASTT clients	3,5,7,8
Informal discussion with upper management personnel in FASSTT agencies	3,4,6,7,8
Case studies provided by FASSTT agencies (client and community level data)	3,5,6,7,8
Consultation with the Commonwealth Department of Health	1,6
Email communication (Department of Home Affairs, international centres for trauma and torture rehabilitation, FASSTT agencies)	1,7,8
Qualitative + quantitative	
Grey literature (government and non-government websites, reports, operating guidelines)	1,6
Peer-reviewed literature	1,3,4,5,6,7,8
Online questionnaire with external stakeholders	5,8
Client satisfaction survey data (STARTTS, STTARS)	3

2.5.1 PASTT stakeholder consultation and interviews

A semi-structured interview guide, designed to elicit responses to the evaluation questions, was used to direct conversation in all interviews (Appendix 1). In total, AusHSI conducted 26 (14 individual and 12 group) interviews with a total of 73 participants[b]. Interview length ranged from 29min 39sec to 1hr 31min 26sec. A total duration of 26hrs 29min of interviews was collected. Almost all interviews were conducted virtually using Zoom or Microsoft Teams and ranged in size from 1-5 participants. There was one large town-hall style interview with 22 participants conducted in-person by AusHSI evaluators.

Participants represented range of internal and external roles in relation to PASTT. Most participants were employees of FASSTT organisations. Participants in some interviews were from homogenous teams or areas within FASSTT organisations (e.g., were all clinical/counselling team members) while other interviews included a range of people in different roles in the FASSTT agencies (or external). Thirteen interviews included participants with upper managerial (e.g., CEO, CFO) or other managerial roles (e.g., team leaders). Nine interviews included FASSTT employees engaged in clinical or counselling roles. One interview included only FASSTT employees who were engaged in community capacity building roles; and one interview included only FASSTT employees in corporate services or administrative roles. Most interviews were conducted with stakeholders located in metropolitan areas of their state. There was one interview conducted

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[b] This does not include additional informal conversations with FASSTT agency CEOs and the FASSTT network coordinator which totalled 8-10 hours.

solely with external participants (not FASSTT organisation employees) to gain additional perspectives about relationships and impact on mainstream services. A summary of the characteristics of those consulted throughout the interview process is provided in **Table 4**.

As part of our ethical commitment to protect the privacy of individual interview participants, interviewees are not named by agency, organisation, or specific role within the report. This anonymity increased the likelihood that the participants could speak openly and honestly. This is important as there is a risk that interview participants may be identifiable to each other due to relationships within the FASSTT network and small size of some FASSTT agencies.

__Table 4.__ Characteristics of interviews and participants

Interview number	Interview and participant characteristics		
	Individual vs group	**FASSTT vs external**	**Role and level***
1	Individual	FASSTT	Upper management
2	Group (n=22)	FASSTT	Large multidisciplinary group including upper management
3	Individual	FASSTT	Upper management
4	Individual	FASSTT	Upper management
5	Group (n=3)	FASSTT	Upper management
6	Individual	FASSTT	Clinical/counselling services
7	Individual	FASSTT	Clinical/counselling services
8	Individual	FASSTT	Upper management
9	Group (n=5)	FASSTT	Clinical/counselling services
10	Group (n=4)	FASSTT	Community capacity building; Administration and corporate services
11	Group (n=4)	FASSTT	Upper management; Administration and corporate services
12	Individual	FASSTT	Upper management
13	Individual	FASSTT	Upper management
14	Group (n=3)	FASSTT	Clinical/counselling services
15	Individual	External	Upper management
16	Group (n=4)	FASSTT	Rural and regional services[#]
17	Individual	FASSTT	Upper management
18	Individual	FASSTT	Community capacity building
19	Group (n=2)	FASSTT	Administration and corporate services; community capacity building
20	Group (n=4)	FASSTT	Clinical/counselling services
21	Group (n=2)	FASSTT	Clinical/counselling services
22	Group (n=4)	FASSTT	Clinical/counselling services; Community capacity building
23	Group (n=2)	External	Upper management
24	Individual	FASSTT	Clinical/counselling services
25	Individual	FASSTT	Clinical/counselling services
26	Individual	FASSTT	Upper management

*Upper management includes positions such as CEO and CFO; clinical/counselling services includes positions that provide direct mental health interventions to clients as well as team leaders and managers; community capacity building includes positions that engage in community development work including team leaders and managers; administration and corporate services includes positions that perform functions related to the operation of the organisations not captured in the other categories; rural and regional includes positions that work primarily in or with rural and regional locations including direct service providers, team leaders and managers; large multidisciplinary group consisted of positions working across the spectrum of the other categories.

#While only one group specifically comprised rural/regional participants, the topic of regional service delivery was raised in almost all interviews, and those working regionally were captured in other roles (e.g., counselling)

2.5.2 PASTT client interviews

A semi-structured interview guide, designed to elicit responses to the evaluation questions, was used to direct conversation in all client interviews (Appendix 2). AusHSI conducted seven individual client interviews which ranged in length from 14 to 41 minutes. A total duration of approximately 2hours 40minutes of data was collected[c]. Interviews were conducted via Zoom or phone, depending on the client's preference. Six interviews were audio recorded and transcribed verbatim. One interview was conducted immediately upon first contact by AusHSI to schedule an interview, due to the client's preference which resulted in it not being audio recorded. All clients were offered a trained interpreter or bicultural worker to join an interview and assist with communication, however none requested this service. Three participants requested for their family member to join the interview to assist with translation, four participants were fluent in English and did not require an interpreter.

The interviewed clients accessed two PASTT services from four different agencies. This included homework club and counselling. Six client interviews are presented as case studies in Appendix 3 and referred to throughout this report.

2.5.3 Engagement survey

A brief online questionnaire was developed by AusHSI to capture data from a larger and broader sample of PASTT stakeholders outside the interviews. Content comprised demographic questions, provider/partner satisfaction, and benefits of the partnership. The results were used to triangulate the findings about implementation, engagement, and communication, reflect on satisfaction with partnerships established, and focus on ways to sustain collaboration into the future. FASSTT agencies distributed a link to the online REDCap questionnaire to relevant partners, third-party providers, and community organisations identified as supporting or delivering PASTT services.

2.5.4 Review of literature

Peer-reviewed and grey literature was sought, reviewed, and analysed to support the evaluation data and contextualise the findings. Grey literature included government and non-government reports (both published and unpublished), operating guidelines, and information available via several reputable websites. Published peer-reviewed literature was purposefully sourced from reputable academic journals and databases. A full reference list is provided at the end of the report.

2.6 Data analysis

Data analysis was conducted using de-identified aggregate and individual level outcome data. For quantitative data, descriptive statistics such as counts, costs, percentages, and means were used to calculate and present the relevant results of each outcome measure.

For all types of qualitative data (including that collected from interviews, written survey responses, discussion groups, and electronic platforms), data analysis adopted an inductive thematic approach. The raw data was used by individual researchers to group and categorise data, derive concepts, and develop preliminary themes which were later discussed in regular data analysis team meetings. During these meetings, higher level concepts and themes were derived. No predetermined expectations or themes was applied. Methods used to maintain trustworthiness and rigour of the qualitative analysis included reflexive journaling through data collection and coding, and coding by AusHSI researchers experienced in qualitative research and implementation science.

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[c] One interview was not recorded thus an estimation of overall length of interviews is provided.

2.7 Data limitations

Overall, the AusHSI team assessed the data as being sufficient to inform a robust evaluation of PASTT. FASSTT agencies have generally been rigorous in their data collection. However, some limitations should be noted. Quantitative data was provided by the agencies and not collected by the AusHSI team. The data that was provided included some missing data and there were occasionally discrepancies between data tables and workplans provided by the same agency, for the same reporting period. While similar types of quantitative data were provided by all FASSTT agencies, there were some inter-agency differences and inconsistencies in how the data was reported or how it was provided. In particular, reporting of community engagement work varied markedly by agency making it challenging to count activities, classify organisations/groups, or report on more granular or subgroupings of data.

PASTT agencies nominated internal and external stakeholders, and past clients for AusHSI to approach for qualitative interviews and were responsible for distributing the online survey for external stakeholders. Hence, it is possible that the stakeholders who shared their opinions and experiences about PASTT differ from those who did not participate in this evaluation. Further, some interview participants, for a variety of reasons, may have shared information that they believed to be more socially acceptable than their true beliefs. AusHSI limited opportunity for these biases to affect data collection and analysis by devoting time to developing a good working relationship with each agency and engaging with all key stakeholders in regular communication. Further, when possible, AusHSI ensured a broad range of stakeholders from each agency was engaged as participants.

Also, as further described in Chapter 5, attribution of outcomes is often difficult in social service delivery. However both quantitative and qualitative data have been used and triangulated where possible to increase confidence in findings while acknowledging limitations.

Chapter 3. Appropriateness and Acceptability of PASTT

This chapter considers PASTT appropriateness and acceptability using stakeholder consultation and existing client feedback. It also draws on published literature where appropriate. This chapter focusses on answering sub questions from key evaluation questions one and three as outlined below.

— *Key evaluation question one: How appropriate is the PASTT model? (suitability of the delivery model and program governance)*
— *Key evaluation question three: How effective has the program been? (appropriateness of services provided, addressing client needs)*

This analysis of the implementation of PASTT includes 'what has' and 'what has not' worked in terms of the delivery model along with its appropriateness and ability to effectively address client needs. The suitability of current program governance processes are also discussed. It draws largely on qualitative analysis which has occurred after extensive consultations with FASSTT agency CEOs, staff members, former PASTT clients, and external stakeholders. Where relevant, illustrative quotes are provided to highlight points. Additional supporting quotes can be found in Appendix 9. Quantitative analysis has been undertaken based on a review of existing client feedback interviews and surveys conducted by STARTTS and STTARS.

The following sections summarise analysis completed relating to:

— Appropriateness of PASTT
— Acceptability and client-centredness of PASTT

3.1 Appropriateness of PASTT service model

Appropriateness is the perceived fit or compatibility of a practice for a given consumer. This evaluation highlights three key features in relation to the appropriateness of PASTT in providing services to meet the needs of clients. These can be broadly described as:

1. The provision of a specialised refugee trauma informed service model
2. Flexibility in the approach to service delivery and client engagement
3. Building and maintaining connection to community

A visual representation of these three features is provided in **Figure 4**, along with an explanation of **why** these features are important for delivering appropriate services and **how** they help PASTT address client needs. These are explained in further detail in the subsequent sections. We suggest these three elements should be considered core features of PASTT as they are directly related to the philosophy that underpins the program and appear to be essential contributors to its effectiveness. These features also characterise PASTT's unique contribution to the sector and are relevant to defining the program's scope.

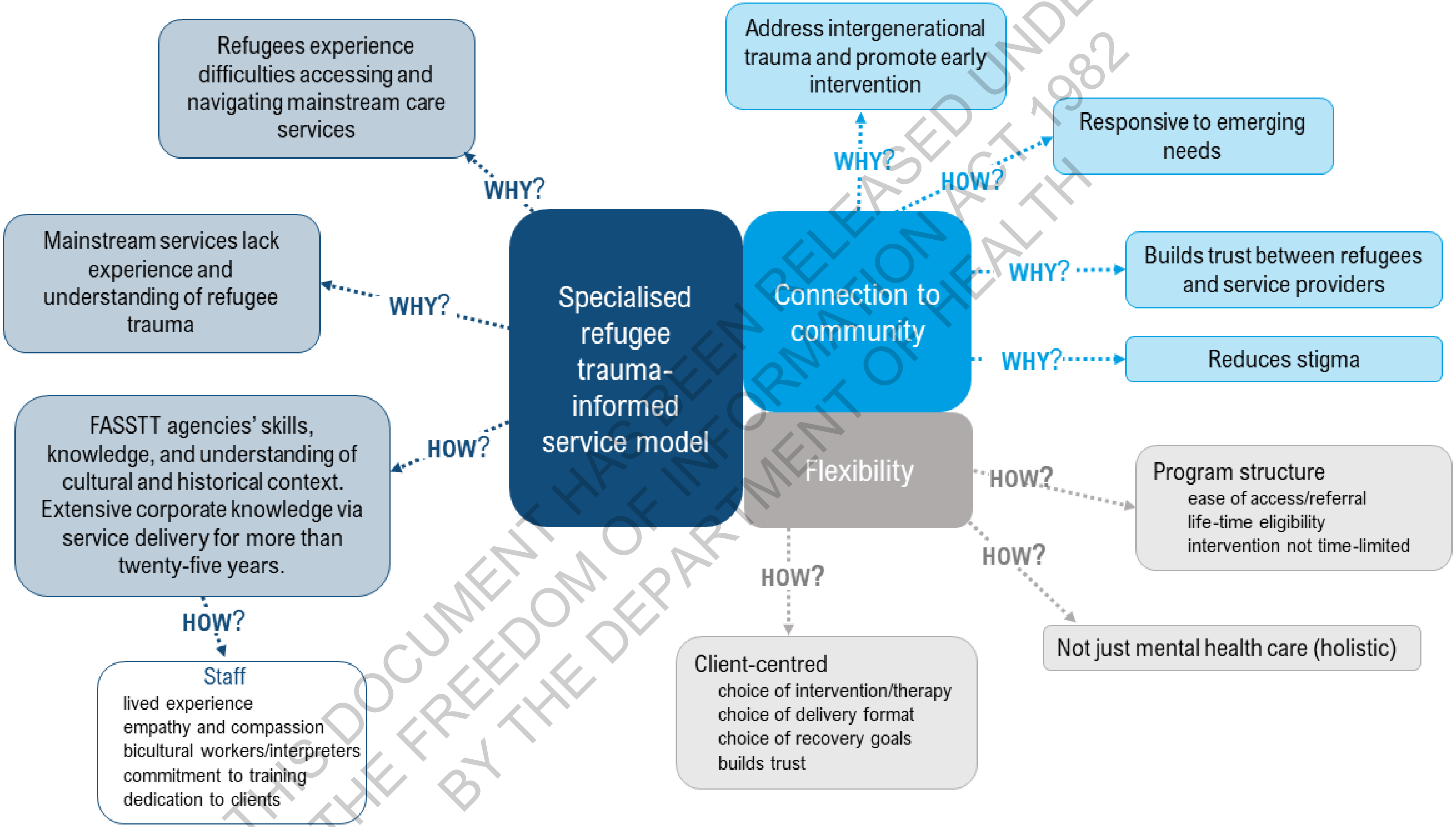

Figure 4. *Visual representation of key features contributing to the appropriateness of PASTT for survivors of torture and trauma (including how and why each feature does so*

3.1.1 A specialised refugee trauma informed service approach

Research has demonstrated that **refugees struggle to access and engage with mainstream healthcare services** both in Australia and internationally[31, 32]. Reasons include language barriers (perpetuated by a lack interpreter use), healthcare differences, cultural incompatibility of services, cultural stigma, discrimination/racism, service provider knowledge, and the consumer's lack of knowledge about the system[d]. These challenges were also raised in discussions with a range of PASTT stakeholders who additionally described the extra burden that accessing care via mainstream services disproportionally places on refugee clients. These challenges appeared to be exacerbated in regional and rural areas where mainstream services are already constrained. One stakeholder in a clinical/counselling role noted:

> *"In general, access to mental health services for our clients in [location] is really poor. It's pretty much impossible for people to find a psychologist who speaks their language and psychologists are generally not funded to access interpreters. So other forms of mental health support that the broader community are able to access are really just not available to our clients"*
> ***Interview 25, Clinical/counselling services, FASSTT***

Additionally, both FASSTT agency staff and clients reported that the eligibility criteria, complex referral pathways, intake processes, cost, service environment, limited treatment flexibility, fragmented nature, and time-limited duration of mainstream care was not appropriate for many PASTT clients due to the complexity of their situations.

Many of the challenges for refugees engaging with mainstream services occur because such services are not fully equipped with the level of intercultural capacity required to meet the unique and diverse needs of refugees[33, 34]. While **mainstream service providers** are skilled in mental health treatment, they **often lack the required understanding about torture and trauma, and its intersection with cultural and historical factors[e]**. This is important as trauma exposure has been found to be the most important predictor of current mental illness in resettled refugees, even decades after settlement[35]. Consequently, **guidelines recommend that services for refugees and their families should provide trauma-informed care as best practice[36].**

Trauma-informed care is defined as "an approach that recognizes the pervasive impact of trauma on development and health, applies this knowledge of trauma and its consequence into practice, and actively seeks to prevent re-traumatization"[37]. Principles include promoting safety, culturally competent trust-building, providing peer support, empowerment and collaboration, social connectedness and acknowledging cultural, historical and gender issues. Importantly, research evidence supports the effectiveness of such trauma focused therapy for treating post-traumatic stress disorder and depression in this population[38]. However, evidence also suggests that many Australian service providers do not know how to use such methods to work with refugees who are experiencing psychological trauma[32]. This is evident in the high proportion of referrals PASTT receives from mainstream health services (**Figure 20**, Chapter 5). Consequently, it is important that PASTT continues to enhance the skills and experience of mainstream providers in working with this population. Many FASSTT agency stakeholders see a valuable role for mainstream services in supporting clients with less complex presentations however, there remains a need for specialist care which enables greater choice and confidence in accessing support. This was highlighted in client interviews (Appendix 3) and reinforced by client feedback to FASSTT agencies which indicates that mainstream services are often not able to meet their needs, and in some cases make them feel uncomfortable. The client

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[d] *"We are trying to use mainstream services to get people services as quickly as possible and sometimes that will work with, you know [English] speakers but often it won't' work with others"* **Interview 12, Upper management, FASSTT**

[e] *"I think if we didn't exist, if PASTT didn't exist –there would not be an avenue for trauma recovery, really, for people ... [the mental health system] really doesn't understand the nature of refugee trauma... It understands trauma, but not refugee trauma."* **Interview 1, Upper management, FASSTT**

case study in **Box 1** describes the problems experienced engaging with mainstream services, and how PASTT is able to provide more appropriate care for this client.

***Box 1**. Client case studies: Client 1*

Case 1 – “H”

Background

‘H’ is teenaged female who accesses ASeTTS services. She was originally from Afghanistan, arriving in Australia eight years ago as a refugee with her parents and siblings. H has directly experienced war trauma in her home country, and traumas during her journey to Australia. As a result of trauma H experiences intrusive thoughts, nightmares, and has limited capacity to concentrate. This has led to her becoming completely disengaged from school. H also experiences social anxiety and has difficulty interacting with people outside her home.

Engagement with mainstream services

Initially she was referred to the Child and Adolescent Mental Health Service (CAMHS) for mental health support by a tertiary hospital. She attended only a few sessions before completely disengaging. She was also referred to Headspace and again attended only a few sessions before disengaging. H has reported that it was difficult to get to appointments and that the use of public transport worsened her anxiety. It became difficult for her to get out of bed, leave the house, or to attend appointments. She also reported the clinical environment at CAMHS and Headspace felt cold, threatening, and unfriendly; like a hospital, and that the significant stigma in attending a mental health services within her community was a barrier to her continuing. H has reported that CAMHS and headspace staff didn’t understand her, her culture or needs, or her experiences, and didn’t take the time to get to know her.

H was eventually referred to AseTTs by CAMHS. ASeTTS has maintained constant involvement with H for over the subsequent three years. During this time other services have cycled in and out of her life; including Department of Communities: Child Protection. Services dipping in and out of young person’s life creates instability within family units. It becomes unclear who is involved and what they are assisting with, and makes it difficult to develop trusting relationships and maintain meaningful change.

Engagement with PASTT services

H was allocated to ASeTTS Outreach Youth service. ASeTTS involvement at that time was as an adjunct to other tertiary hospital supports. The ASeTTS clinician allocated to support H delivered session at her home, and during walks around her neighbourhood. The clinician provided psychoeducation and practical supports to H, including explaining that trauma can have different impacts on young people and that there are different ways a person can be supported to explore those challenges and overcome them. H reported that she had benefitted from the flexible support model. Specifically, while other services are time limited and require the client and their family members to attend sessions at a designated office, ASeTTS approach to providing services through outreach and without time limits was considered responsive to H, and her family’s needs.

H has reported that she feels understood by, and finds it easy to talk to, ASeTTS staff. She has explained that unlike staff and clinicians from other organisations and agencies, ASeTTS staff are experienced in supporting refugees and addressing refugee trauma. With ASeTTS she does not need to moderate what she says, and is not concerned about ASeTTS staff becoming overwhelmed by her history and experiences. As a result of ASeTTS continued support and counselling, H recently advised she would like to get back to school and feel less anxious in public.

It is because **FASSTT agencies provide both culturally responsive and specialist trauma informed care** that PASTT demonstrates high levels of appropriateness in meeting client needs and improving access and outcomes for refugee communities. Knowledge, experience, and understanding has been built by each agency, and by FASSTT as a collective, over more than two decades. The program's unique perspective normalising and linking the impact of culture, historical context, and past trauma with current mental health and wellbeing is lacking from most mainstream services[f]. This can have significant impacts on the care and outcomes these vulnerable clients receive. For example, PASTT providers were able to link a young woman's eating disorder with her previous experience of trauma, despite this being missed multiple times as an inpatient in mainstream care. Another was diagnosed by mainstream providers as having paranoia and placed on multiple medications, however PASTT providers changed her declining trajectory when they were able to talk to her from a trauma-informed perspective, assess the scenario, and establish that the paranoid thoughts may have been founded in past events.

Information provided in a client case study from Companion House demonstrated the impact of normalising trauma for their client 'N', who presented with debilitating symptoms of posttraumatic grief and secondary depression. In counselling she was able to finally find a safe, non-judgemental place. She said this was the first time she had found such a space. Once her symptoms were reframed and normalised in the context of past childhood war related trauma, long experiences of refugee camps, forced separation, and death of loved ones she began to realise that her current grief and depression were her body's way of acknowledging all her history. N began to better relate to her children, move through her grief of loss of loved ones, establish professional relationships, gain part-time employment, and reported feeling fulfilled.

FASSTT agency staff are also key to its appropriateness and effectiveness. The high level of interpreter involvement in service delivery, engagement with community leaders, and employment of those with lived experience and of similar refugee backgrounds (including bicultural workers) drive a considerable amount of PASTT's appropriateness as a specialised service. Additionally, FASSTT agencies invest heavily in training, clinical supervision, mentoring, and professional development for their staff to deliver high quality care (see Chapter 7, Alignment of PASSTT with international best practice). This training also extends to that of mainstream service providers where PASTT aims to increase knowledge and change attitudes, enabling delivery of more appropriate care in that setting.

3.1.2 Connection to community

Another essential feature that sets PASTT apart and drives its success is an implicit understanding of the communities it supports and the long-term connections that agencies have built within these communities[g]. Significant time, resources and effort are invested in this process through engagement and community development work. These connections allow FASSTT agencies to take **an innovative and responsive service approach** based on an understanding of the needs of a dynamic and evolving population. For example, FASSTT agencies adopt a range of community advisory models including refugee reference groups and community consultations to respond to emerging needs and design appropriate solutions. Most recently this type of work has occurred to respond to the crisis affecting the Ukrainian community in New South Wales. Co-creation and co-design with communities was identified as a common thread across all agencies whether that be through leveraging internal or external connections, existing groups, or mainstream services. In 2021, one agency co-designed and assisted in the successful delivery of a mental health and

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[f] *"We hold specialist knowledge in refugee trauma - it's really important because that looks different from other kinds of trauma, it has a different nuance and complexity, and being able to be specialist and understand our communities and their type of trauma is really important as well". **Interview 2, Participant in large multidisciplinary group, FASSTT***

[g] *"In our recovery context we also need to be working at those different levels [individuals, families, communities and societal] and I think that's quite rare and where we are differentiated from mainstream services who don't necessarily understand that we're holding individual and collective recovery, not in competition, but alongside and, kind of, intertwined."* **Interview 2, Participant in large multidisciplinary group, FASSTT**

wellbeing psychoeducation program for community leaders which aimed to build the community leaders' capacity to support their community members during COVID-19-related distress.

The community engagement work of PASTT also helps to **rebuild trust within these communities** so that they are better able to seek help, **breakdown cultural stigmas,** and open up about their experiences[h]. This is crucial, as accessing and engaging with healthcare is intimately related to trust within refugee communities[31]. For example, one agency has employed community connectors to go into newly arrived communities to build trust and connection and combat mental health stigma in the early stages of settlement. Another way this has been achieved is by employing staff with refugee backgrounds themselves and who can use their own lived experience within communities to foster trust and build relationships. Additionally, by having staff play the role of counsellor advocate (rather than counsellor) agencies can work on building trust by providing a soft entry into the service and meeting client needs for support outside of mental health. Once this trust has been built, it is easier for counsellor advocates to address mental health concerns. This is particularly important where communities may have reservations about seeking counselling due to stigma. Finally, **building and sustaining a long-term connection with communities was perceived to be essential if PASTT is to contribute to early intervention and prevention work including helping families to deal with the impacts of intergenerational trauma**, which is of growing concern to communities.

3.1.3 Flexibility of approach

Tailoring and adaption of service delivery to respond to and meet the needs of communities and individuals is a key element of PASTT's work and contributes greatly to its effectiveness and appropriateness. The agencies place a high value on ensuring their clients' specific needs are considered and that they receive support according to these needs, which was recognised and appreciated by the interviewed clients (case studies C2, C3, C4, C5, C6, C7 in Appendix 3). Further, FASSTT agency staff interviewed emphasised that being responsive and not prescriptive in their approach to trauma rehabilitation is a great strength of the PASTT program. For example, each agency **uses diverse forms of engagement and therapy** to foster recovery from an individual and societal perspective. This includes individual counselling, group work, complementary therapies, social support and advocacy, and community healing processes. Some of these more culturally appropriate approaches (e.g., community healing) are not available to clients within mainstream health services. Additionally, PASTT provides both outreach to communities and in-reach to schools to better meet their clients where help is needed most.

Moreover, the agencies take a more **holistic approach to support** offering not only therapeutic services but also helping clients with multiple needs including schooling, advocacy, settlement, legal services, housing, health system navigation, and translation. Addressing these issues can ultimately be more important for improving clients' well-being than providing counselling (see Appendix 4, case study "P"). Often this support can be provided 'in-house' due to the structure and services provided by FASSTT agencies, thereby reducing the need for clients to visit multiple organisations for assistance (see large number of internal referrals, **Figure 20** and **Table 10**, Chapter 5). Additionally, this holistic care usually occurs in a much more integrated approach with partner services than within mainstream care (for example, via case management or a liaison worker), reducing access barriers that might otherwise exist. The interviewed clients expressed their appreciation in being able to share and discuss all life aspects with PASTT counsellors (e.g., homework club example discussed in case study C2, Appendix 3). An example of PASTT's flexibility in approach to service delivery and support for holistic care is also described in case study 2, Box 2.

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[h] *"It's about our connection with refugee communities… at both an individual level but also at the community level. I think that is probably a huge thing that defines how we deliver PASTT, is that ability to focus on connection…re-establish a sense of safety and a sense of trust."* **Interview 1, Upper management, FASSTT**

***Box 2**. Client case studies: Client 2*

Case 2 – "M"

Background

M is 19 years old. His family escaped the violence and trauma of war in their home country. His father was estranged from the family and M lives with his siblings and mother. M had stopped going to school and had withdrawn into a very internal psychological space where he would play video games in his bedroom until the early hours of the morning and then sleep until late afternoon. He had lost contact with friends.

Engagement with PASTT

A Companion House counsellor began home based visits to M in which they would sit outside in the backyard for sessions. M would not attend Companion House but did agree for these visits. The counsellor and M had a pre-existing relationship from an earlier period of counselling conducted at his school. A level of trust existed that enabled the initially reticent M to gradually open up about his feelings and internal state and for him to be receptive to some psycho-educational discussion around depression. Sessions in the back yard moved to neighbourhood walks. M expressed some satisfaction in a newfound awareness and language for what he was feeling. He began to talk with a greater future focus around the possibility of work and study.

The counsellor consulted with his mother around the possibility of her and M going to visit extended family overseas who M was very attached to. The counsellor supported this idea and a visit happened some months into the counselling intervention. On return, the counsellor continued working with M on neighbourhood walks. After a request from M the counsellor assisted him in applying for work and he was successful in gaining employment.

M eventually re-connected with his friends, applied for admission to university and was accepted. He also stopped taking the anti-depressant medication and was able to re-engage with the outer world and sustain a more functional daily pattern of sleep, diet, and relational connection.

Another key consideration associated with PASTT's flexibility (compared to mainstream services) is that it can be **accessed by survivors of torture and trauma at any point in their Australian post-settlement journey**. This is important as resettled refugees may not experience mental health issues in the immediate settlement period (when their focus is on accessing basic needs) but may be triggered by local or international events many years later. This was the case for one of the interviewed clients (C3), who was trigged by an event twenty years after settlement. This issue was also described by one FASSTT agency member as such:

> *"Regardless of how long they've been here…trauma is not something that always has an immediate effect, many people can overcome the trauma, and do quite well, and then something happens, and changes in their lives that undermines their coping mechanisms … that then can bring back the trauma to the full."*
>
> ***Interview 8, Upper management, FASSTT***

This lifespan approach, coupled with the ability to work with clients for as long as they need, at a frequency that is comfortable for them, was perceived to be one of PASTT's key strengths. It is also a defining characteristic in terms of appropriateness for this population (who often have long-term/recurring issues) compared to time-limited mainstream mental health services which have a greater focus on treating acute episodes. This was described by one counsellor advocate as such:

> *"It's not prescriptive, so while some clients might need 10 sessions for individual counselling, some might need 50, and so it's really based on what the client needs rather than being prescriptive in terms of counselling or support, and that's what we get complimented on for a lot of agencies and stakeholders that – that we actually don't have that prescribed sessions"*
>
> ***Interview 2, Large multidisciplinary group, FASSTT***

Additional elements of service flexibility which are contributors to PASTT's appropriateness are broad eligibility criteria, multiple avenues for referral (including self-referral, **Figure 20**, Chapter 5), triaged intake processes, and the ability to re-engage with the service after discharge.

The combination of flexibility in service delivery and in client engagement creates a model of care in which refugees and their communities are placed at the forefront. This was evident in discussions with all PASTT stakeholders who unanimously acknowledged **the client-centeredness of PASTT**. Counselling, individual youth work, case work, community engagement, and most group work interventions are tailored to the goals and aspirations of clients and participants. Counselling sessions are client directed and conducted at a pace set by the client in order to build trust[i]. For example, creating a safe space for discussion is a key priority, with therapeutic counselling often delayed until this can occur. Counsellor advocates achieve this by intentionally conducting sessions that are intended to make clients feel respected, welcomed, and listened to. This was highlighted by one of the interviewed clients, C6, who felt that their counsellor advocate was able to "*read the room*" and listened to what they wanted and needed from each session. The effectiveness of PASTT in delivering client-centered care was supported by feedback from former clients (see Sections 3.4.1 and 3.4.2) and in all PASTT client interviews.

3.2 Appropriateness of PASTT governance

3.2.1 The Forum of Australian Services for Survivors of Torture and Trauma

As described in Section 1.4.3, PASTT is administered by eight state and territory-based member agencies forming the Forum of Australian Services for Survivors of Torture and Trauma (FASSTT). Having FASSTT as the structure underpinning PASTT delivery was reported to be a key benefit by many agency stakeholders. FASSTT has built up decades of institutional knowledge and experience with refugee populations which can be directly applied to PASTT service delivery. It was also perceived that FASSTT as a network has a greater impact than each of the eight agencies could have on their own when advocating for funding and providing input into national and state-based policy making.

Such a network also enables significant opportunities for knowledge sharing, resource development, mentoring, supervision, professional development, financial support, and collaboration. Sharing and leveraging such resources within the FASSTT network has been key to supporting the smaller agencies in the delivery of PASTT and ensuring long-term sustainability in times of vulnerability for individual agencies[j]. This sharing overrides any potential competition between agencies and leads to increased opportunities for national collaboration and a broader perspective on the program, as described by one FASSTT agency stakeholder:

> *"There's strength in being able to collaborate with our organisations in other states and bring together resources, but also see patterns emerge as well, in terms of the work and developing things like a national minimum dataset, things like that which really show a national picture rather than just in particular states."*
> ***Interview 2, Large multidisciplinary group, FASSTT***

One of the keys to successfully delivering PASTT within this multi-organisational network is that each agency can adapt service delivery models to their own setting and client needs and allocate overall budget accordingly. As is discussed in more detail in Chapter 6, FASSTT directors agree together the distribution of total PASTT funds across agencies using an established formula. Each agency then has an individual funding agreement and activity workplan with the government. This is a clear strength of current funding and

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[i] *"Our role is not to say to the client 'we need to do this', it's time to allow the client to say what they need… these clients are basically now with us having the opportunity to be the leader in the session, to be the one who is able to tell us what they need, and to voice their opinion. And that on its own is therapeutic."* **Interview 9, Clinical/counselling services, FASSTT**

[j] *"Sustainability is proven, largely because of the relationship with the Department and the emphasis on collaboration across the country and the [FASSTT] network"* **Interview 8, Upper management, FASSTT**

governance arrangements between the government and FASSTT agencies. Being able to develop their own activity workplans ensures the individuality of the agencies is maintained and allows them to be innovative in approach and better respond to local client needs. FASSTT agency stakeholders commended the government for having such a non-prescriptive contracting model and for being open to dialog about adaptations and program deliverables. One FASSTT agency member described this as such:

> *"I think another really important component of the PASTT contract is that we get to say what we want our work plan to be, there's a lot of trust that we've got a really good knowledge about what's presenting, we can articulate what the need is and how we might innovatively respond to it. I think that's incredibly beneficial and quite rare- usually you get a prescriptive contract to complete. There's also quite good consultation between the folk down in Commonwealth Health and us and our contract liaisons to be able to negotiate about what's required to complete the work."*
> **Interview 2, Large multidisciplinary group, FASSTT**

The unification of individual FASSTT agency contracts into a single funding agreement with the government has been proposed. If this was to occur, the ability of agencies to agree funding distributions and devise individual work plans would need to be maintained. Additionally, current governance structures are not appropriately resourced to support the additional work required of such a contracting model. There would need to be additional support for the current part-time FASSTT network coordinator to take on extra reporting responsibilities, administrative load, and contract management tasks if adopting such a model. Alternately, FASSTT may be better served as a peak agency providing services for survivors of torture and trauma which could be run by a secretariat and adequately resourced and funded.

3.3 Challenges to appropriateness and sustainability

Several key challenges were highlighted by PASTT stakeholders in interviews which directly impact PASTT's ability to maintain its appropriateness and sustainability. These are mostly related to FASSTT and organisational expectations, the difficulty many stakeholders reported in balancing a client-centred care philosophy with current funding levels, and service delivery constraints.

3.3.1 Reporting requirements and outcome measures

As will be described in further detail in Chapter 5, there was a perception by FASSTT agency staff that reporting requirements and performance indicators failed to adequately capture the broad scope and impact of their work. In particular, some felt that there was an over reliance on quantitative data (numbers of clients/activities), at the expense of being able to capture qualitative data, subjective measures, and narratives related to impacts. This was perceived important for capturing the impact of community work and advocacy – key outcomes of PASTT. Indeed, previous research[39] has reinforced the importance of subjective indicators to understand whether refugees are achieving outcomes that are personally meaningful. Additionally, key activities to support PASST delivery, such as accreditation via the National Standards for Mental Health Services (NSMHS), could not be reported on under current arrangements.

On the whole, the agencies understood the need for a focus on targets to demonstrate effectiveness of service delivery and their ability to meet client demand. However, there is an impertative for consultation among the agencies, and with government, to revist how these indicators are selected, defined, measured, and synthesised. Finally, individual agencies may capture and report data differently, and have different levels of support and systems for doing so, impacting both the quantity and quality of data available for benchmarking and evaluation. Ultimately a better **balance is required in terms of data collection, targets, evaluation, and funding to more adequately capture the range of services which may be appropriate to meet clients' needs** (for example, support groups and community healing).

Several agency stakeholders also raised the need for better sensitivity in the wording of current contracts, particularly around the use the word 'targets' when defining and measuring performance. The reason for this is best described by one clinically focused FASSTT agency stakeholder as such:

> *"The persons we work with are not targets, and targets are – is a really terrible word. Because target is used in war. And we are all – we're survivors of torture and trauma, so that is a terrible – terrible word. But nevertheless, we use it. And I think it is wrong – from a philosophical perspective; it's not okay."*
> ***Interview 25, Clinical/counselling services, FASSTT***

3.3.2 Balancing client-centred care philosophy with organisational constraints

Due to limitations in current funding levels, agencies are in a continuous balancing act between addressing service demand for individual services, responding to crisis-driven client surges, and proactively engaging with communities on a larger scale. Stakeholders felt that their ability to deliver strategic and proactive community-level services was impacted, as decisions about which services to prioritise and which refugee groups to support often had to be made in the context of extensive waitlists. This was described by one PASTT stakeholder as such:

> *"So, we're constantly feeling very reactive. So, we're always responding to the next emergency, we're responding to the increasing constant demand, but being able to do that preventative work is really difficult. And…within that community space, we've got such limited resources, we've got resources to connect and – and meet with communities and to have some ideas, but rarely do we have actually the resources to do that community healing that we actually really want to do".*
> ***Interview 2, Large multidisciplinary group, FASSTT***

Additionally, some counsellor advocates perceived that FASSTT agreed organisational requirements (such as time-based assessments of mental health and Key Performance Indicators – see Client reported outcomes: WHO-5 section) place restrictive timeframes on counselling work, impacting their client's ability to lead their own trauma-informed recovery.

3.3.3 FASSTT collective decision making and sustainability

Key challenges of operating within the FASSTT network were also reported by several agency stakeholders in the interviews. The disparity in size and influence of members of FASSTT is something that is acknowledged by the agencies. Hence, in drafting the Constitution of FASSTT Ltd a decision-making process was agreed which is democratic and collaborative while embedding the best interests of clients. The FASSTT constitution (signed off by all agency boards) formalises cooperative arrangements to preserve a national program, gives direction to FASSTT leaders, and supports a consensus building culture based on the notion of a shared national responsibility for the healing of torture and trauma survivors. Despite this, multiple interview participants questioned whether the views of some agencies were adequately being heard in national discussions. The main issue of concern was maintaining a successful and timely democratic process for FASSTT decision making when the outcome impacts all agencies.

Finally, while FASSTT has seen significant stability over many years due to longevity of leadership, some concerns were raised by stakeholders about the long-term impacts on FASSTT and PASTT if these key agency stakeholders were to exit without sufficient succession planning. This potential circumstance poses a risk to the program and could create vulnerability within the network. Succession planning for FASSTT will therefore be key if the governance of PASTT is to be sustainable in the future.

3.4 Acceptability and client-centredness of PASTT

Closely aligned to the concept of appropriateness is the concept of acceptability – the perception of clients that a program is satisfactory to meet their needs. In the case of this evaluation, client satisfaction was deemed to be a proxy measure for the client-centredness of PASTT. Quantitative data capturing client satisfaction was available from STARTTS and STTARS and has been included. Companion House provided summaries of client feedback surveys from 2017 and 2019, and Foundation House piloted use of a client satisfaction questionnaire in July 2021. However due to the low number of responses and/or brief summary of qualitative responses provided to AusHSI, those data have not been included here. Nevertheless, the trends in data from Foundation House and Companion House mirror those observed via STARTTS and STTARS.

3.4.1 STARTTS client satisfaction outcomes

STARTTS clients typically complete a client satisfaction questionnaire (CSQ8[40]) with their counsellor advocate at discharge. The CSQ8 Scale is a standardised, validated client satisfaction measure designed to enhance measurement of client satisfaction with the provision, quality, and outcome of services provided. The scales are widely used in health care, mental health programs, education, legal, social service, and other human services. The CSQ8 is considered to have excellent reliability and internal consistency, with high levels of client and staff acceptability when tested across diverse client samples and a range of health and human service programs. Interpreters are used to administer the questionnaire, and translations of the CSQ8 can be found in Arabic, Dari, Persian/Farsi, Hazaragi, Karen (S'gaw), Swahili, and Tamil.

Initially, PASTT clients were reluctant to complete the questionnaire, leading to low response rates. This approach may also introduce bias due to the close relationship built between clients and the service provider. STARTTS employed a separate team to conduct these questionnaires in 2015, with dramatic impacts in completion rates, but financial constraints have prevented this from occurring since. However, the agency aims to undertake an independent questionnaire collection process later in 2022.

Figure 5 summarises the results from the client satisfaction surveys completed by 574 STARTTS clients between the 1st July 2016 to 30th June 2021. Clients were asked to rate each question between 1 (lowest) and 4 (highest). Responses were strongly positive for all 10 questions, with 3% or fewer selecting the least positive category in any question. Of note, 93% of clients ranked the quality of the service they received as being excellent or good, while 94% reported they were very satisfied or mostly satisfied with the overall service they received. Eighty percent of clients reported that almost all or most of their needs had been met by the program. Lower ratings related to expectations that were not able to be met by the service and are beyond the scope of PASTT activities (for example, assistance with payment of an overseas debt, provision of social housing, or bringing family members to Australia).

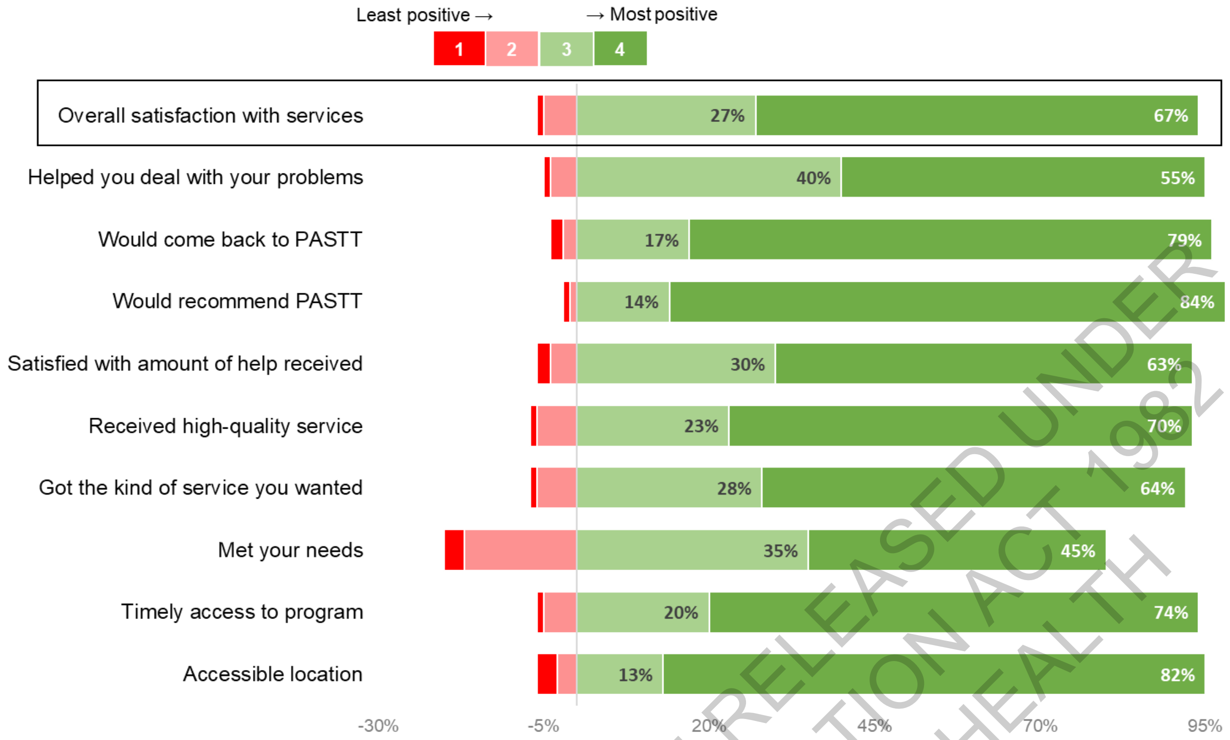

Figure 5. *STARTTS client satisfaction questionnaire responses received between 2016-2021 (N=574)*

3.4.2 STTARS client satisfaction outcomes

In March 2022, STTARS engaged an experienced torture and trauma counsellor to interview people who had previously received services from STTARS. A series of questions were asked about individuals' experience of accessing STTARS services and the outcomes achieved. Interpreters were used in most interviews. Where possible participants were asked to verbally rate their experiences using a Likert scale from 1 (lowest) to 4 (highest) and to provide comments to add context where comfortable.

A total of 32 interviews were conducted. **Figure 6** summarises the quantitative outcomes from these interviews. Responses were strongly positive for all questions. Overall, 90% of respondents were satisfied or very satisfied with the services received at STTARS; 96% selected the most positive response ("very much") when asked whether the service was delivered in a way that responded their culture and background; and 96% responded positively when asked whether they received a high-quality service. Qualitative comments from clients about these ratings were also overwhelmingly positive. Low scores for 'ability to complain about service' were reported by clients as being related to personal beliefs, or their culture or religion, rather than a lack of agency processes to do so. Clients who reported lower levels of satisfaction with the agency (in the 'overall satisfaction' question) rarely explained this score with supporting information. However, the few that did were again dissatisfied because they required assistance beyond the scope of the agency. For example, one client responded:

> *"STTARS hasn't done anything special for me. I had headaches…they helped me with my headaches. When I was in Malaysia and came here and I was in debt. I had taken lots of money from many people. I asked for help from STTARS but they didn't help with the money and so I left STTARS."*

Consequently, there may be an opportunity for FASSTT agencies to **better communicate with clients** regarding services that the agency can and cannot provide them at the outset of engagement.

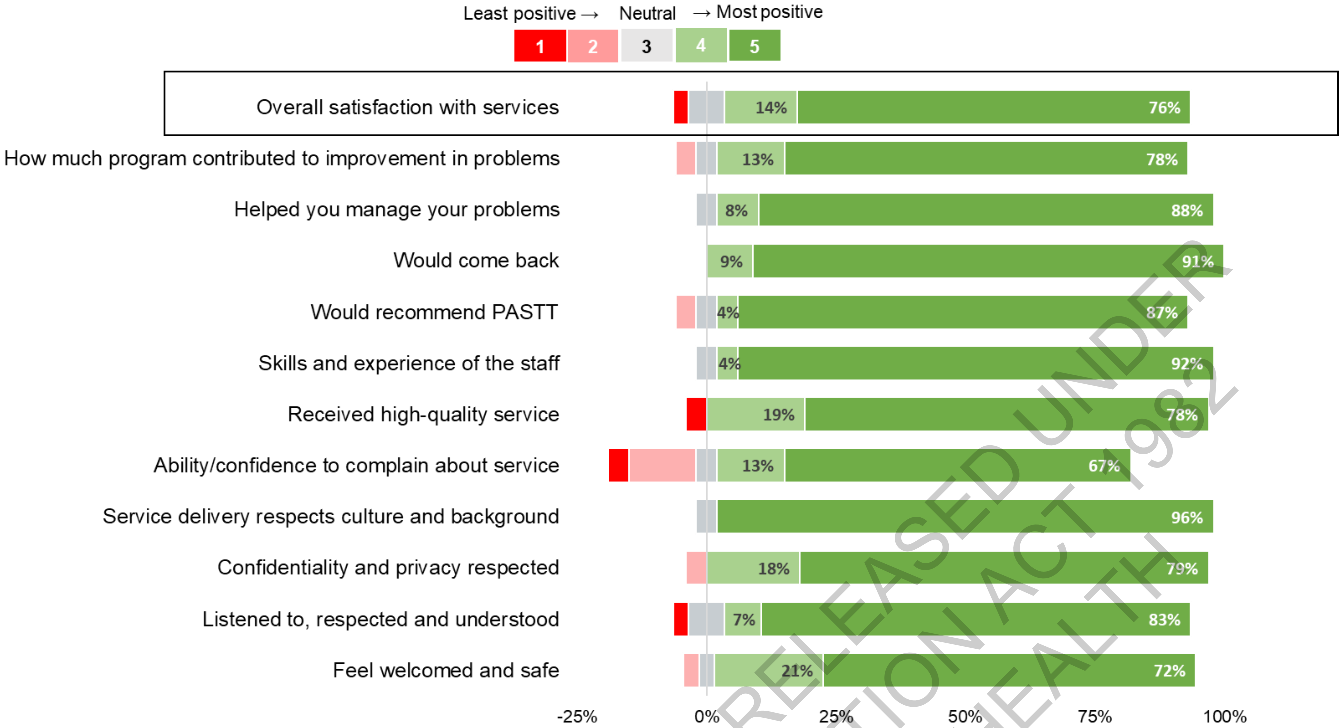

Figure 6. *STTARS client satisfaction interview responses received March 2022 (N=32)*

Feedback supporting client-centredness and appropriateness
Additionally, qualitative client feedback recorded as part of this interview process which supports PASTT's acceptability, client-centredness and appropriateness is presented below.

> *"How I describe is they [STTARS] give service according to our needs, according to our problems… it's what happened to me."* ***Client 1***
>
> *"I can say that the good thing is people are coming from different countries with languages. They try to solve different problem especially for people with language barriers. STTARS is a good place"* ***Client 2***
>
> *"[My counsellor advocate] respects a lot my culture and religion. When there was a problem in Afghanistan, some people were killed, he called me and send messages saying I am there for you."* ***Client 3***
>
> *"When you found people who makes you feel comfortable [STTARS] you feel safe with them to say everything that's bothering you… if you with someone who doesn't make you feel comfortable you cannot say anything."* ***Client 4***
>
> *"We came from a war zone. STTARS would help in managing of getting what we went through during the war. We were depressed. We experienced horrific things, but you guys helped us without us noticing how to deal with it. I am very, very happy with STTARS. I don't know what I would have done especially because of our background."* ***Client 5***
>
> *"I cannot say 5/5, I would say 10/5. They have provided very good service without them I would have been lost. I don't know what I would have done without them".* ***Client 6***

3.4.3 Satisfaction of interviewed clients

The interviewed PASTT clients reported being very satisfied with the PASTT services they accessed and other services offered within the FASSTT agencies. Case studies C2 to C7 (Appendix 3) provide details about the clients' experiences which were overwhelmingly positive. The clients appreciated the flexible, client-centered, tailored, and culturally sensitive approach. This assisted one client (C3) in feeling safe enough to open up and share very sensitive pre-arrival stories that had never been shared before, and made the client appreciate their own journey of survival. This client was very satisfied with the counselling service; the counsellor advocate created a welcoming and comfortable environment and established a good rapport with the client who was surprised to be able to share very personal stories with a counsellor in the first session. Another client (C4) commented that the agency provided a safe and secure environment which allowed them to calm down and commence rehabilitation. The same client expressed strong feelings about the need to recognise the agency's work because it allows refugee communities to heal and contribute to society. Yet another client (C6) praised the agency's intake process system by which they were 'matched' with an understanding, responsive and respectful counsellor who adapted each session to what the client needed at the time. This client spoke very positively about counselling services which were very beneficial in their rehabilitation journey, allowed them to overcome negative thoughts, and left them feeling "lighter" after every appointment.

3.5 Appropriateness and acceptability findings

Finding A1. Culturally appropriate approaches (e.g., community healing) and needs-based support (e.g., helping with schooling, advocacy, settlement) are equally important for improving clients' well-being as therapeutic approaches (e.g., counselling). Mainstream care was not perceived to be appropriate to meet the complex needs of many PASTT clients.

Finding A2. PASTT demonstrates high levels of appropriateness in meeting client needs and improving access and outcomes for refugee communities.

Finding A3. The three defining features of PASTT's appropriateness are: (1) delivery of a specialised culturally responsive and trauma-informed service model; (2) establishment and maintenance of a connection to community; and (3) flexibility in approach regarding how, when, and which services are accessed and delivered. Any future iteration of PASTT should seek to retain these three key features at its core.

Finding A4. There is a continued need for PASTT to build the skills and capacity of mainstream services to respond to and care for refugee clients appropriately.

Finding A5. Building and sustaining a long-term connection with communities is essential if PASTT is to reduce stigma and contribute to early intervention and prevention work.

Finding A6. The Forum of Australian Services for Survivors of Torture and Trauma (FASSTT) is effectively facilitating the funding allocation and service delivery of PASTT. However, to support sustainability consideration should be given to leadership succession planning and maintaining a successful and timely democratic decision-making process.

Finding A7. The flexibility provided in PASTT contracting agreements is a strength of current governance arrangements as it allows individual FASSTT agencies to maintain autonomy, be innovative, and respond to local needs.

Finding A8. Consideration should be given to reviewing current reporting requirements, performance indicators and evaluation criteria to align with PASTT's underpinning philosophy and adequately capture the range and type of services which may be appropriate to meet clients' needs.

Finding A9. PASTT is client-centred and satisfactorily meeting the needs of its clients for service delivery within its scope. There may be an opportunity for FASSTT agencies to better communicate with clients regarding services that the agency can and cannot provide them at the outset of engagement.

Chapter 4. Regional and rural implementation of PASTT

This chapter considers the implementation of PASTT in regional and rural areas using stakeholder consultation and existing program data. It also draws on published literature where appropriate. This chapter focusses on answering sub questions from key evaluation questions one and three as outlined below.

- *Key evaluation question one: How appropriate is the PASTT model? (suitability of the delivery model and funding arrangements in regional areas)*
- *Key evaluation question three: How effective has the program been? (achieving program objective of regional and rural service delivery)*

This analysis of the implementation of PASTT includes 'what has' and 'what has not' worked in when providing activities in regional and rural areas, along with how this impacts PASTT's ability to effectively address client needs. This is important to consider in the context of this evaluation as the nature of regional and rural communities necessitate service delivery in different ways to that in urban locations[41]. It draws largely on qualitative analysis which has occurred after extensive consultations with FASSTT agency CEOs, staff members, and external stakeholders. This is supported by national settlement data and quantitative analysis from agency reports where appropriate. Where relevant, illustrative quotes are provided to highlight points. Additional supporting quotes can be found in Appendix 9.

4.1 Classification of regional and rural areas

For migration purposes, Sydney, Melbourne, and Brisbane (including Logan) are categorised as metropolitan locations by the Department of Home Affairs - all other locations are categorised as regional[42]. For FASSTT agencies however, service delivery is best categorised as:

- **Metropolitan**: based within the capital city and surrounds of the FASSTT agency state/territory office (as depicted in Chapter 1, **Figure 1**. FASSTT member agencies in Australia).
- **Regional and rural**: any service delivery occurring beyond the limits of the capital city e.g., Launceston in Tasmania; Wagga Wagga in New South Wales; and Cairns in Queensland. This mostly (but not always) includes localities classified as rural or remote by the Modified Monash Model (MMM)[43].

The FASSTT agency service delivery categorisations are adopted throughout this chapter and have also been used in economic analysis in Chapter 6.

4.2 Implications of settlement in regional and rural areas

Traditionally, locations outside of Australian capital cities have received only a small proportion of humanitarian entrants each year. However, more recently, settlement policy from both Commonwealth and state governments has encouraged regional settlement as a means of achieving mutual long-term benefits for communities, refugees, and Australia as a whole[44]. The Australian Government now has a target of 50 per cent of humanitarian entrants to be settled in a regional location by 2022[42]. The locations of such regional and rural settlement sites are decided by the Department of Home Affairs however some refugees may also choose to resettle more organically in non-metropolitan regions. As a result of these policies and practices, over one-quarter of all humanitarian entrants in 2019-2020 settled in regional or rural locations (**Table 5**).

***Table 5**. Growth in proportion of humanitarian entrants to Australia settling in regional and rural locations from 2016 to 2020 (source[30])*

Proportion of all humanitarian entrants settled in regional or rural locations	2016/17	2017/18	2018/19	2019/20
Nationally	**11%**	**21%**	**27%**	**27%**
Tasmania	43%	53%	53%	75%
Queensland	22%	42%	46%	56%
New South Wales	9%	19%	27%	27%
Victoria	10%	16%	20%	15%
South Australia	5%	7%	11%	8%
Western Australia	3%	2%	2%	3%
Australian Capital Territory	0%	0%	0%	0%
Northern Territory	0%	0%	0%	0%

This has implications for programs such as PASTT, which aim to support the needs of all resettled refugees in Australia, regardless of geographical location. Consequently, despite FASSTT agencies being based in capital cities in each state, 16% of their clients nationally now reside in locations beyond these cities (in regional locations). This figure is as high as 38% in Tasmania, 25% in Queensland, and 22% in New South Wales (**Table 6**). For some states, such as Queensland and New South Wales, this includes areas classified as rural or remote by the MMM (e.g., Toowoomba, Townsville, Cairns, Wagga Wagga, and Coffs Harbour).

***Table 6.** Proportion of PASTT clients residing in regional and rural areas: 2017/18 to 2020/21**

Proportion of all PASTT clients residing in regional or rural locations	2017/18	2018/19	2019/20	2020/21
Nationally	11%	14%	15%	16%
Tasmania (Phoenix)	18%	21%	31%	38%
Queensland (QPASTT)	14%	24%	25%	25%
New South Wales (STARTTS)	20%	21%	23%	22%
Victoria (VFST)	0%	4%	6%	8%
South Australia (STTARS)	9%	7%	8%	8%
Western Australia (ASeTTS)	0%	0%	0%	0%
Australian Capital Territory (CH)	5%	4%	2%	2%

*Data not available for Northern Territory (Melaleuca). All Tasmania (Phoenix) regional and rural clients reside in Launceston.

The FASSTT agency stakeholders interviewed did not express criticism of government policies related to regional settlement, or of the resettlement of refugees in non-metropolitan areas: PASTT goals and processes put in place to deliver services to regional and rural communities were highly valued by organisational stakeholders. Rather, they were concerned by the **challenges that existed in being able to provide services to clients, in an equitable manner compared to service provision in metropolitan areas**. These challenges have persisted despite FASSTT quarantining $2 million of its 2021 budget for regional and rural service delivery. The following sections summarise outcomes of the analysis completed relating to the three main concerns for adequately meeting the objective of regional PASTT delivery:

- Balancing service demand and capacity
- Metropolitan versus regional and rural delivery: a false dichotomy
- Need for tailored state-based models of care

These points are discussed in further detail in the subsequent sections along with a description of factors that are contributing to these concerns. The evaluators suggest these three elements should be given consideration in any future refinement of PASTT's regional service delivery as they likely impact on its effectiveness in regional areas. This is important as clients in regional and rural areas have a broad a range of needs, issues, and experiences of trauma that are comparable to those of clients in metropolitan areas.

4.3 Balancing service demand and capacity

One of the key challenges to PASTT regional delivery is balancing growing demand within existing organisational capacity. FASSTT agency stakeholders perceived demand to be largely driven by regional settlement policies, but this has been compounded by an increasing demand for PASTT services nationally due to a growing pool of eligible clients, life-time service eligibility, and re-traumatising world events (see Section 6.3 for more details). On the other hand, capacity to deliver these services is stretched regionally due to a range of factors including limited staffing, lack of resources, few or unskilled third-party providers, newly formed community relationships, and increased costs of service delivery (**Figure 7**). Such issues are not unique to PASTT, with similar barriers noted across Australia when providing services in regional and remote settings[41]. Nevertheless, the different internal (e.g., organisational) and external (e.g., socio-economic, demographic, geographic, legislative, and infrastructure) challenges faced by each agency in balancing service demand with service capacity in regional and rural areas may facilitate or constrain the work they can complete. This leads to increased complexity of providing PASTT effectively to vulnerable people in regional and rural Australia.

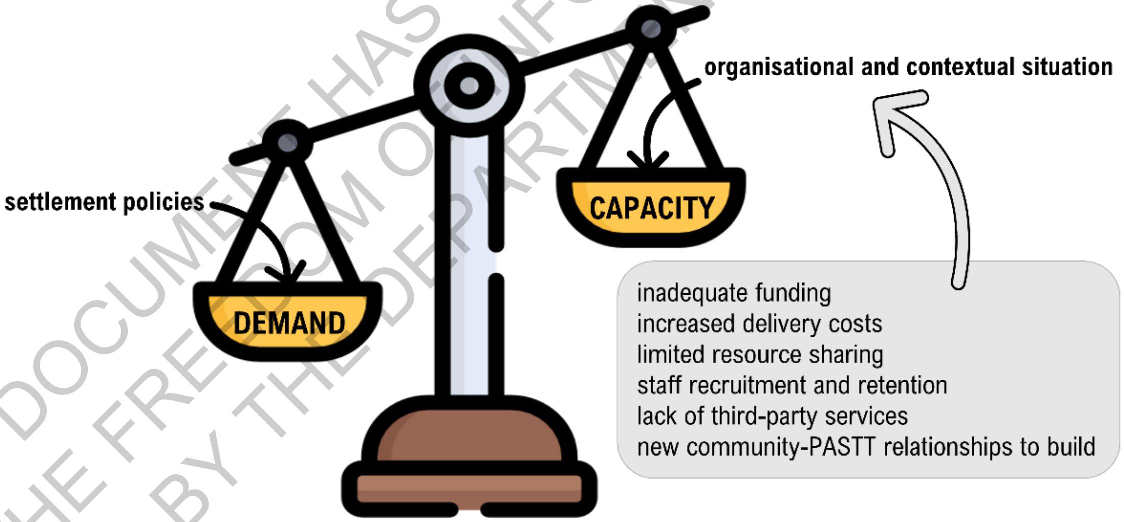

__Figure 7.__ The key balance of demand and capacity for regional and rural PASTT delivery

4.3.1 Capacity: staffing and staff management

The ability to meet service demand in regional and rural areas is **highly impacted by staffing**. Interview participants reported that the FASSTT agencies had issues attracting and retaining enough regional and rural workers with adequate skills to deliver PASTT[k]. The number of suitable available staff in regional and rural areas was very small due to prevailing workforce issues in country areas. This is confirmed by another data source which demonstrates the number of employed health professionals decreases with remoteness[45]. A poor distribution of psychologists, psychiatrists, occupational therapists, and nurses in regional areas has

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[k] *"We've had a senior counsellor vacancy since September last year. We advertised that twice last year and did not get one application, and I've never heard of that in my life"* ***Interview 13, Upper management, FASSTT***

also been found in previous analysis[46]. Additionally, it was suggested that there was little ability within existing PASTT funding to counteract this by providing incentives for people to relocate from metropolitan areas to work in regional and rural areas. Even where this had been done, for example in Queensland (**Box 3**), the FASSTT agencies were not able to offer employment conditions as competitive as other major employers (e.g., Queensland Health). These factors result in a very limited base from which to recruit employees in regional and rural areas and little likelihood of increasing the size of that base by sourcing employees from metropolitan areas. Some interview participants associated the perceived under-staffing in regional and rural areas with the existence of long waiting lists for service in those areas. Staff turnover was also perceived as impacting on the agencies' ability to connect and engage with communities.

Box 3. *Strategies used by QPASTT to increase regional and rural staff recruitment*

1. Immigration sponsorship of qualified counsellors (costing an additional $13,000 per staff member)
2. Higher wages incorporating a regional loading and relocation expenses
3. Provision of accommodation (additional $25,000 per region to costs)

Difficulties in staff management and supervision in regional settings were also experienced by FASSTT agency staff. In some cases, managers were located in metropolitan areas (because of costs in setting up rural and regional locations; see Section 4.3.3) and hence were disconnected in some ways from the staff in local areas. Economies of scale, travel costs, and other issues (such as the lack of third-party provider services in regional areas; see Section 4.3.2) led to difficulties providing supervision, training, and professional development opportunities to staff in regional and rural locations. Difficulties in these areas had real impacts. Without managerial oversight, staff supervision (clinical and non-clinical), training, and professional development, the quality of service provided may not be equivalent to metropolitan areas. Consequently, the risk of overwork, burnout, stress, and vicarious trauma for employees is high. Addressing this challenge is also important as a strong professional environment including mentorship, support, and development for staff has been identified as a core component of staff retention in regional and rural areas[47].

Organisational interview participants described how **FASSTT agency staff in regional and rural areas were often required to work beyond the scope of practice required in metropolitan areas**. For example, assisting refugee clients with activities such as finding suitable housing or applying for work in addition to activities more specifically related to torture and trauma recovery (e.g., counselling). This was because there was often no other local service equipped to help refugee populations meet these immediate and basic needs, particularly when clients become ineligible for settlement support after 5 years. Addressing these issues are considered fundamental to recovery, as trauma-informed interventions are unlikely to be successful unless basic needs are met first. Regionally-based staff members also often fulfil a range of roles including individual counselling, group work, community engagement, administration, and responding to client/community needs and demands. The challenge of balancing these roles is not always acknowledged by the agencies in renumeration, resources, or support[l].

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[l] *"It's actually quite a difficult balance to be a counsellor and also have some responsibility around community engagement and still hold that trust and confidentiality. It's not that our workers can't do that, but it's very difficult, but if there was additional resource to recognise that [role]…"* **Interview 2, Large multidisciplinary group, FASSTT**

In some smaller communities, '**boundary issues', confidentiality and other ethical considerations** were important concerns. For example, in metropolitan-based settings, counsellor and client interactions are usually confined to the time and place that counselling sessions are conducted. In regional and rural areas, interactions can extend beyond this as FASSTT employees are known in the community, have access to confidential information about other members of the community, and may interact with clients in non-professional capacities (e.g., during everyday life). While in some ways this may be perceived as a positive for trust and relationship building in local communities, it can also present challenges for staff in balancing their personal and professional roles in the community. For example, one interviewee described how a FASSTT agency employee in a regional area was required to have two wedding receptions - one in which close family and friends were in attendance, and another because the local refugee community became aware of their wedding and wanted to attend.

4.3.2 Capacity: local community characteristics

The characteristics (e.g., socio-economic, demographic, geographic) of the local area in which the FASSTT agency is required to work also present challenges to the provision of regional PASTT services. The interviewees reported on issues they noted with general poverty among clients, and challenges those clients had seeking and securing safe, affordable and suitable housing, gaining meaningful and appropriate employment, and accessing responsive, knowledgeable and experienced health services. These issues impacted the ability the FASSTT agencies had to engage with clients and communities, and reduced opportunities to participate in rehabilitation. PASTT stakeholders were of the view that if clients' basic health and safety needs were not fulfilled, then clients in need would not be likely to engage with FASSTT agencies and interventions, and services focused on trauma recovery were unlikely to be successful.

Third party providers

The availability and perceived competence of third-party providers in regional and rural areas was raised by the majority of interview participants who commented on regional and rural activities. **FASSTT agency representatives voiced that there were often fewer social, community, government, health, and specialist services available in these areas to collaborate with or refer clients to.**

> *"The services to which you might want to refer our clients are not as prevalent in rural and regional areas, there might be 'one of' rather than 'a number of' providers"*
> ***Interview 11, Upper management; Administration and corporate services, FASSTT***

This is supported by data from the Australian Institute of Health and Welfare that shows there are less than half as many mental health specialists, nurses, and psychologists per 100 000 people in regional areas compared to cities[45]. **Services that were available were mostly inexperienced with refugee clients or had inadequate knowledge of trauma-informed care[m].** Thus, the FASSTT agencies believed they were less able to refer clients out of PASTT and were not always confident that it would be beneficial for clients to do so. Ultimately, this challenges the ability of PASTT to provide holistic care unless the agencies dedicate time to training and capacity building of these regional service providers.

As in previously reported research[48] **resource constraints also become more apparent in regional Australian settings** and play a role in limiting service delivery. In metropolitan areas, FASSTT agencies were often able to share resources and work with other providers, but this was much harder in regional and rural locations where there were few services and a low number of clients who may utilise expensive resources if purchased.

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[m] "*Because in the regions, people have got to do it all themselves, schools are kind of clueless, health services are clueless, haven't used an interpreter before, there's nothing like a legal office that might help you, or a migration agent, nup, none of that."* **Interview 3, Upper management, FASSTT**

A **key issue identified was the difficulty in providing acceptable and cost-efficient in-person interpreter services in regional and rural areas**. Some interviewees highlighted that while this was already a challenge in some metropolitan centres, it was exacerbated in country areas, and particularly new settlement regions. Relying on phone interpreters as an alternative is both costly and impractical for therapy. One set of regional stakeholders described the positive impact that employing and training a local bicultural worker had on their ability to provide culturally and linguistically appropriate services for clients, as well as the considerable cost-saving of this in-house approach. Another agency reported working with the Translating and Interpreting Service to develop a glossary in Kurdish Kurmanji to assist their interpreters.

Local engagement and networks

Due to settlement policies and the establishment of new settlement locations, FASSTT agencies were sometimes required to begin **working in areas where they had no relationships with local providers and no local network of suppliers**. Additionally, resettling 'new' groups of refugees in existing regional locations could also present challenges. For example, a 'new group' of refugees might be settled in an area who had different characteristics, needs, and features to groups that had previously been settled. Time and effort are needed to locate, upskill, and establish links with local providers experienced in working with this new group. Interview participants described how establishing trust and credibility, and building capacity, in regional and rural communities, particularly with respect to local suppliers and other organisations, was paramount. It took time to do so, and therefore, the effectiveness of PASTT in regional and rural locations was related to how successfully links with local suppliers and stakeholders were established and maintained. This aligns with previously identified enablers of effective rural service delivery including reciprocity between providers within a community, links with service providers, shared infrastructure, and trust with communities[41].

Community readiness, local knowledge, and investment in community development are key enablers to effective and sustainable regional service delivery[41]. Yet, many interviewees commented on the **difficulty in conducting community capacity building activities with regional and rural refugee communities**. Gaining community trust and establishing and maintaining interpersonal relationships with key figures in local refugee communities was of importance in conducting successful community development activities. It was highlighted in many interviews that having a stable and visible physical presence in local communities where refugees were settled in regional and rural areas was needed to do this[n]. However, some interview participants described difficulties in locating suitable physical locations in regional and rural areas and obtaining necessary plant and equipment. Fly-in-fly out models of service delivery have been trialed before but are perceived to be ineffective, costly, unsustainable, and less preferable to clients.

4.3.3 Capacity: inadequate funding

Increased costs of delivery

Regional and rural delivery of services by FASSTT agencies is more expensive than in metropolitan areas. AusHSI's previous analysis of costs per client for STARTTS, QPASST, Foundation House, and Phoenix (Appendix 5) demonstrated increased costs of service delivery in non-capital city locations. Similar increases in operational budgets for remote Queensland hub and spoke health services have also been reported in the literature[49]. This was also a critical issue for PASTT stakeholders with the majority of interviewees who were asked about regional and rural service delivery commenting on costs. An exploration of drivers of capital city vs regional costs is presented in Section 6.3.3 , however key pressures included:

- Renting or purchasing appropriate facilities in regional areas which was untenable for some agencies, particularly where there was a small or highly dispersed client population
- Overheads being generally more expensive in regional and rural areas. For example, telecommunications, petrol for vehicles, and the higher quality of technological devices required to effectively connect and operate in these areas

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[n] *"People from those areas see that as an organisation we [PASTT] are validating the space by having a physical presence".* **Interview 16, Rural and regional services, FASSTT**

- Significant amounts of travel for frontline staff (who serviced large areas) and managers (to maintain appropriate oversight of frontline staff activities). Travel could be costly in time and money, and sometimes required hard decisions to be made between the costs and benefits of different travel modes (e.g., driving versus flying in a large state like Queensland).

Provision of a comprehensive service
Despite increasing regional settlement and higher client costs associated with PASTT delivery for these areas, the current funding distribution model agreed by FASSTT agencies does not apportion additional funding to those states with higher rates of regional settlement.

Consequently, while FASSTT agencies aim to provide the same level of care and comparable services in the regions, this is rarely the case. Many stakeholders expressed concern regarding inequity in the ability to provide, what they suggested were, more comprehensive and effective services beyond 'base services' they currently delivered in regional and rural areas. For example, counselling and client-level support could often be provided within the constraints of regional services, however capacity building of mainstream providers and communities, and advocacy work was often limited or slow to progress due to the reasons already highlighted in this chapter.

> *"We actually need more than just a couple of counsellors on the ground in those regional areas. We do need a community development worker or a youth engagement worker. We do need someone who's able to do some sector development, but again, our resources just don't spread"*
> **Interview 1, Upper management, FASSTT**

As a result of this insufficient resourcing, some metropolitan based programs or activities with evidence of benefit and efficacy for clients are not provided in regional areas. For example, STARTTS has a research-backed program based on neurofeedback as an intervention offered only to metropolitan clients. Several other FASSTT agencies have similar expanded programs, services, and interventions delivered only in metropolitan areas which are often not funded by PASTT but act in ways that are complementary to it. Most FASSTT agency representatives said that it was unlikely that their organisation would be able to provide additional services and activities in regional areas due to the financial cost of doing so, the lack of facilities or appropriately trained staff, or the lack of surrounding and supporting infrastructure.

While PASTT funding may be better allocated or increased to address some of these issues, inherent systematic challenges are likely to remain (e.g., workforce shortages). Consequently, it may be pertinent to discuss whether the PASTT model of care needs to be re-engineered for regional services. A key question will be what services should clients of different sized communities, in different geographical locations, be able to equitably access and how can that be achieved (e.g., telehealth, local partnerships)? This approach of locally adapted regional service delivery aligns with the National Strategic Framework for Rural and Remote Health[50].

4.4 Metropolitan versus rural and regional: a false dichotomy

Research highlights the variability and diversity of Australia's regional and rural communities[51, 52]. Evidence gathered from consultations with PASTT stakeholders affirmed this perspective. Interviewees asserted that the tendency to assume that refugee communities can be homogenously grouped into 'those who live in cities' and 'those that live in regional areas' represents a false dichotomy[o]. This is because the needs and challenges of one regional and rural refugee community may be very different from the needs and challenges of another regional and rural community (even in the same state). Consequently, recognition of

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[o] *"[each rural/regional service] carries its own set of circumstances. The reality is that rural and regional isn't one big group, it's a number of different areas that have their own aspects to work with and that we've needed to develop strategies to support people in those areas"* Interview 11, **Upper management; administration and corporate services, FASSTT**

the substantial variation that occurs between regional and rural refugee communities within and across FASSTT agency boundaries is necessary.

The impacts of these regional differences are interwoven into the way FASSTT agencies operate to effectively deliver PASTT in non-metropolitan areas. As a result, no ‘one size fits all’ approach has been used in regional PASTT implementation (see Section 4.5 below). Rather, FASSTT agencies have developed locally relevant solutions, an approach which is encouraged in the National Strategic Framework for Rural and Remote Health[50]. This is also congruent with PASTT’s defining feature of flexibility and adaptability to meet client and community needs. While the overall funding amount may not be sufficient to deliver the scope of regional services required, the inherent ability to use available funding for a range of purposes (e.g., respond to emerging needs) was however highly regarded by regional PASTT stakeholders. One FASSTT agency member working in regional community capacity building described it as such:

> *"...the differences in those needs between each regional area can be quite substantial, indeed, so too can the communities that each of those regions is working with, so in terms of having funding that is flexible and allows us to be specific to their needs is, you know, PASTT is brilliant for that”.*
>
> ***Interview 10, Community capacity building participant, FASSTT***

4.5 Need for locally relevant models of service delivery

The need to deliver locally relevant models of regional and rural service delivery to meet the needs of diverse communities within the constraints of each agency’s existing capacity is further explored in this section. Key themes are highlighted in **Figure 8**.

Figure 8. *Key themes supporting locally relevant models of service delivery for regional PASTT implementation*

4.5.1 Regional reach of FASSTT agencies

Given the close alignment of PASTT with the Humanitarian Support Program (HSP), it is unsurprising that the regional reach of PASTT mirrors the settlement locations supported by that program. To visualise this reach, **Figure 9** maps settlement locations in eleven different regions where HSP providers operate (red and green markers). Green stars highlight the location of FASSTT agency metropolitan offices.

As a result of these differences in national settlement patterns and HSP support across states and territories, the FASSTT agencies have different amounts and types of engagement in regional and rural locations. Some agencies have only minimal reach, engaging in a minority of locations with minimal staffing while others have large and comprehensive programs. For example,

- STARTTS (New South Wales) has locations and services in most areas except far western NSW
- QPASTT (Queensland) operates in several regional and rural locations, namely Toowoomba, Cairns, and Townsville
- Foundation House (Victoria) and STTARS (South Australia) have varying levels of engagement in regional and rural service provision.
- Phoenix (Tasmania) operates in Hobart and Launceston via offices of The Migrant Resource Centre Tasmania. Launceston is classified as regional service delivery by Phoenix.
- Companion House (Australia Capital Territory) does not engage in any significant regional and rural service delivery, and this will only change if there are new regional/rural settlement sites (e.g., Goulburn)
- Melaleuca (Northern Territory) does not provide services outside of Darwin
- ASeTTS (Western Australia) does not operate services outside of Metropolitan Perth

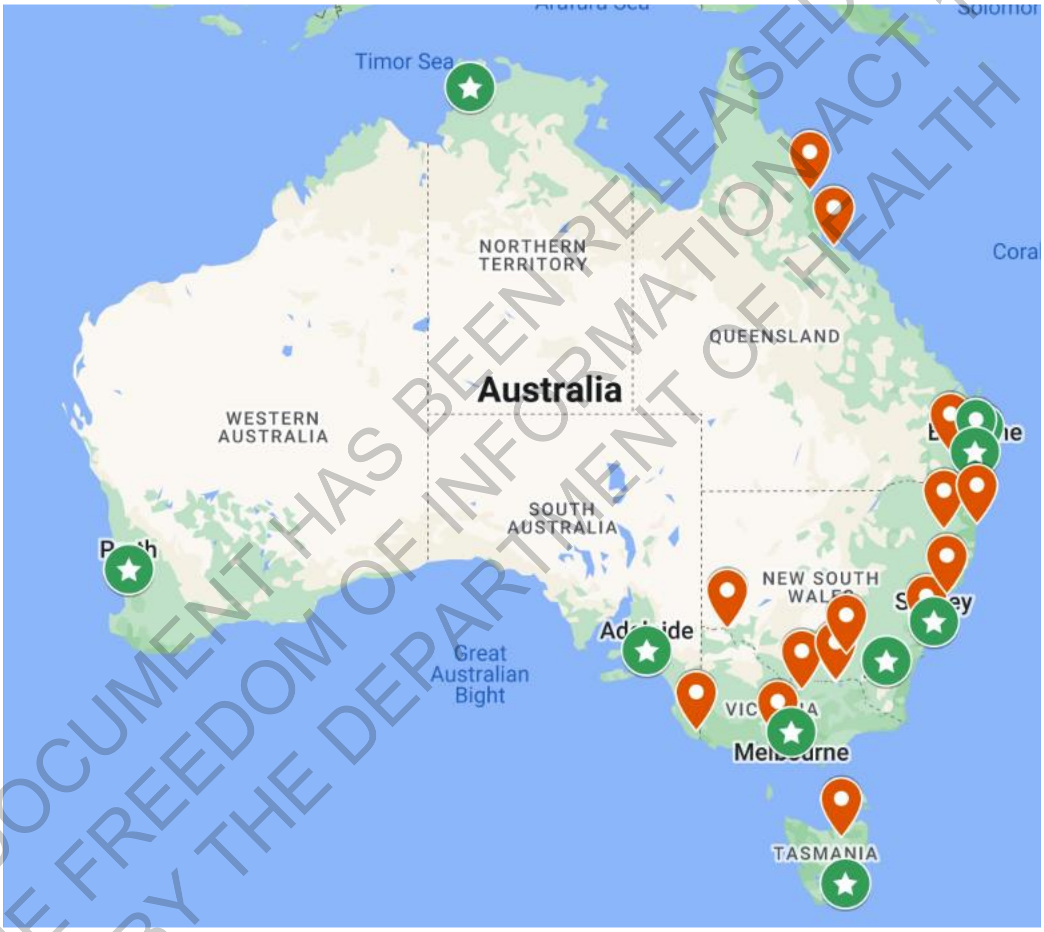

Figure 9. Map of settlement locations supported by the Humanitarian Settlement Program (HSP). Data taken from [53]

Given this variation in reach, it is unsurprising that each FASSTT agency that conducts activities in regional and rural areas does so according to their own unique state-based model of care. **It is the non-directive, flexible and adaptable nature of the PASTT program that facilitates each FASSTT agency to work in regional and rural areas using models of care appropriate to the local and state-based context.**

Determinants of reach and service delivery

Some interviewees suggested that the geographical size of the state or territory was connected to the ability of the FASSTT agency to provide PASTT in regional and rural areas. However, given the apparent success of STTARTS in NSW, **it is unlikely that geographical size is the single explanatory factor regarding the success of regional and rural service delivery**. Factors such as the total settlement intake, proportion of total clients in regional areas, and distance of regional settlement locations from capital cities may be more relevant. State-based funding sources or partnerships also facilitate regional service delivery in some instances.

QPASTT provides an interesting example to demonstrate the convergence of geographical size, number and dispersion of clients, and other issues in impacting regional and rural service delivery. Firstly, the driving distance from Brisbane to two of QPASTT's regional locations (Cairns, Townsville) is 15-20 hours, whereas all of the regional NSW localities are less than six hours drive from STTARTS' base in Sydney. Consequently, this has impacts on how these sites can be effectively and efficiently serviced. Additionally, while only 19% of the Queensland population live in MMM2 defined rural regions[54], 50% of QPASTT's eligible clients (resettled refugees) currently reside in these areas. Finally, Toowoomba is the only regional location nationwide to consistently rate in the top 10 settlement locations by number of arrivals annually[30]. This combination of factors, plus Queensland experiencing the highest cost of service delivery outside a capital city (**Table 15**, Chapter 6) is likely driving the challenges in regional service delivery QPASTT is currently experiencing.

4.5.2 Regional models of service delivery employed by FASSTT agencies

In discussions with key stakeholder participants, three major strategies that FASSTT agencies use to connect and provide services in regional and rural locations were identified. These were:

1. Establishment of local offices and staff, usually in shared facilities with other services (e.g., QPASTT)
2. Partnering with local third-party organisations (e.g., STARTTS)
3. Digital solutions (e.g., telehealth) (e.g., all agencies)

As summarised in **Table 7** there are advantages and disadvantages to each of the models. Importantly, there is limited published research evaluating the effectiveness of any of the models presented[41]. Some agencies engaged in a mix of these strategies as part of their overall model of care. For example, there was indication that most FASSTT agencies utilised digital solutions alongside the other strategies, particularly during the COVID-19 lockdowns. QPASTT indicated that for some rural and regional areas they operated local offices in a shared arrangement with other services and that they had staff, particularly managers, operate in local areas in a part-time capacity (e.g., Fly In-Fly Out).

Ultimately, there is a need to understand that while the PASTT client base in regional and rural areas is growing, service delivery models that are appropriate for metropolitan communities do not always translate well into regional settings. There is a pressing need to design, deliver, and support regional and rural health services using more flexible, innovative, and locally appropriate solutions, without compromising the quality and safety of care.

***Table 7**. Advantages and limitations of models for regional and rural delivery of PASTT services*

Advantages	Disadvantages/Limitations
Local offices	
— Physical presence to maintain local relationships with suppliers and refugee communities — Control over processes, activities, programs, and interventions — Direct management of staff	— Very costly to set up and maintain — Lacking economies of scale necessary to make this model viable over the long-term — Attempting to reduce costs by sharing facilities with other local services limits space available and impedes on client privacy
Partnering/subcontracting with local providers	
— Local knowledge and networks can be leveraged, leading to better care for PASTT clients — Long-term cost savings when compared to the cost of establishing their own presence in the location	— No physical presence or direct visibility of FASSTT agency in local community — Existing skilled third-party providers required in area of resettlement — Need to establish and maintain relationships with third-party providers 'by distance' — Ongoing time and cost in maintaining appropriate oversight of the local provider to ensure that they are working in accordance with the FASSTT agency goals and PASTT requirements and principles
Digital solutions	
— Counselling activities can be provided to geographically dispersed participants without the financial cost and difficulty of setting up a local office — Counselling activities can be provided directly without engaging a local partner, ensuring greater control over service delivery — Travel costs in terms of both money and time are eliminated	— Clients sometimes have limited access to devices or do not have access to a private or safe location to engage in digital or virtual counselling — Clients sometimes have limited experience using applications and programs (e.g., Zoom) — For some issues, digital solutions were not effective, adequate, or able to be employed — Reliability and/or comprehensiveness of telecommunications infrastructure is poor in some rural and regional communities — Other costs in providing staff with devices and software including, for example, licensing costs for software — For many clients, face-to-face therapy is still the preferable option

4.6 Findings

Finding R1. Overall, the findings support a need for PASTT delivery in regional and rural communities, however the service delivery models used in metropolitan areas have not been fully realised in regional settings.

Finding R2. Balancing service demand and organisational capacity is a key challenge for regional and rural PASTT delivery. Capacity to respond is impacted by organisational factors (e.g., resourcing, staffing) and the region's geographical context (e.g., higher cost of service delivery, limited workforce, and lack of third-party providers).

Finding R3. Regional and rural communities are not homogenous so a single model to fund or deliver all regional PASTT services is not appropriate. Rather, it is important to support and encourage the development and delivery of locally relevant models of care.

Finding R4. The non-directive, flexible and adaptable nature of the PASTT program and its funding facilitates each FASSTT agency to work effectively in regional and rural areas using models of care appropriate to the local and state-based context.

Finding R5. The three major strategies used by FASSTT agencies to adapt PASTT delivery for regional and rural areas are: (1) establishing local offices to provide direct service delivery; (2) partnering with local third-party organisations to deliver PASTT services; and (3) using digital solutions.

Finding R6. FASSTT agency staff in regional and rural areas are often required to work beyond the scope of practice required in metropolitan areas (e.g., assisting refugee clients with finding suitable housing or applying for work).

Finding R7. There is a need to dedicate time and funding to training and capacity building of mainstream regional service providers and undertaking regional community development work to enable holistic delivery of PASTT in these communities.

Finding R8. PASTT funding could be better allocated or increased to address some of the current challenges in regional service delivery. However, inherent systematic challenges associated with service delivery in regional and rural Australia are likely to remain. Consequently, it may be pertinent to discuss whether the PASTT model of care needs to be re-engineered for regional services.

Chapter 5. Outcomes achieved

This chapter examines the outcomes and impact of PASTT using existing administrative and program data, previous agency evaluations, a partnership/engagement survey, case studies, and stakeholder consultation. It also draws on published literature where appropriate. The focus of the chapter is key evaluation question three: *How effective has the program been?*

Quantitative analysis has been undertaken based on a review of existing organisational documents including annual PASTT reports and via specific requests for data on client numbers, service delivery and engagement activities, and client reported outcomes (goal setting, WHO-Five wellbeing index). Quantitative and qualitative data was also analysed from an engagement questionnaire sent to a range of external PASTT stakeholders. Descriptive analysis of data, including trends over the past five financial years where available, is presented. In addition, qualitative analysis has occurred after conducting interviews with PASTT clients, reviewing case studies and client feedback interviews conducted by FASSTT agencies, and extensive consultations with agency CEOs/directors and staff members. Where relevant, illustrative quotes are provided to highlight points. Additional supporting quotes can be found in Appendix 9 and client interview case studies in Appendix 3.

The following sections summarise analysis completed relating to:

- Client-level outcomes
- Service provider and health system level outcomes
- Community-level outcomes

5.1 Considerations and limitations in measuring outcomes

As with any health or social services evaluation assessing a broad range of activities and outcomes, limitations in the robustness of the data means that it is not possible to make causative attributions. To increase robustness, quantitative and qualitative data have been used to undertake the evaluation while acknowledging limitations. The considerations and limitations discussed below shaped data collection and analysis and ultimately informed the evaluation response.

5.1.1 Multilevel impact of PASTT

Given that the activities of PASTT occur at the client, health service, and community level, outcomes should also reflect impact across this same range of settings (**Figure 10**). All stakeholders interviewed also reiterated the importance of considering PASTT's impact across multiple layers of the system. Impacts at the client level and provider level were easier to document for agencies compared to community level impacts which often take many years to eventuate. However, evaluation of such impacts is important as programs that support community and social healing processes can be powerful and cost-effective tools for enhancing the lives of many[14]. Additionally, impacts on individual clients can have flow on effects to their families and communities which may be missed if focusing only on proximal impacts of counselling and recovery.

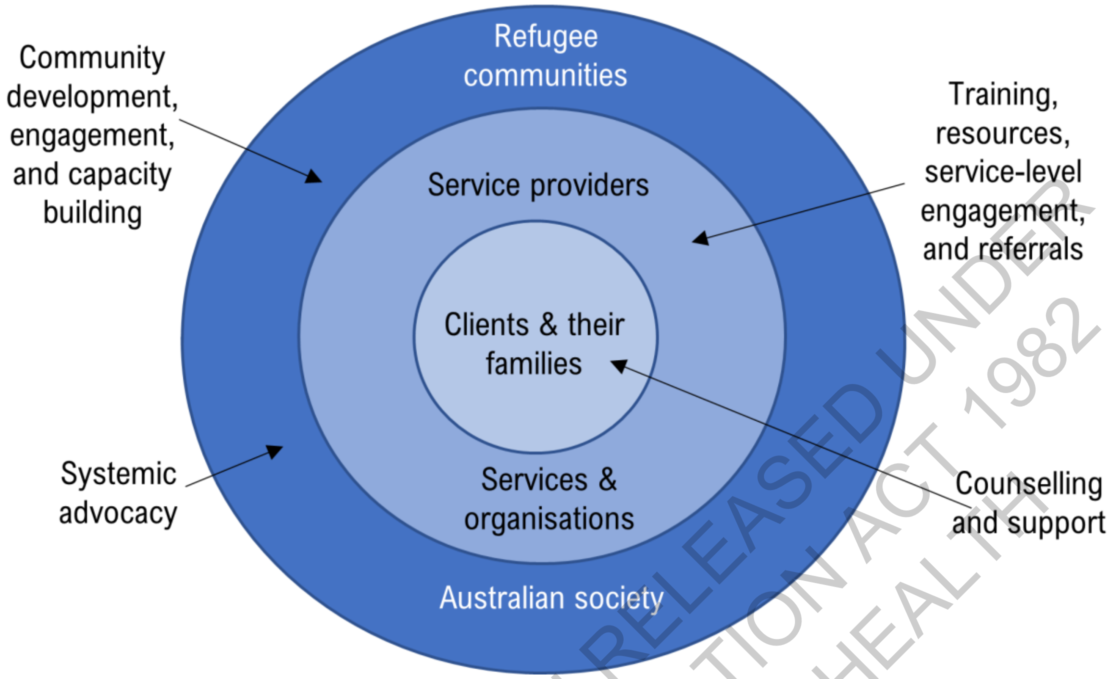

Figure 10. *Multi-level impact of PASTT activities*

5.1.2 Challenges evaluating social service programs

One key challenge in PASTT evaluation is that FASSTT agencies undertake work that can be difficult to quantify and attribute in a meaningful way. In part this is because of their varying activities, wide reach, long or varying duration, individualised nature, and multitude of potential outcomes. Tracking and isolating long-term impact is also difficult in the dynamic environments where these agencies are providing a range of services in collaboration with other partners (for example, demonstrating PASTT's contribution and impact to a policy change). This challenge is also reflected in the literature, with research evaluating the effectiveness of social service programs for refugee communities limited and lacking methodological rigour[13].

Consequently, there needs to be nuance in how the impact of PASTT is understood, and acknowledgement that some forms of work (e.g., community development) face challenges in evaluation. For such programs, service effectiveness is often seen as success across a number of hard or measurable indicators, such as an individual's employment, health, or English language proficiency. However, previous research[55] has reinforced the importance of subjective indicators to understand whether refugees are achieving outcomes that are personally meaningful. Therefore, to provide a full picture of the effectiveness of PASTT, a comprehensive approach should be taken to capture all the elements of the program, process, and context in which the program is delivered, using both objective and subjective measures of impact.

5.1.3 Limitations of available program data

Current data for the program provides only a partial picture to assess whether PASTT meets its objectives and outcomes. The expert opinions of FASSTT agency staff, staff from other stakeholder organisations, and available administrative and program data (supported by relevant literature), are the principal sources for most of the key findings. Inconsistencies were sometimes found in the reporting of activities and participants between different data sources from the same agency for the same reporting period (for example, activity work plans compared to data tables submitted to funders). Additionally, data for sector development/training and community engagement was not reported in consistent ways across agencies. For example, description was not provided of how agencies counted the number of organisations represented at large multi-disciplinary training events. Finally, community engagement work would benefit from tighter definitions or categorisations of activity/engagement type that could be applied nationally, and clearer ways of highlighting events in partnership with, or part-funded by, external organisations/groups. Sometimes it was not clear whether groups such as parent's or youth groups were counted in both counselling groups and community engagement activities.

5.2 Client outcomes

The following section details findings related to PASTT outcomes at the level of the individual client. This section draws on qualitative and quantitative data, and case studies. Due to the lack of quantitative data to report measurable outcomes, the qualitative interviews with FASSTT agencies and their stakeholders were the primary data source. Analysis of qualitative data captured during client interviews provides further examination of client reported outcomes and experiences. Where relevant, illustrative quotes are provided to highlight points. Interviewed client case studies are included in Appendix 3. Narrative case studies detail the experiences of individual clients and were developed and provided by the FASSTT agencies. Quantitative data provided by agencies supported analysis of client-reported outcomes. This includes data from 32 former STTARS clients who were interviewed about their experiences with the agency by two torture and trauma counsellors (one internal and one external to STTARS). Clients/caregivers interviewed ranged in age from 8 to 76 years and represented a range of cultures, ethnicities, and service engagement patterns.

Overall, PASTT clients experienced improved mental health and wellbeing, and increased engagement in Australian society after engaging in the program, although challenges were experienced in achieving these improvements. Key findings related to client level outcomes are summarised and presented in Section 5.5 .

5.2.1 Counselling, groupwork and complementary therapies

While PASTT has impacts on individual clients through its range of service delivery, advocacy, and capacity building activities, counselling services, groupwork, and complementary therapies are key drivers in delivering improved client level outcomes. Provision of counselling services and direct client services also takes up a significant proportion of each agencies budget (**Table 14**). Broadly categorised, each FASSTT agency engages in individual counselling and group counselling/groupwork with PASTT clients. These services may be provided to new clients or continuing clients. Foundation House also provides complementary therapies such as trauma informed yoga, naturopathy, massage, body work, and mindfulness to clients.

Individual counselling

FASSTT agencies have demonstrated significant reach of counselling activities across the communities they support. On average, PASTT funding has supported FASSTT agencies to provide individual counselling services to 9,396 total clients across Australia each year between 2016 and 2021. **Figure 11** plots the Australia wide (i.e., FASSTT network) trend for individual new client counselling, individual continuing client counselling, and total individual counselling (new plus continuing) engaged in by the FASSTT agencies from 2016-17 until 2020-21. As can be seen, after a slight decline in 2017-18 the total number of clients receiving individual counselling via PASTT has remained relatively constant despite reductions in humanitarian intakes. The number of new clients decreased in 2017-18 (aligned to a halving of intake numbers that year) while the number of continuing clients has increased. Continuing clients have comprised almost 50% of all counselling provided via PASTT since 2019.The number of new clients seen each year from 2016 to 2020 is equivalent to 30-40% of the humanitarian entrants to Australia in that same year. Although, for reasons which will be discussed in Chapter 6, this underestimates the true eligible client pool for PASTT services.

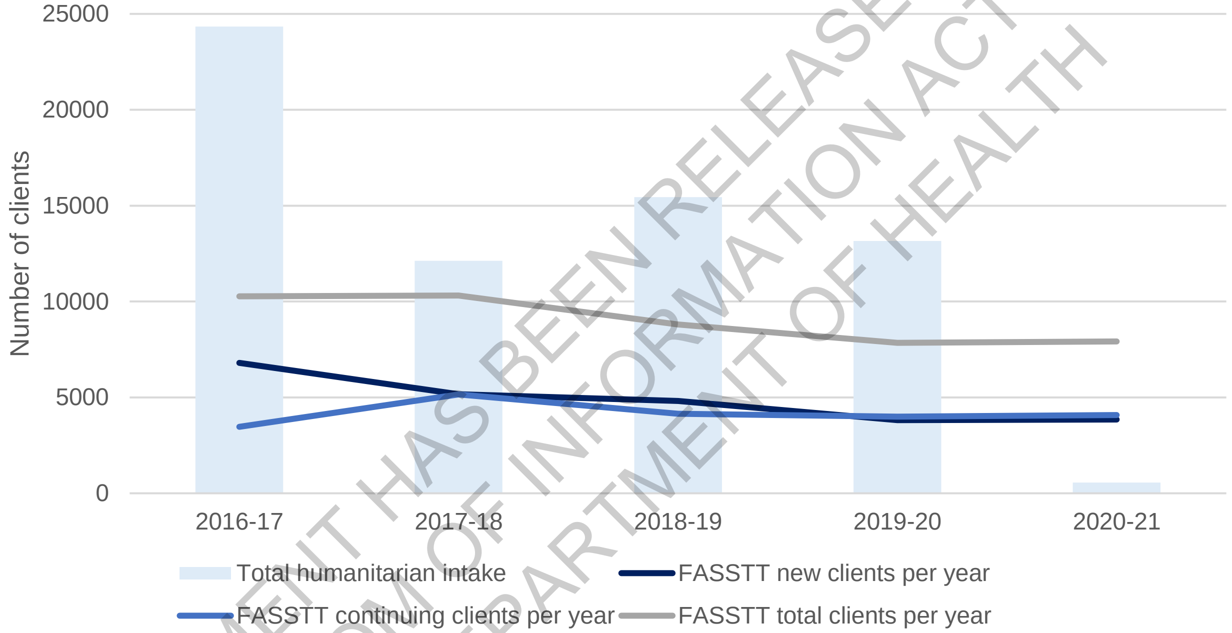

***Figure 11**. Trend in individual counselling clients (Australia wide) 2016-17 to 2020-21*

Annual targets for individual counselling are proposed by each agency in their Activity Work Plans. Analysis determined that these targets were generally met or exceeded, and sometimes by large amounts. However, it is noted that two organisations (ASeTTs and Melaleuca) had difficulties meeting individual counselling targets in 2020-21 due to lower than predicted arrivals via the Humanitarian Resettlement Program as a result of COVID-19. However, this was an anomaly and targets for following reporting periods have again been exceeded. The individual counselling activities and targets for each FASSTT agency (where data were provided) are consolidated in **Figure 12** and **Table 8**. In 2018-19, around 8% extra individual counselling activities above targets were completed while in 2019-20 about 2% extra were completed. In 2020-21 about 2% fewer than targeted individual counselling activities were completed, although the reason for this has been explained above.

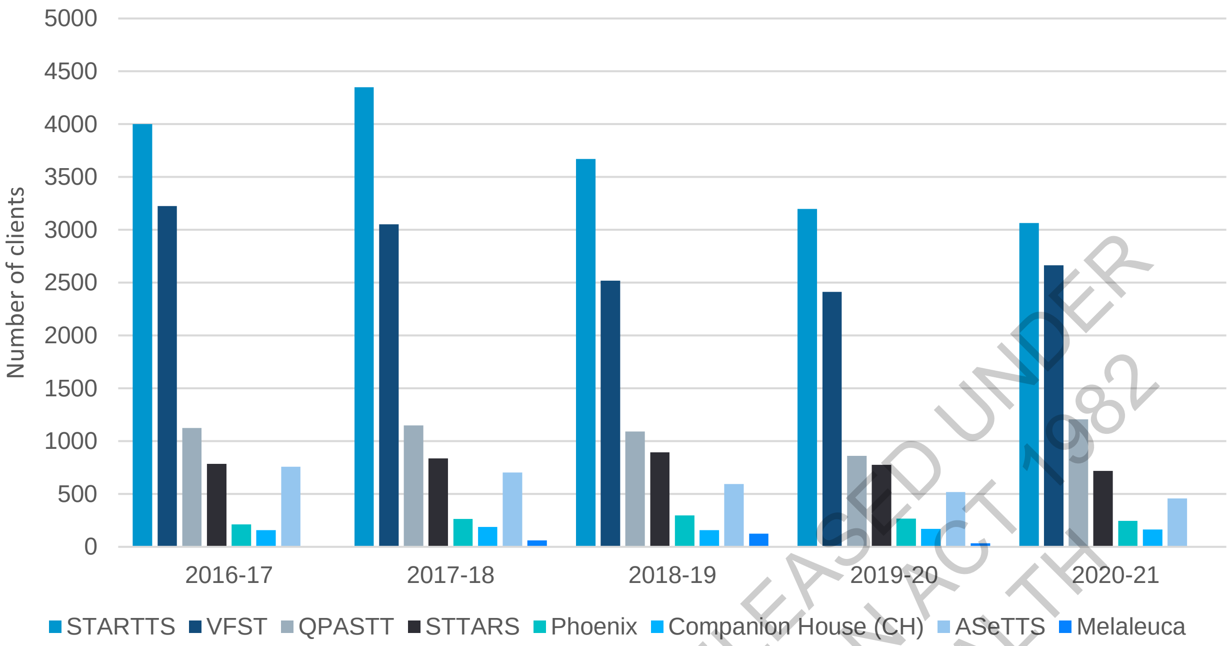

Figure 12. *Total individual counselling clients per year by FASSTT agency*

Table 8. Australia-wide individual counselling activities compared to target

Year	Total	Target	Discrepancy* (%)
2016-17			
2017-18			
2018-19	5024	4648	376 (8%)
2019-20	7469	7340	129 (2%)
2020-21	8307	8458	-151 (-2%)

* Discrepancy: positive number means that target was met or exceeded; negative number means that target was not met. Target vs total counselling activities not available for all agencies. No data provided for 2016-17 and 2017-18.

Group counselling and groupwork

This category of service delivery includes group counselling, psychoeducation, wellbeing and belonging group work (e.g. women's groups, sport's groups, parent's groups), and youth group activities. While acknowledging some missing data exists, the total number of groups facilitated by PASTT, Australia-wide, for the past five years is displayed in **Figure 13**. On average, PASTT ran 205 groups each year over this period. The number of groups peaked in 2017-18 declining for the following two years (impacts of reduced humanitarian intakes and COVID-19 restrictions) before increasing considerably in 2020-21. Each group held multiple sessions across these years, with the total group sessions for each agency ranging from 5 (Melaleuca) to 2,724 (STARTTS).

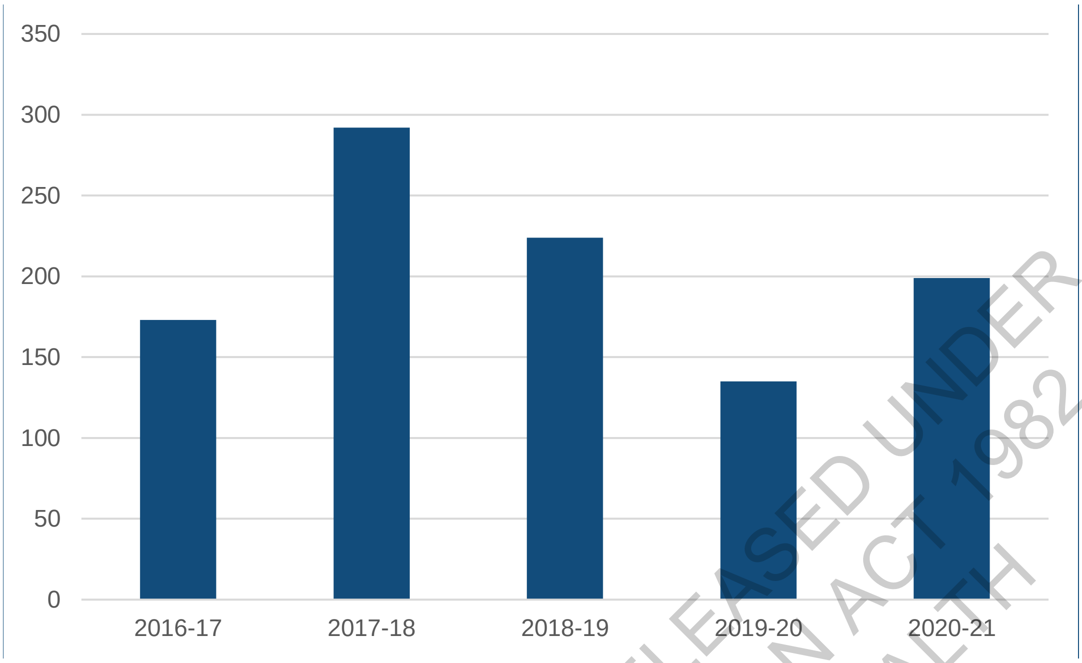

Figure 13. *Total number of PASTT groups (Australia-wide) per year 2016-17 to 2020-21*

There was some variance in the number of groups conducted each year depending upon agency. In **Figure *14***, the number of groups for six agencies where full data sets were available, is plotted. The number of groups remained relatively constant for STTARS and Phoenix. There was a noticeable drop in the number of groups conducted by VFST and STARTTS in 2019-20 (due to COVID-19 restrictions/lockdowns), and a noticeable increase in the number of groups conducted by QPASTT and STARTTS in the following year (successful transition to remote working/therapy arrangements, easing of lockdowns).

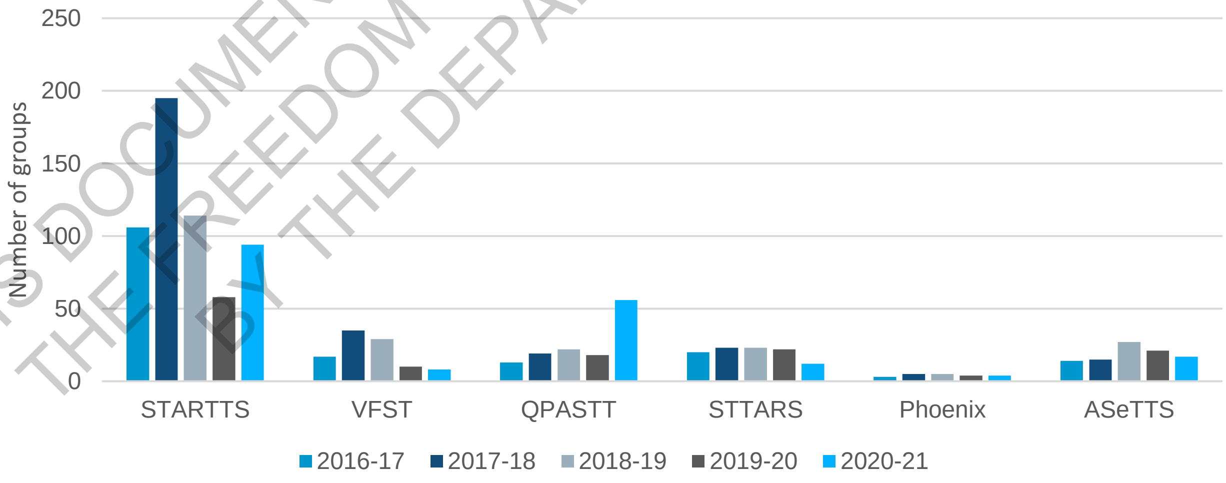

Figure 14. Total number of counselling groups per year for selected FASSTT agencies, 2016-17 to 2020-21

There was also more variation, compared to individual counselling activities, in meeting targets related to groupwork, however some of this is due to missing data about targets across agencies. Across the FASSTT network, about 78%, 11%, and 21% more group activities were conducted than predicted in 2018-19, 2019-20, and 2020-21 respectively (**Table 9**).

Table 9. *Australia-wide group counselling activities compared to target*

Year	Total	Target	Discrepancy* (%)
2016-17			
2017-18			
2018-19	82	46	36 (78%)
2019-20	59	53	6 (11%)
2020-21	139	115	24 (21%)

* Discrepancy: positive number means that target was met or exceeded; negative number means that target was not met. Target vs total counselling activities not available for all agencies. No data provided for 2016-17 and 2017-18.

Complementary therapies

Foundation House (VFST) is the only FASSTT agency to offer a full range of complementary therapies (provided by specialised complementary therapy practitioners) as part of PASTT. Modalities include naturopathy, massage, yoga, and other body-based therapies. These therapies are provided alongside, or as an alternative to, counselling and biomedical treatment options. They are particularly useful for clients experiencing physical symptoms or somatic presentations. A recent evaluation of VFST's complementary therapy program provided evidence that it delivers positive outcomes for clients including relief from physical symptoms, and improvements in social, emotional, and mental wellbeing[p]. Moreover these therapies were perceived as accessible, culturally meaningful, and translatable to many clients. There are almost no other free or low-cost complementary therapies available for refugees in Australia. Consequently, VFST provides a significant, beneficial service that is not otherwise available to this client group.

Current challenges to the implementation and sustainability of the complementary therapies program at VFST are resource related. These include long wait times, a capped number of sessions, and limited availability of staff. Additionally, the complementary therapies program at VFST was entirely funding by PASTT income for many years, but recent resourcing constraints have meant that 30-40% of the costs of this program now need to be cross subsidised from other funding streams.

5.2.2 Improvements in mental health and wellbeing

One of the key objectives of PASTT is to improve the psychosocial health and wellbeing of refugees who have experienced torture and trauma prior to their arrival in Australia. International research has shown that counselling, psychotherapy, advocacy, healing circles, and group support can have positive effects on mental health (including depression and distress) of refugee participants[14, 15]. In the qualitative interviews with FASSTT agency stakeholders, evidence for such improvements in client-level mental health and wellbeing outcomes was also found for the program, despite counsellor advocates reporting that it was often hard to see day-to-day improvement. The counsellor advocates interviewed provided several descriptions of the way that PASTT clients experienced reductions in depression, anxiety, and other psychosocial outcomes including reductions in suicidality, and improvements in sleep and behaviour[q]. This is exemplified in the client case study in **Box 4** below. Concurrently, PASTT clients were described as demonstrating increases in self-confidence and self-esteem, resilience, self-directedness and autonomy, decision-making capability, and improvements in appearance, hygiene, and self-care practices. A key issue for survivors of torture and trauma relates to reduced ability to trust. Reports of clients experiencing increased trust in relationships,

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[p] Foundation House complementary therapies services: final evaluation report. Emma Thomas and Jo Farmer. June 2022. *Shared with AusHSI by VFST.*

[q] *"We work at the extreme end of the trauma spectrum every single day…we don't have easy cases, everyone has been tortured or deeply traumatised, yet in those circumstances we have very low suicide rates"* ***Interview 5, Upper management, FASSTT***

especially with counsellor advocates or therapists, were provided. This was further supported by comments provided by the interviewed clients (Appendix 3).

__Box 4__. Client case studies: Client 3

Case 3 – "D"

Background

'D' is a 57-year-old Bosnian man who arrived in Australia in 2000 with his wife and three children. While a soldier D directly witnessed and/or was confronted with war atrocities and experienced frequent and continued physical and psychological torture at the hands of prison guards and government administrators once captured by enemy forces.

D was referred to ASeTTS for counselling in 2005. Upon commencing engagement with ASeTTS D was experiencing significant psychological distress, difficulties sleeping, nightmares, severe anxiety, and depression. He presented with chronic suicidal thoughts and violent behaviours. Misuse of alcohol was affecting D's mental and physical health and impacting D's familial relationships. He appeared dysfunctional in all practical and personal areas of functioning.

Engagement with PASTT

Individual torture and trauma counselling provided to D focused on his suicidal thoughts, feelings of guilt and shame. Self-esteem issues, and behavioural and relationship difficulties. ASeTTS Consultant Psychiatrist was also involved; assessing D's psychiatric state and suicide risk, and co-managing D's needs with the ASeTTS' counsellor; this included implementing suicide risk protocols and regularly monitoring clinical progress. Alongside counselling and psychiatric support provide to D, D's family was also provided counselling to develop understanding of trauma and trauma responses, and to support the family in stabilising their dynamics.

After 1-year D reported a reduction in his psychological pain and suicide risk, symptoms of anxiety and depression had reduced, family functioning was improved, and alcohol abuse had ceased.

D continued counselling for a number of years with sessions focused on addressing unresolved feelings of guilt, shame and anger in order to reduce hypervigilance, and hypersensitivity to repeated harm. Counselling also addressed ongoing issues of suicide risk, substance use, healthy relationships and family and domestic violence.

As evident is the above case study, PASTT clients represent a unique, complex, and challenging population to work with. During the interviews, the counsellor advocates and clinical stakeholders drew on their experiences with PASTT clients to provide other specific examples of mental health improvements in individuals. One interviewee described how a depressed and suicidal client, who had stopped bathing regularly, was now practicing self-care and was an integral part of the counselling group. In another example, counselling group work with teenagers resulted in positive behavioural changes such as reductions in aggressive physical behaviours and disengagement in gang-related behaviour. Interviewees described how their work assisted clients to get 'better' or to make as much improvement as they could rather than on focusing on 'curing' people. Multiple interviewees highlighted how their clients often became more engaged in the treatment or counselling process as the number of sessions increased. This engagement was viewed by the interviewees as demonstrating a form of success along the client's journey to recovery. For example, an interviewee discussed how a shy client with very low self-esteem, who rarely spoke in counselling sessions, had progressed to be engaged in the counselling process and to be actively using the training and other services provided by the FASSTT agency. Clients' autonomous decisions to reduce counselling frequency due to self-perceived improvement was also viewed similarly as a marker of success.

Similar examples of benefits to clients' mental health and wellbeing were also reported by the interviewed clients (e.g., case study C3, C5, C6, C7 in Appendix 3) and observed in the STTARS client feedback interviews (described in Section 3.4.2). These examples included dealing with depression and emotions, improved relationships with family, better sleep, and initiation of medications. Direct quotes from clients obtained in the STTARS feedback process best exemplify the importance of PASTT in improving mental health and wellbeing:

> *"I remember I used to feel really, really down and they would talk to me, build my self-esteem and make me feel better. Yes, before I used to cry a lot, used to feel like someone was suffocating me and feel a lot of pressure. They used to talk to me. I still go through some of those moments. I remind myself what the counsellor used to say to me and that helps."*
>
> *"STTARS helped me a lot. I give high score for STTARS wherever I go. I wouldn't be able to sleep otherwise. I had a lot of nightmares but now things are better, and I can sleep"*
>
> *"Without STTARS I wouldn't have been able to survive. At that time, it was very difficult, the doctors thought I wouldn't come [good] by myself but STTARS supported me"*
>
> *"It was really helpful when I compare from before and after of service there is a lot difference. Its good difference. I also had to take medication from STTARS help and the medications were good for me"*

It is important to note that a unique and important aspect of PASTT is its client-centredness which allows it to be flexible, adaptable, and for clients to re-engage if needed after initial treatment is completed or discontinued. The complexity of cases and the types of treatment and outcomes that are achieved, including the impact on families and the fact that many clients re-engage with PASTT, are vividly evident in the case studies provided in **Box 5** and **Box 6** (source for case studies – Foundation House). These cases also demonstrate the significant duration of engagement required by some clients, and the variety of external services engaged by PASTT via referral to improve outcomes.

***Box 5**. Client case studies: Client 4*

Case 4 – "C"

Background

"C" is a man aged in his early 40s who is of Chin ethnicity. He was referred by a concerned community member after receiving a drink driving charge resulting in the loss of his license. He presented with unexplained outbursts of anger, alcohol abuse, and sleeplessness. He had come to Australia on a refugee visa in 2016, accompanied by his wife and three children.

Assessment

He was assessed to suffer from Post-Traumatic Stress Disorder (PTSD) and depression caused by (i) burning down of his village as a young man and the death of his father, (ii) dangerous transit to Malaysia, followed by 12 years of precarious living which included several detentions and police beatings, (iii) death of a child from Dengue Fever.

PASST engagement outcomes

He attended 4 counselling sessions which included a referral to Complementary Therapies for naturopathic assistance for his insomnia. He gained full time employment which meant his capacity to attend appointments was difficult and contact continued for several months with phone 'check-ins'. During Victoria's lockdown due to COVID-19, in 2020 his referrer recontacted the counsellor to request his treatment be re-established, (which was possible with the assistance of telehealth) as his employment had ceased. Since then, he has primarily received fortnightly Cognitive Behaviour Therapy for 20 months. He also resumed a therapeutic connection with the Complementary Therapist and found herbal treatment and massage beneficial. His PTSD symptoms had decreased, however, the recent genocide in Myanmar targeting Chin state, has re-triggered his nightmares and flashbacks.

In late 2020 his Counsellor/Advocate became aware that his wife was threating to leave, and the children had not been able to engage in on-line learning and this had caused additional stress and exacerbated his symptoms. A family assessment was completed, and his daughter aged 14 was linked to a Child and Youth Counsellor/Advocate as she was displaying behaviour of concern including self-harm. The family assessment has exposed a family under great pressure with financial strain, potential homelessness, disengagement with education for the children and significant conflict in the home. Both he and his daughter continue to engage in work with the FASSTT agency with regular reviews against goals set by them. Several referrals to external providers have been made including to school welfare staff (primary and secondary), emergency relief services, housing assistance organisations, community support program, and employment services provider.

Box 6. *Client case studies: Client 5*

Case 5 – "E" (first referred 2014; re-engaged 2019)

Background

"E" is a woman aged in her late 20s who is of Afghan Hazara ethnicity. She was initially referred by the refugee clinic at Monash Hospital because she expressed high levels of distress including suicidal ideation. Her husband had arrived via boat in 2000 and had eventually received a substantive visa. She and two of her children had arrived in Australia in 2013. She subsequently had two further children after her arrival in Australia.

First Assessment (2014)

She was assessed to suffer from anxiety and depression. The risk assessment indicated she was of medium risk for suicide. The major protective factor was her Muslim faith and her love for her children.

PASTT engagement and outcomes (first engagement)

E was seen by a counsellor/advocate for 14 months including 53 counselling sessions along with some advocacy and telephone 'check ins'. Initially, weekly sessions were conducted due to the potential suicide risk, however this reduced to fortnightly and then monthly as time progressed. There was a clear plan to assist her to gain insight into her psychological presentation and provide strategies for coping with the pressures she was under. Her case was closed in mid-2015. Several referrals to external providers were made including to an Afghan Women's Group, a GP who assisted with medication for anxiety and depression, migration legal assistance to investigate the possibility of sponsoring family to migrate to Australia, and massage therapy to assist with sleep/relaxation.

Second Assessment (re-engagement 2019)

E self-referred with a similar presentation of anxiety and depression. She stated that the 'bad thoughts' were back and that she could not see a way out of her darkness. While still married, her family situation had deteriorated. There was ongoing concern about eviction from their rental property. Recent bombing targeted at Hazaras in Afghanistan had killed a relative, and her mother and sister called constantly begging to get them to safety. This led to resurgence of feelings of hopelessness. She said her days were spent alone in her house, crying, with no one to help. Her children and role as a mother were no longer as strong a protective factor.

Treatment and outcomes (re-engagement 2019)

She resumed counselling due to the ongoing worries and preoccupation about what was happening in both Afghanistan and Pakistan. She has seen the counsellor advocate 23 times in 2019 and monthly (usually via tele-health due to COVID-19 restrictions) from 2020 onwards. There was a closure plan in place, however this was extended due to the ongoing trauma for her family overseas. At the time of writing the intention was to close this case in three more sessions. Several referrals to external providers were made including to a family violence service, a material aid provider and housing service, and Red Cross Tracing.

Improvements in mental health and wellbeing were also observed in the analysis of quantitative data made available to the evaluation by FASSTT agencies to examine client reported outcomes. This data is generated from the reflections of clients through therapy sessions and surveys conducted by PASTT program providers.

Client reported outcomes: WHO-5

The World Health Organisation-Five Well-Being Index (WHO-5) is a short self-reported measure of current psychosocial wellbeing. It has been validated for use in adults and children aged 9 and above, is available in over 30 languages and has been used with refugee populations in other settings. It has been found to have adequate validity in screening for depression and other mental health outcomes, with good construct validity as a unidimensional wellbeing scale, including in children and older people[56].

The questionnaire consists of five statements in relation to respondents' experiences over the past two weeks, with respondents rating each statement on a 0-5 Likert scale. The statements are positively worded rather than focusing on perceived hardships or negative experiences. An example item from the WHO-5 is 'I have felt cheerful and in good spirits'. A participant's total raw score is multiplied by four to give a final score, with 0 representing the worst imaginable level of well-being and 100 representing the best imaginable well-being.

WHO-5 PASTT protocol

The following process for the collection of client WHO-5 data has been agreed by all FASSTT agencies. The protocol was officially implemented on 1st July 2020. Since this time, all agencies have implemented the protocol for all individual counselling clients and for all groups that are meeting over a period of at least three sessions. Compliance rates with the protocol are high for new clients enrolled since July 2020, however there were some difficulties experienced in bringing established clients on board in a consistent way.

For individual counselling clients, it is recommended that the questionnaire be introduced as early as appropriate in the session at the following time points:

- Initial WHO-5 administered at the earliest engagement with the client. This may be at intake or at the initial assessment
- Second WHO-5 administered at Session 5
- Third WHO-5 administered at Session 10
- Subsequent WHO-5 administered after every 10 sessions
- Final WHO-5 at closure/discharge

For group counselling that involves 3 or more sessions (including family groups), WHO-5 is administered to each group member:

- Before the intervention
- Post the intervention
- Every three months (for ongoing/long term interventions)

For pragmatic reasons, if it is not feasible for a WHO-5 questionnaire to be administered in alignment with the agreed protocol, a flexibility of up to 2 sessions is considered acceptable. For example, if for any major reason the WHO-5 cannot be implemented in session 10, then it should be implemented in session 11 or no later than session 12. If implemented in session 11 or 12, the next WHO-5 will be due in session 20 as per the protocol.

WHO-5 outcomes

Between June 2020 to December 2021, there were 1,702 WHO-5 questionnaires completed by 1,192 individual PASTT clients. Of these clients, 59% were female and the mean age was 37.0 (range 9 to 82). 70% of respondents had been born within the WHO Eastern Mediterranean Region and 69% required an interpreter. Approximately one third of respondents were engaged in other programs in addition to counselling.

Overall, 68% of completed questionnaires were the initial WHO-5 assessment. There were 366 individuals (31%) who had completed a second survey, 122 (10%) who had completed a third survey and 46 (4%) who had completed four or more surveys. A total of 94 clients (8%) had reached closure status.

Figure 15 highlights the improvements observed in WHO-5 scores over time. Outcomes have been stratified according to the total number of questionnaires completed, to account for the likely bias in the complexity of clients who undertake counselling for a longer period of time. Clients that completed two questionnaires experienced a 23% average improvement in WHO-5 score over time, while clients that completed three questionnaires experienced a 29% improvement and clients that completed four questionnaires experienced a 47% improvement.

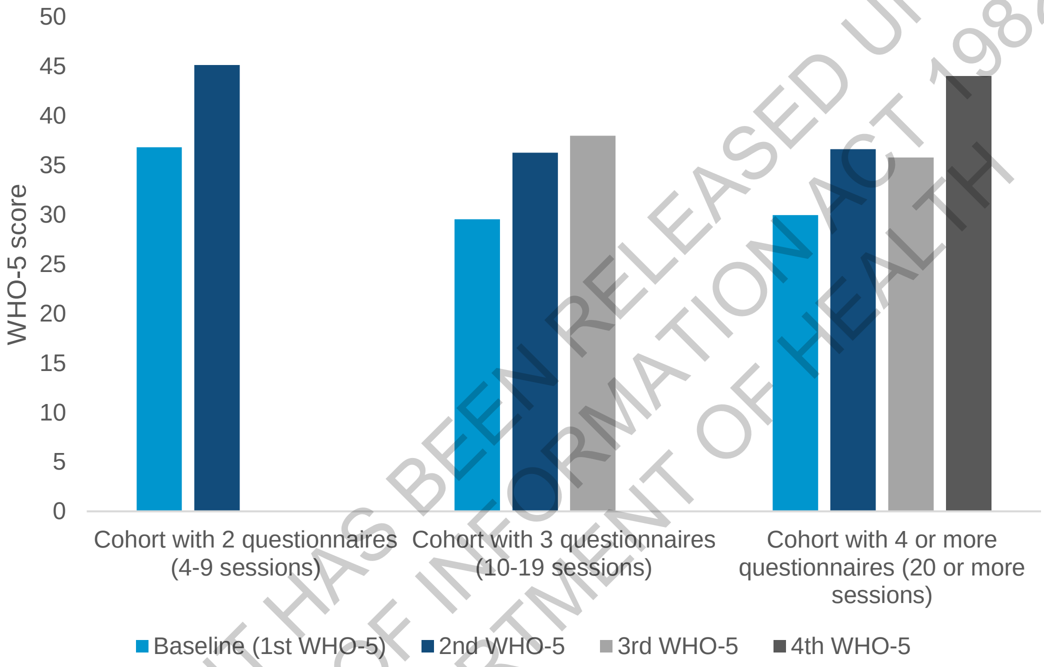

__Figure 15__. WHO-5 score improvements over time, stratified by number of surveys completed

Figure 16 highlights the improvement observed between baseline and closure assessments, for the 94 clients who had recorded a closure status. These clients reported an average 36% improvement in WHO-5 score over the duration of their enrolment in PASTT counselling services.

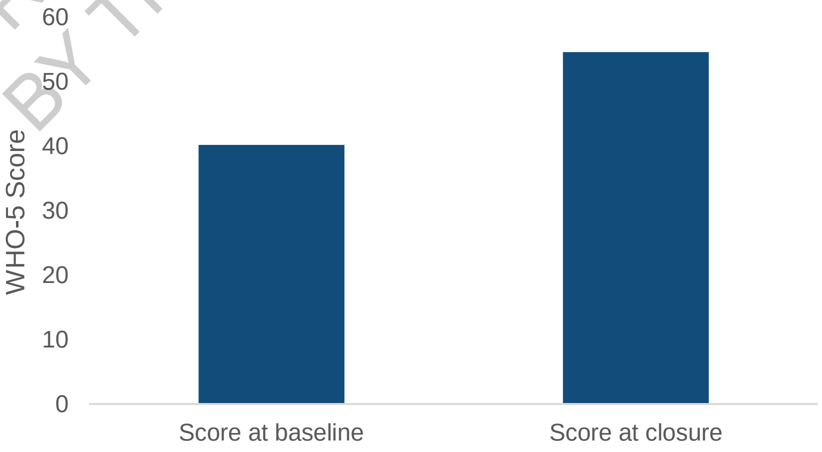

***Figure 16.** WHO-5 scores assessed at baseline and closure timepoints*

Client reported outcomes: Goal achievement

For clients attending individual counselling, a goal setting process is embedded into the service. Goals are set by clients in partnership with their counsellor advocates at the beginning of their engagement with the service, as part of the assessment process. Progress towards goals is assessed at every ten sessions and at closure. For a variety of reasons, not all clients will remain engaged until there is a formal closure.

Data on client goal achievement was available from STARTTS, QPASTT and VFST. As data from STARTTS and QPASTT were reported using a consistent categorization and assessment framework, data from these agencies has been collated and summarised in **Figure 17**. Of the 10,306 documented goals, the most reported related to the management of anxiety symptoms (13%) and management of traumatic stress (12%). Overall, 80% of goals were assessed to have been achieved 'somewhat' to 'very much'.

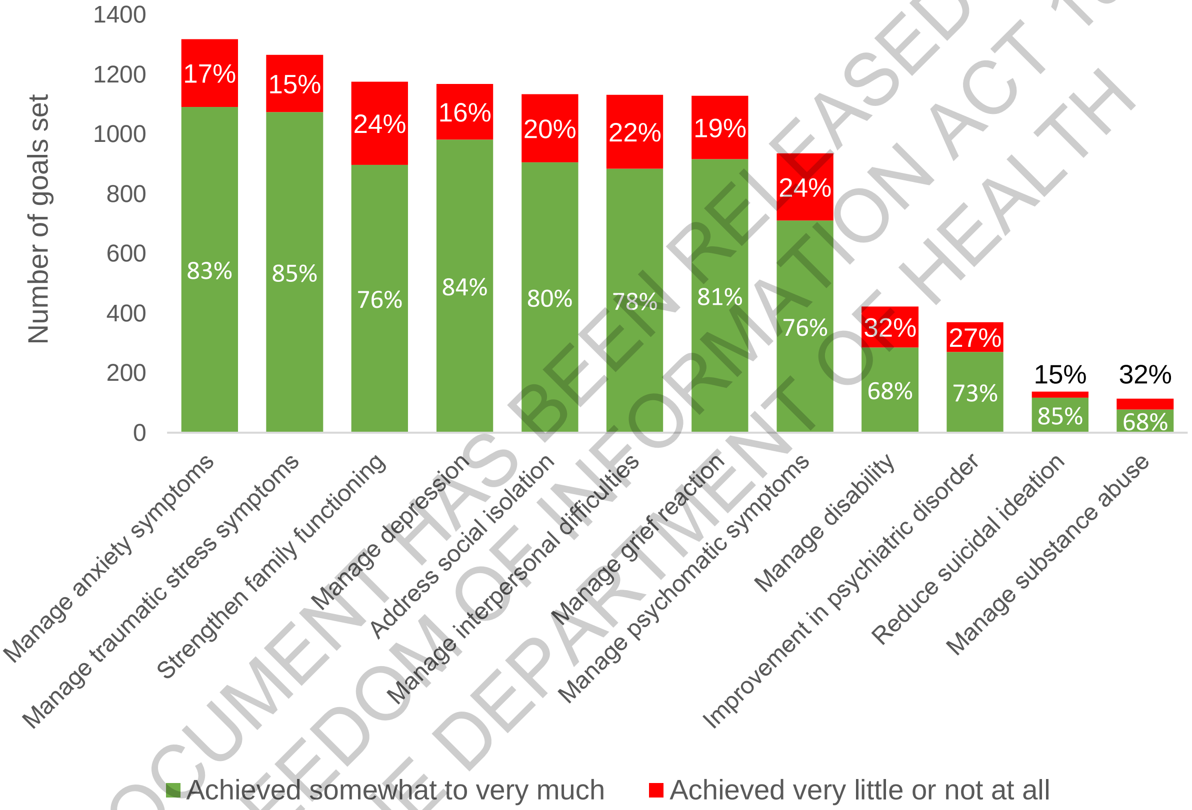

Figure 17. Goal achievement outcomes for STARTTS and QPASTT: 2016-17 to 2020-21

Within VFST, client goals are formulated and assessed using the "Goal Tree" framework. The Goal Tree applies to all VFST clients (adults, children, and adolescents) who have had a comprehensive psychosocial assessment and for whom subsequent interventions are planned. There are two levels adopted in conceptualizing goals. The first level captures the eleven domains of functioning that reflect core areas of desired improvement (summarised in **Figure 18**). The second level disaggregates each of these domains into several sub-goals that may be selected, as relevant to the individual client. Achievement ratings for each goal are completed by counsellor advocates at the point of closure.

Figure 18 summarises VFST client goal achievement outcomes between 2017 to 2021 across each of the eleven domains of functioning. Of the 3,005 documented goals, the most common fell within the domains of: signs and symptoms of mental health (22%); interpersonal functioning (17%); and family functioning (14%). Overall, 87% of the goals were achieved 'somewhat' to 'very much'.

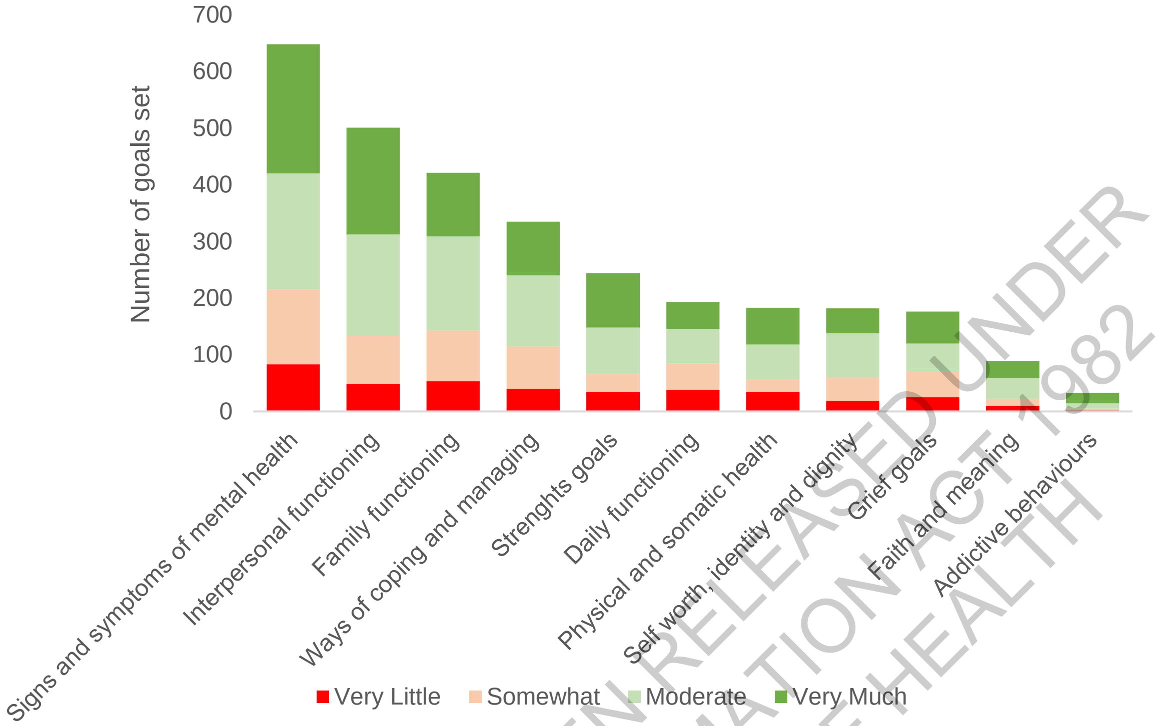

Figure 18. *Goal achievement outcomes for VFST: 2017 to 2021*

5.2.3 Engaging in Australian society

One of the long-term goals of both PASTT and the Humanitarian Settlement Program, is to help new arrivals integrate into Australian life and become self-reliant members of the community. The client interviews provided evidence that PASTT contributed to assisting people from refugee background in advancing their education, realising their own potential, and improving their personal and professional life. The case studies, FASSTT agency qualitative interview data, and STARTTS client feedback also demonstrated that PASTT was successful in creating positive opportunities for clients to engage more fully in Australian society. This was demonstrated through clients' improved ability to undertake activities of daily living; engage with education and training; and obtain meaningful employment.

Daily living and activities

FASSTT agency interviewees discussed how engagement in PASTT provided clients with greater confidence to undertake important aspects of daily living. PASTT clients became more confident in using public transport and moving around, obtaining housing, using banking services, negotiating Centrelink, and demonstrated improvements in English language competency. Clients became confident in advocating for themselves and their communities. PASTT clients were able to move from trauma to success in education and training, and to obtain or re-engage in employment. Support and advocacy from PASTT enabled many children and youth to re-engage at school. Direct quotes from clients, obtained during the STARTTS feedback interviews, best exemplify the importance of PASTT in assisting social and economic participation in society:

> *"They are there all the time. I'm illiterate [the bicultural worker] used to help me read letters. I felt that I was drowning and there was a straw that was hung into save me and people at STTARS was the straw".*

> *"[My son] got much help, how to live in Australia, what will be the challenges of Australia, how he can defeat the challenges, many things."*

> *"STTARS did organise a home tutor for me through TAFE. A volunteer has been coming to my home to help me"*

> *"One of [my daughter]'s main problems was with her responsibility to studies and school. She had problem with these things. With homework, with school stuff, with teacher… STTARS helped a lot with all that"*

Engagement with education and training
Several examples were provided by FASSTT agency stakeholders related to positive client engagement with education and training. One agency described how a previous client had completed training and accreditation in childcare, receiving full marks. Another client had obtained a university degree since engaging with PASTT and was now resourceful and resilient.

Interviewed clients also provided examples of the positive impact of engagement with PASTT on their education and training. One client (C2) reflected on their experience accessing the QPASTT homework club to assist with high school education. The client struggled with learning, especially with speaking English, which he was often mocked about by school peers. Involvement with the homework club provided a safe space to openly speak and practice English without being humiliated or embarrassed. This client recognised the need to change schools to improve future outcomes and, with the assistance of a PASTT counsellor who ran the homework club, received a scholarship to one of the top high schools within the state. The client successfully completed high school and a university degree, and now is a successful professional who previously worked for the FASSTT agency. This client largely attributed this positive outcome to involvement with PASTT and its homework club and reflected that *"If I had not received assistance from [the agency] it would have been a very different story".* Another client (C7) expressed that as a result of being engaged in counselling sessions, they commenced studying early childhood education and completed work experience in this field. The counsellor also assisted the client in obtaining employment in an early childhood role.

In **Box 7** and **Box 8**, two case studies are provided further detailing the influence of PASTT on school engagement for refugee youth (source of case studies: QPASTT and STTARS).

Box 7. *Client case studies: Client 6*

Case 6 – (school engagement)

Background
A female student was referred to QPASTT because she was skipping school, distracted in class and on a pathway to expulsion for school.

Treatment and outcomes
Key school staff worked with QPASTT's Youth Engagement and Advocacy officer. The school was made aware of the barriers facing the student, both at home and school, and the impact of her refugee experience. Additional supports were put in place for the student to complete schoolwork. The student's teachers were supported to improve communication with the student and provide appropriate classroom interventions. QPASTT organised case conferences between the student's family and the school to improve family engagement and understanding of the child's experience. As a result, the student's engagement in school improved. The student joined the school rugby team and participated in excursions. Relationships between the school staff and the student improved significantly allowing the student to communicate her needs to teachers and wellbeing officers.

***Box 8**. Client case studies: Client 7*

Case 7 – "E" (school engagement)

Background

When "H" was a young child his family fled Afghanistan, seeking safety in Pakistan. H experienced significant trauma when he witnessed a bomb blast where several of his friends were killed. He often missed school to look for work and ways to support his family. Seeking work required H to spend time with older males and he experienced severe abuse from them. Consequently, H and his father, an ethnic Hazara, sought asylum in Australia. It was almost 10 years before the family was able to reunite in Australia.

H's Australian school noticed that he was frequently hyper-vigilant and anxious and finding it hard to engage. H was also engaging in risk-taking behaviour including experimenting with smoking cigarettes and other substances. H found it hard to sit in class because learning was hard after having missed so much school and he described often feeling overwhelmed with bad memories. H's situation was complicated due to needing to navigate changes in family dynamics and roles.

Engagement with PASTT and outcomes

H's school referred him to STTARS for support. H was uncertain about engaging in counselling as it wasn't a familiar concept to him. However, after a few appointments he remarked 'counselling feels like I can share my heart'. Initially H had weekly counselling appointments offered in a confidential space at his school where he felt safe. He was supported to build body awareness and ways to regulate his emotions. H was able to speak about things that had happened to him that he had never talked about before and to unpack his feelings of shame, fear and anger. His counsellor also supported him acknowledge and work through grief he felt about living in a new country and leaving behind peers that felt like family. As well as working individually with H his counsellor was able to provide consultancy support to the school about how to support H within the classroom setting.

As H felt more in control and engaged better at school his appointments were gradually moved to fortnightly then monthly. In addition to processing past traumas he was supported to explore themes of his identity and how he could stay close to his culture and also embracing life in Australia.

At the end of his counselling journey with STTARS, H transitioned from school into a training course to pursue his goal of working in the construction industry. He reflected - '*I am proud of myself and am more control of my emotions and behaviour than before*'.

Obtaining employment

FASSTT agency stakeholders also described the impact of PASTT on clients being able to seek and obtain employment. In one example, the agency interviewee described how a male client who held high status in his country of origin, and was a successful business owner and employer, was affected by loss of status, role change, and experience of unemployment in Australia. Involvement in PASTT had helped this man to recover such that he was actively searching for employment. In a second example, the interviewee described how a long-term client, who had been involved with PASTT for 10-15 years and had experienced family violence, was finally able to gain employment and have some financial security.

In many cases, previous PASTT clients obtained employment within FASSTT agencies. This was seen as extremely beneficial because, along with providing the client employment and opportunities for growth, the organisation obtained bicultural workers. Bicultural workers provided the FASSTT agencies with a wealth of lived experience and culturally appropriate understanding to draw upon, making the organisation more effective in meeting the goals of PASTT. Many of these employees also came with skills from their previous lives in their country of origin. In addition, employment of previous clients as bicultural workers increased the visibility of PASTT within the refugee community, providing additional pathways to conduct community capacity building work, and increased the overall cultural capital of the FASSTT agency and PASTT within the community. Importantly, this embedding of peer workers and lived experience into the development and delivery of PASTT aligns with key national, state, and territory strategic policy for improving and sustaining mental health service delivery[57, 58].

A case study describing the impact of PASTT on a client who later obtained employment with STARTTS and the subsequent impacts on her family and the agency is presented in **Box 9**. The client described the range of impacts as such:

> *"The intervention of STARTTS started with me, but uplifted my whole family, and through a ripple effect helped me uplift my community and people from many different refugee communities. STARTTS' impact has spread the benefits further that way. STARTTS gave me life which is a permanent feature in my mind and heart. Material things do not make me happy. Acceptance and recognition are the biggest things for me; and that is what I was given at STARTTS – as a client and as an employee. This acceptance is beautiful and life changing."*

***Box 9**. Client case studies: Client 8*

Case 8 – "S"

Background

S was born in Sri Lanka in a Tamil family. Her home was burnt down in 1983 and her family displaced. She worked as a research assistant/interpreter for a project related to the positive impact of the peace process in Sri Lanka. S also had to listen and provide counselling for torture survivors as part of her job as a field counselling officer. All the women she was supporting were sexually abused by soldiers. S was personally tortured by the Sri Lankan Government to reveal information of these young women. S also provided counselling in schools and she was forced to share information she was given by students. She was eventually asked to leave the country with four days' notice, due to the risk to her life.

Engagement with PASTT

When S came to Australia, she didn't know anyone. She was on a tourist visa and then sought asylum which was granted. She could not return to Sri Lanka as it was too dangerous. House of Welcome (Catholic Church run service for asylum seekers) referred her to STARTTS. At that time, S felt she was going through an identity crisis. While life in Sri Lanka was dangerous, she had an identity that revolved around her work and her life had meaning. Losing that had a significant impact on her. She could not stop crying, was very depressed and refused to leave her house.

STARTTS' counsellor conducted a home visit. The counsellor also helped with case management/practical assistance for the whole family. The counsellor understood the cultural transition process and she built a trusting relationship with the whole family, at the time when S did not trust anyone in Australia. S was refused assistance by other organisations and she felt humiliated after her interaction with them. STARTTS' Counsellor was different. S felt she was finally able to trust someone, and she felt that her Counsellor also trusted her.

The counsellor organised a psychologist for S's son. She connected S and her husband with TAFE. The Counsellor came to the hospital when S was delivering her daughter. The Counsellor provided support for 12 months. She also supported S to obtain her driver's license. She helped S develop a life plan and a professional development plan. S felt able to follow this plan and feels she would not have been able to develop one for herself. STARTTS' counselling assistance was crucial to this.

Employment with PASTT

S completed her Diploma in Community Services at TAFE, a bachelor's degree at university and Social Work master's degree. S started work with a Settlement Agency as a case manager and then applied and was trained to become a Families in Cultural Transition (FICT) program facilitator with STARTTS. S loved FICT as this helped her healing journey, and she trusted STARTTS implicitly because of her positive experience with the Counsellor. S felt that through facilitating FICT groups she formed and created a community. She felt she had recognition and respect and felt empowered. S felt that FICT expanded her horizons and gave her a rebirth in a new country. This work is what led to S engaging in further studies, and she felt that FICT work was life changing for her. S became more confident and felt that STARTTS staff who managed her work listened and encouraged her, and valued her experience and the context she brought to STARTTS.

5.3 Health provider and service-level outcomes

This section reports findings related to PASTT outcomes at the service provider level. This encompasses all health, social, education, and government and non-government organisations (and their staff) who contribute to, or are impacted by, PASTT implementation (hereafter termed third-party providers). It specifically seeks to examine the effectiveness of PASTT and FASSTT engagement with such third-party organisations and how well this helps them delivering against program objectives. The findings emerged from qualitative interviews with FASSTT agencies and stakeholders that PASTT interacts with, and case study data provided by the agencies. Quantitative and qualitative data was also analysed from agency reports, client feedback interviews conducted by STTARS, and an engagement questionnaire sent to a range of PASTT partners and third-party service providers (see Section 2.5.3).

Overall, the FASSTT agencies worked with a large variety of service providers to achieve PASTT outcomes. The third-party organisations worked in many different contexts, were engaged by the FASSTT agencies for different reasons, and were utilised at varying levels of frequency. There were three overarching reasons for engaging with third-party providers. Firstly, **to receive referrals into PASTT and to refer clients out** to receive services that the FASSTT agency could not provide. Secondly, **to provide training and upskilling to third-party organisations** to better provide trauma-informed care to refugee survivors of torture and trauma. Finally, the FASSTT agencies interacted with third-party organisations in collaborative ways to **raise awareness of PASTT or the FASSTT agency's profile** in that area, or to accomplish activities not directly related to service delivery but deemed important such as collective advocacy work on behalf of clients[r]. Key findings related to provider and service-level outcomes are summarised and presented in Section 5.5 .

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[r] *"it's also building a bridge with other services so that they are better linked to the communities as well"* **Interview 4, Upper management, FASSTT**

5.3.1 PASTT referral considerations

It was apparent in the interviews with FASSTT agency stakeholders that engagement with third-party providers was an important but complex part of PASTT delivery. One reason for this complexity was that each FASSTT agency operates with a different suite of PASTT and non-PASTT service provision activities. For example, some FASSTT agencies (such as QPASTT) are primarily focused on delivery of PASTT, while other agencies (such as STTARS) have a broader incorporation of mental and physical health services, or other services within their organisational structure. Hence, some FASSTT agencies interact ‘outside’ with third-party providers to a large degree, while others have greater ability for ‘internal’ referrals. Agencies employing this later approach use staff and case managers working in other FASSTT service streams to identify clients who may benefit from referral to PASTT and provide conversations regarding mental health in a sensitive and informed way. Most agencies provide some services not directly within the scope of PASTT but stressed that they received additional funding from non-PASTT sources to engage in these other activities (Chapter 6). There was a strong belief by FASSTT agency stakeholders interviewed that the ability to internally refer to provide additional services ‘in-house’ was beneficial for PASTT clients.

There were mixed views about referring PASTT clients out to third-party providers/mainstream services. Some FASSTT agency staff were cautious or apprehensive about doing so due to concerns about potential lack of skill, capacity, effectiveness, and appropriateness of the third-party providers to work in a trauma-informed way or with complex and vulnerable clients. This hesitancy was also felt on the side of some of the third-party providers interviewed as well, who experienced this distrust as a barrier to fully engaging with and referring to PASTT services. Some FASSTT interviewees also highlighted a duality of effects in relation to having strong connections with third-party providers outside of the agency. For example, seeking expertise and assistance outside of the FASSTT agency (i.e., ‘referring out’) was required to increase the health and wellbeing of clients. However, these linkages increased the visibility of PASTT within the sector which, in turn, often led to increases in referrals into PASTT and increased service demand without corresponding increases in organisational capacity to meet the demand.

5.3.2 Referrals into PASTT

Over the five-year period from 2016-17 to 2020-21, a total of 45,111 referrals into the PASTT program were received by FASSTT agencies. The greatest number of referrals into PASTT occurred in 2016-17. This is likely due to the additional humanitarian intake of a Syrian/Iraqi cohort which occurred at this time. It is evident in **Figure 19**, that there was a decreasing trend in referrals into FASSTT agencies, overall, between 2017-18 and 2019-20 before leveling off to be more constant between 2019-20 and 2020-21. The overall decrease in referrals appears to be mainly attributable to decreases in referrals in to the two largest FASSTT agencies, STARTTS and VFST. The number of referrals into the other FASSTT agencies remained relatively constant or increased slightly during the same period.

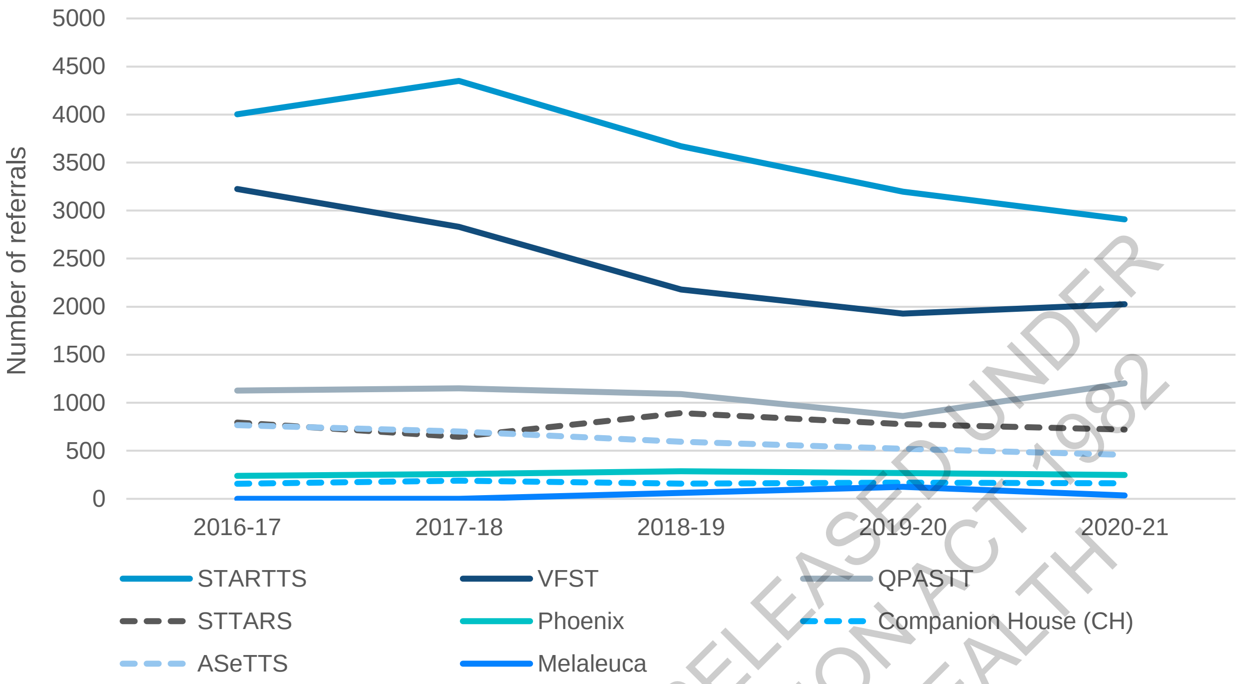

Figure 19. *Referrals into PASTT (per FASSTT agency) per year, 2016-17 to 2020-21*

FASSTT agencies received referrals into PASTT from organisations in several different sectors. **Figure 20** indicates that client self-referral (22.2%) was by far the greatest source of referrals into the PASTT program followed by 'internal' referrals (14.3%) from within the FASSTT agency itself. In this context, this means that many PASTT clients are identified and enrolled in PASTT after becoming involved with a non-PASTT service provided by the same FASSTT agency. Primary and secondary schools (12.9%) and the Humanitarian Settlement Program (12.8%) were also the source of large numbers of referrals in. General medical services (11%) were more likely to refer into PASTT than mental health services (3.0%) or allied health services (1.3%). Notably, a large number of referrals were designated to come in from 'other services'. This category captures referrals from charity services, children's/youth services, community services, correctional services/police, emergency services, interpreters/translators, parenting groups, Red Cross, religious organisations, and volunteers.

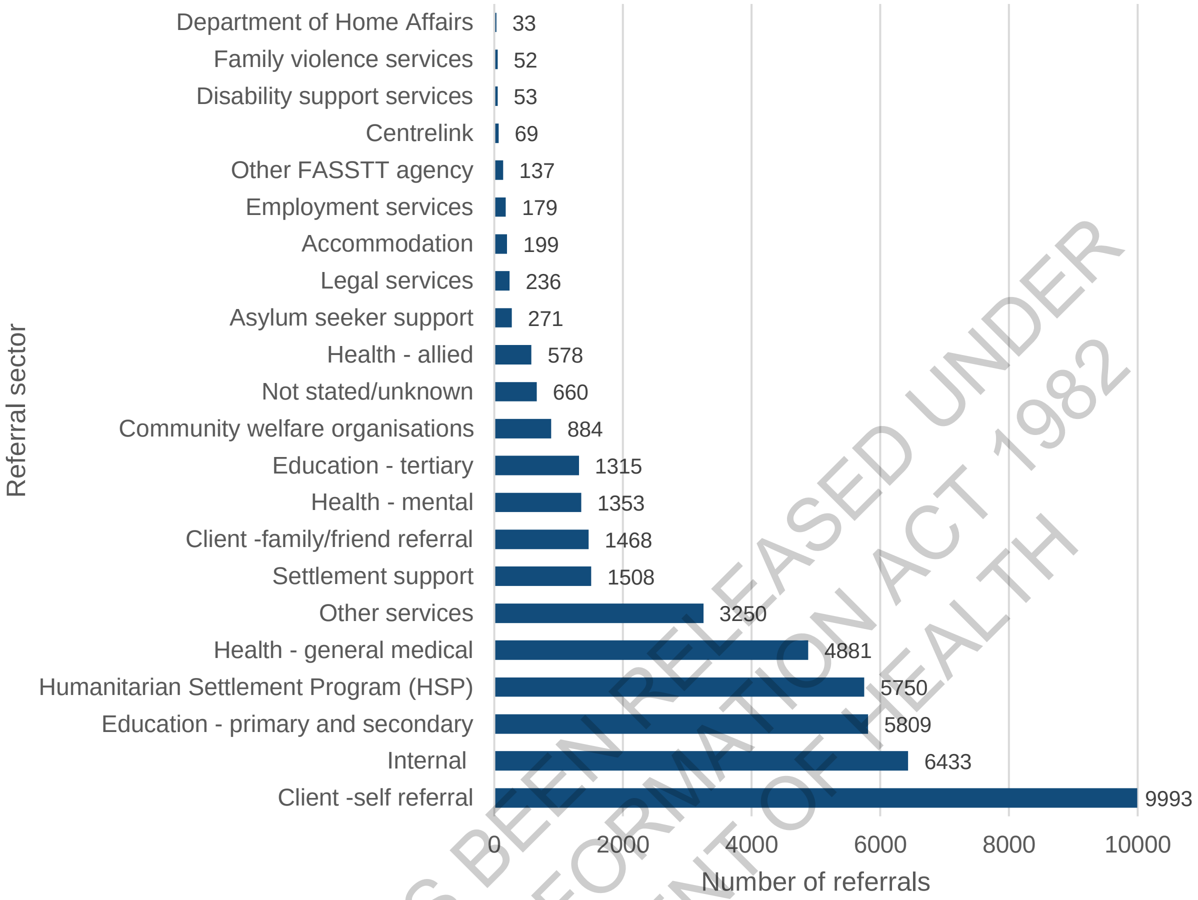

***Figure 20**. Overall number of referrals into PASTT by sector from 2016-17 to 2020-21*

When reflecting on this data however it must be noted that FASSTT agencies have identified that improvements are required in accurately capturing and reporting referral data. For example, the high number of internal referrals may also be due to agency staff missing an initial referral from an external service provider into the FASSTT agency and then only capturing the subsequent referral into PASTT (rather than the original source). AusHSI has been advised that steps have been taken to improve referral reporting in recent years.

There were some notable similarities and differences in the source of referrals into PASTT for each FASSTT agency. Appendix 6 presents the proportion of referrals for the previous five years by source of referral for each FASSTT agency. As would be expected, the top five most important sources for referrals into PASTT tended to be the same for each state/territory and match those reflected in **Figure 20**: self-referral, internal referral, HSP, health (general medical), primary and secondary education. However, while some states/territories had very high percentages of referrals from a single source (e.g., Melaleuca via the HSP), others had two or three sources which provided a similar percentages of their referrals (e.g., VFST via self-referral and education services). Internal referrals accounted for the greatest proportion of referrals for Companion House, STTARS, and ASeTTS. QPASTT, Phoenix, and especially Melaleuca, received most referrals from the Humanitarian Settlement Program. STTARS received most referrals from general medical practitioners.

5.3.3 Referrals out of PASTT

Over the five-years from 2016-17 to 2020-21, FASSTT agencies made 15,255 ‘referrals out’ for non-PASTT-funded services. That includes internal referrals, made to another service within the same FASSTT agency, and external referrals, made to a third-party provider.

Total number of referrals out and trends

Figure 21 graphs the trend in the total number of referrals out by selected agencies (where referral out data was available for each of the five years). The organisations included in this figure are VFST, QPASTT, STTARS, Phoenix, Companion House, and ASeTTS. There was some variability in the number of outward referrals made over the period examined. This appears to be mainly the product of variability in referring out in three organisations, STTARS, ASeTTS, and VFST. QPASST, Phoenix, and Companion House had relatively constant numbers of referrals over the five-year period. As noted, this analysis does not include referrals made by STARTTS and Melaleuca.

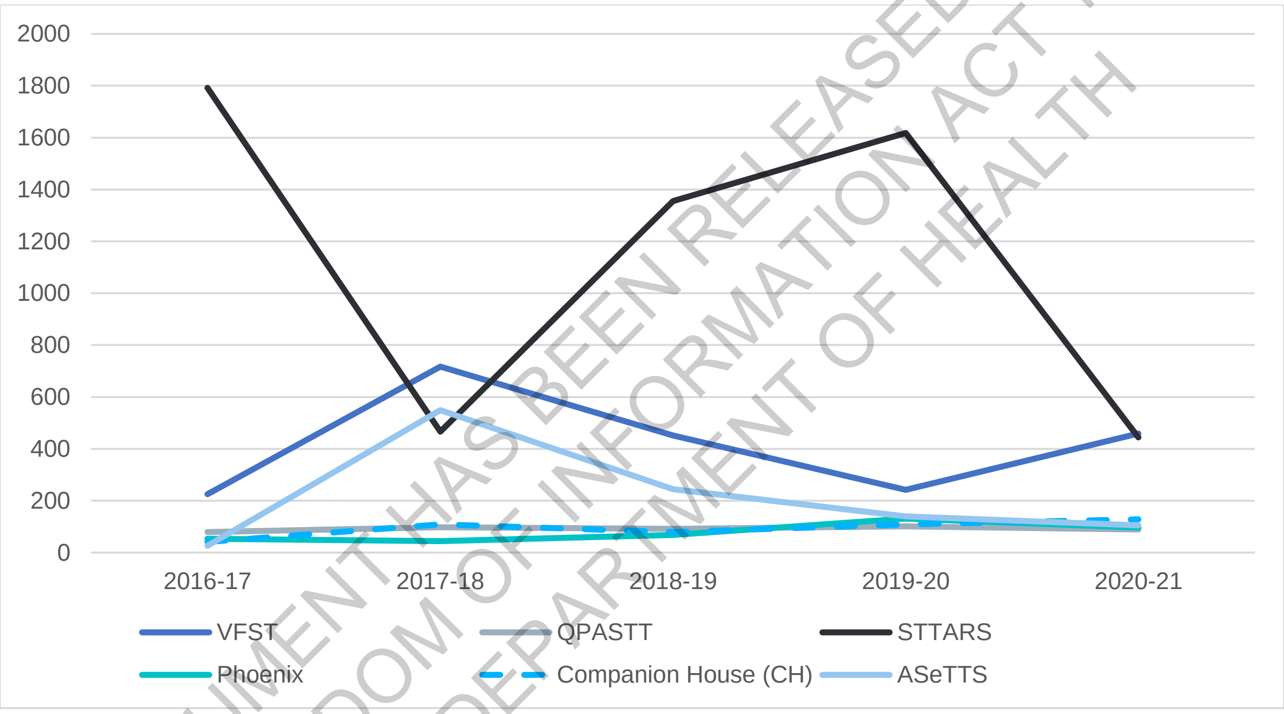

Figure 21. Referrals out for selected agencies, 2016-17 to 2020-21

Most FASSTT agencies predominately made internal rather than external referrals. Internal referrals made up more than 50% of the overall referrals made during this period. For STARTTS, internal referrals made up over three-quarters of ‘referrals out’ (83%), about half for STTARS (51%) and ASeTTS (51%), and about a quarter for Companion House (22%). This high level of internal referral may be linked to the perception of many interviewees that third-party service providers were often not equipped to adequately care for PASTT clients. This may also be due to the issues with reporting of internal referrals as discussed above.

Table 10 visualises the proportion of referrals out to third-party providers made by each FASSTT agency, expressed as a percentage of the total number of referrals for that specific agency in the previous five years. Comparatively large proportions of referrals out were made to community welfare organisations and “other services” (see above) for several FASSTT agencies, such as VFST, QPASTT, and Phoenix. Phoenix, QPASTT, and VFST also commonly referred out to mental health services. A larger proportion of referrals to general medical services were made by Melaleuca and VFST than most other FASSTT agencies. Allied health services generally received low proportions of referrals from each FASSTT agency. After internal referrals, community welfare organisations, other services, health (general), and health (mental) comprised the greatest proportion of onward referrals nationwide.

Clients also recognised this ability of PASTT to provide holistic support via onward referral, with one client reporting during the STTARS feedback interviews:

> *"Beside counselling, STTARS is a place that can't provide all the support but they do link out to other services with our problem. I think that it's best thing to do if they can't do it and they don't provide support themselves. They do link you to get supports from other places that's really good"*

Table 10. *Referrals out to other providers by FASSTT agencies (%) and nationwide (number), 2016-17 to 2020-21*

	STARTTS	VFST	QPASTT	STTARS	Phoenix	Companion House (CH)	ASeTTS	Melaleuca	Total number
Accommodation	0.6	3.1	3.5	6.6	6.6	12.1	1.8	10.0	590
Asylum Seeker Support Service	1.2	0.2	0.4	0.3	1.3	0.4	2.0	0.0	109
Centrelink	0.2	3.7	1.3	4.5	2.3	12.3	1.2	6.0	432
Client - self	0.0	1.1	0.0	0.0	0.0	0.0	0.0	0.0	24
Client - family/friend	0.0	0.7	0.0	0.0	0.0	0.0	0.0	0.0	14
Community Welfare organisations	1.3	23.4	17.7	7.0	16.6	1.5	2.3	6.0	1135
Department of Home Affairs	0.0	0.2	0.2	0.9	0.0	0.4	0.3	0.0	61
Disability support service	0.3	0.4	1.1	0.1	1.0	1.3	0.8	0.0	54
Education – primary & secondary	0.1	8.3	3.3	1.2	0.8	1.9	0.6	14.0	286
Education – tertiary	0.3	1.9	0.9	1.1	0.3	5.0	0.9	0.0	156
Employment	0.3	1.3	3.7	1.5	1.8	11.4	0.5	6.0	214
Family Violence service	0.1	1.3	2.2	0.1	3.1	1.9	0.1	6.0	72
FASSTT Other	0.2	0.2	3.1	0.3	3.8	1.1	0.3	0.0	69
Health – allied	1.2	5.9	4.4	2.5	3.6	4.1	0.0	4.0	385
Health – general medical	1.8	9.7	3.7	7.5	4.1	3.0	2.6	14.0	800
Health – mental	2.0	10.8	16.4	2.3	18.1	1.9	0.9	8.0	626
HSP (previously HSS)	0.4	1.4	0.2	0.6	1.3	0.4	0.0	0.0	92
Internal	83.9	1.7	1.8	47.6	9.2	22.2	54.6	8.0	7712
Legal (migration related)	1.5	2.3	13.3	2.3	4.1	8.0	3.4	0.0	405
Legal (non-migration related)	0.7	2.7	3.5	2.5	1.3	2.2	1.0	8.0	280
Settlement Support	0.6	4.6	2.8	2.9	8.2	2.8	0.4	8.0	357
Not stated/unknown	0.0	0.0	0.0	3.1	0.0	1.7	15.2	0.0	346
Other services	3.5	15.0	16.4	5.0	12.8	4.1	11.2	2.0	1035
Organisation total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	15254

Note: cells are colour coded to represent the highest (green) to lowest (red) proportions of referrals from each agency, and overall

5.3.4 Capacity building of third-party providers and mainstream services

One of the key objectives of PASTT is to increase the responsiveness of mainstream health and related services to the needs of people who have survived torture and trauma prior to arriving in Australia, through the provision of training and support services. FASSTT agency stakeholders interviewed discussed the importance of providing training and development to third-party providers to allow them to work more effectively with PASTT clients[s]. 'Sector development' and the ongoing provision of effective capacity and capability building activities were an important goal referred to by many of the FASSTT agency representatives. There was a strongly perceived need to help mainstream health services and other providers work in culturally appropriate and trauma informed ways, thereby allowing management of less complex cases in the community. Interviewees discussed their belief that it was important to change the impetus of mainstream services from 'getting things done' to being more client centred.

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[s] *"Other services can work with survivors of torture and other traumatic events, so if you have workers in other services who are working from a trauma-informed approach it may be that they can provide the support to the individual which might free us [PASTT] up to work with a survivor who is more traumatised or who needs more of a specialist intervention".* **Interview 4, Upper management, FASSTT**

Examples of such capacity building efforts and collaboration between PASTT and third-party providers were provided in four case studies from Phoenix (1-3) and VFST (4):

1. PASTT client “F” attempted suicide and his counsellor engaged in warm referral to the State Mental Health Services (SMHS). The PASTT counsellor has continued to work collaboratively with the SMHS Psychiatrist and Case Managers to support F, and provided informal training on collaborating with interpreters and working with clients from a refugee background when new SMHS staff have supported F.
2. PASTT client “C” was accessing counselling with significant trauma stress and was experiencing issues with housing, education, and the impact of disability on her ability to pursue employment. The PASTT counsellor referred C to Catholic Care for English classes, Housing Connect for housing support, and to Centrelink for support with a Disability Support Pension (DSP) application. The PASTT counsellor provided advocacy and liaised with services about support needs. Through these external services C has secured housing and is supported by a housing support worker with CatholicCare, is accessing transport support, has been approved for DSP and is accessing English classes. This has enabled the PASTT counsellor support to focus on mental health recovery.
3. PASTT client “K” was accessing counselling and had multiple mental health and health issues and was taking prescription medication. K did not understand the health issues or what the medications were for. The PASTT counsellor worked closely with K’s GP and supported the GP to organise a female interpreter for K. As a result, K and the GP were able to talk through the medical issues and the medications. The GP now has more knowledge of accessing interpreters when supporting people from refugee backgrounds.
4. PASTT client “V” was believed to be suffering from tuberculosis based on a preliminary medical assessment. Making a conclusive diagnosis required an invasive medical procedure (bronchoscopy), which he refused to have. He had been tortured and was overcome by fear at the prospect of having the procedure conducted. With V’s permission, his counsellor informed the specialist of the situation, and she accompanied him to the appointment. During the consultation, she reassured him that he was safe, all steps of the procedure were carefully explained, and he was given the option of terminating the procedure at any point. By maximising V’s control over the situation and providing comfort and reassurance, his anxiety was manageable, and the bronchoscopy was successfully completed.

FASSTT agency stakeholders also talked about the provision of direct training activities to government and non-government organisations including those located in regional and rural areas. Training was provided using a variety of formats including in-person as well as via digital channels. Several organisations discussed the development and distribution of publicly available training resources. Some resources were developed with specific target audiences in mind. For example, STTARTS has a resource kit for social workers and VFST has a range of publicly available resources for schools and teachers available for download on their websites. Some organisations actively engaged with universities by assisting with curriculum development, presenting lectures or seminars to students, or by offering internal placements for students to gain work experience. Engagement with universities in these ways was seen as beneficial for several reasons. Firstly, universities represented a possible source of future staff for the FASSTT agencies. Secondly, interacting with students during their initial training and development was also a method to increase the knowledge and skills of mainstream services that employed the students when they entered the workforce.

Some interviewees discussed feedback and evaluation activities they conducted in relation to the training provided by the FASSTT agencies. These interviewees said that in most cases, the training was viewed very positively and that the third-party providers indicated that the training made them more effective, responsive, and well-equipped to work with PASTT clients when needed.

The main negative spoken about by the FASSTT agency interviewees related to the financial costs of capacity building activities. The proportion of PASTT expenses allocated to sector development and training is outlined in Section 6.2.1 and **Table 14**. The cost of developing and providing training sometimes exceeded what was allocated for it in the overall PASTT funding amount. Therefore, extra burden was placed on FASSTT agencies to obtain additional funding from non-PASTT sources or to reduce or reallocate other costs to ensure that this important work could continue. Additionally, much smaller amounts are allocated per agency staff member to engage in their own professional development than are provided by other employers in the sector, making it much more difficult to upskill and retain staff. For example, QPASTT can allocate $600 per staff member per year for training whereas Queensland Health offers professional development to allied health practitioners of approximately $2500 per year plus three days professional development leave (source: data prepared by QPASST).

Over the five-year period from 2016-17 to 2020-21, 1,456 organisations were provided training by FASSTT agencies, Australia-wide (average of 291 per year). This total includes 40 instances of ‘internal’ training. Overall, 1,524 training sessions were conducted and 35,810 individuals participated. In non-pandemic years FASSTT agencies consistently trained over 7,000 individuals annually (**Figure 22.**). However, these figures are likely to be an underestimate as complete data from at least one agency was missing for every year except 2018-2019 and 2020-2021.

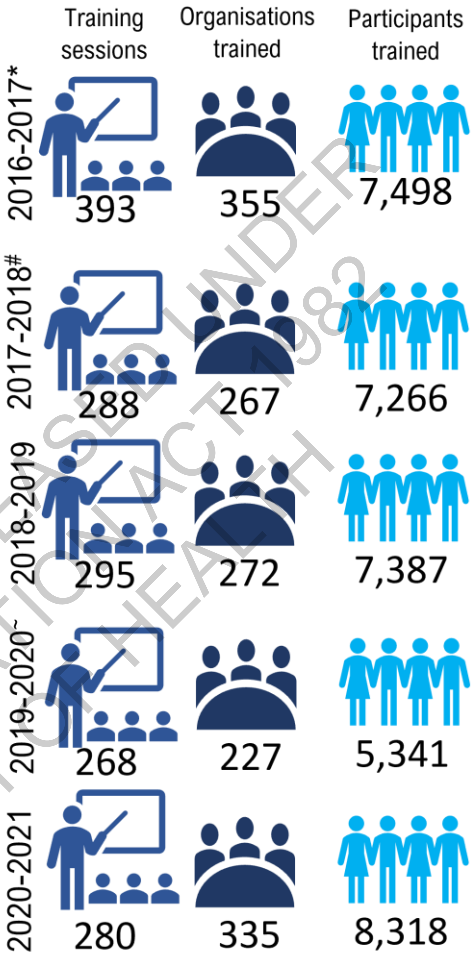

Figure 22. *Statistics of FASSTT agency sector training (2016-2021). *: all data missing for Melaleuca, #: all data missing Melaleuca & total participants for ASeTTs, ~: data missing for total participants Phoenix*

It was not appropriate to provide a breakdown of the number of sessions, participants, and agencies provided training by each FASSTT agency over this period due to inconsistent reporting practices and missing data across agencies. For example, how FASSTT agencies counted the number of external organisations attending training appeared to vary across agencies. Some agencies reported a multidisciplinary training session for a network as one organisation, while others captured representation for all organisations in attendance. Other agencies reported on the number of participants but not the total number of agencies represented each year.

With this caveat in mind, **Figure 23** displays a breakdown of the sectors that received training from the FASSTT agencies from 2016-17 to 2020-21. The greatest number of education and training activities were provided to the following sectors: settlement support, other services, mental health services, allied health services, general medical services, and primary and secondary schools. ‘Other services’ included aged care, multicultural groups, community organisations, and not-for profits.

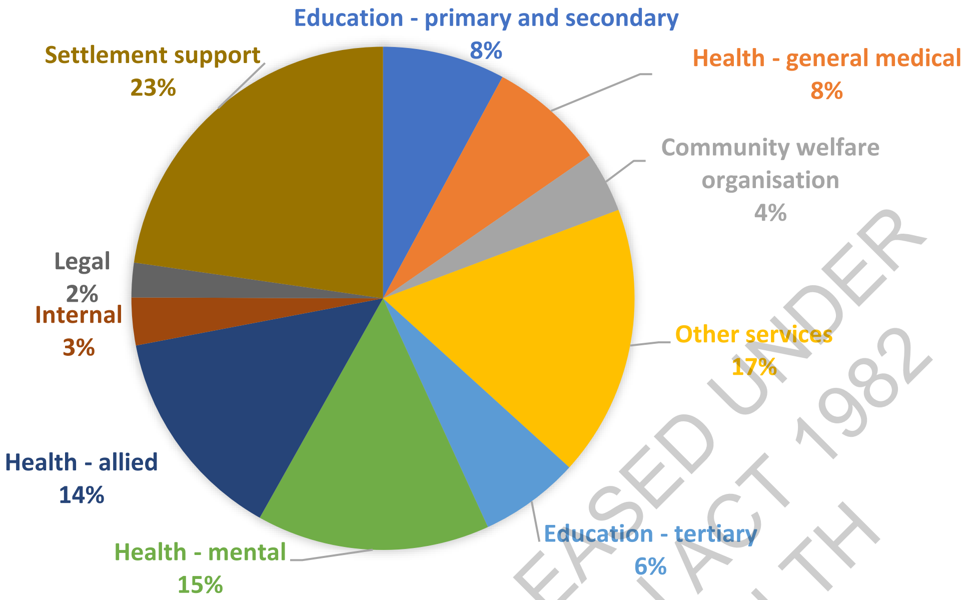

Figure 23*. Sectors provided with education and training (Australia-wide) 2016-17 to 2020-21*

5.3.5 Engagement and collaboration with third-party providers

The FASSTT agency interviewees often discussed interactions and engagement with third-party providers which were not specifically related to referral or training. Thus, these activities were not directly focused on service delivery but concentrated on networking, sharing of ideas and resources, and other activities. Examples of the types of organisations FASSTT agencies engaged with in this way included schools, state government departments and bodies, and other organisations that could or would encounter PASTT clients, such as settlement service providers, the Humanitarian Services Program, Centrelink, General Practitioners, and English Language learning providers. Examples of activities that the FASSTT agencies collaborated with third-party providers on in this manner were advocacy (such as in preparing joint responses to parliamentary enquiries or submissions), or to highlight the existence of PASTT and the FASSTT agency in the sector through an ‘agency champions program’, a ‘portable panel’, and participation in a ‘transcultural mental health network’. One agency described how they took opportunities, particularly in rural areas, to be part of consortia of several types of agencies/organisations to seek funding to develop and administer additional programs and services to PASTT clients or their families and communities. The outcome of such an activity was the development and trial of a youth program, ‘All one under the sun’, which aimed to improve interactions and relationships between refugee youth and local indigenous youth in a major regional centre. Another stakeholder described a collaboration with a local TAFE to provide a structure for sharing and working through grief after a suicide occurred within their refugee student group. This type of intervention had considerable outcomes in terms of reducing stigma and preventing further significant mental health outcomes for these individuals.

Schools

Engaging with schools was also seen to be an important part of PASTT, particularly in regional and rural areas where other supports may often be lacking. One PASTT stakeholder discussed specific engagement activities to develop relationships and connections with schools which were seen as both a source of referrals and a way to increase effectiveness of their services:

> *“Schools are very important places, not just for the kids but for the parents as well. So, if you've got a school that's supportive of the family and understands what a family of a refugee background has been through, then the school can also support."*
> ***Interview 1, Upper management, FASSTT***

It was reported that most teachers are compassionate and empathetic to the refugee experience, however many lack the understanding of how refugee trauma poses barriers to learning and wellbeing. This constrains their ability to implement effective strategies in the classroom and with students. PASTT education and advocacy address this and helps achieve positive outcomes for clients. This is demonstrated in two case studies (**Box 10** and **Box 11**) about the impact of QPASTT's Youth Engagement and Advocacy Officer.

***Box 10**. Client case studies: Client 9*

Case 9 (Youth Engagement and Advocacy Officer)

Issue, engagement and outcome

During a QPASTT school outreach session, a student disclosed past experiences of sexual violence. As well as establishing emotional support plans for the student, QPASTT's Youth Engagement and Advocacy Officer was able to liaise with the school to ensure the student could access culturally appropriate support through an external service during school hours. This was important because the student did not feel safe accessing support outside of school hours and did not want to engage with the school's internal wellbeing team on this issue.

***Box 11**. Client case studies: Client 10*

Case 10 (Youth Engagement and Advocacy Officer)

Issue, engagement and outcome

A student who was accessing QPASTT's school outreach support and counselling became homeless due to family violence. QPASTT's Youth Engagement and Advocacy Officer initiated a partnership with the school to ensure the student could access appropriate support from QPASTT counsellors, housing, and domestic violence services. Collective advocacy from QPASTT and the school enabled the student to access urgent financial support through Centrelink and additional brokerage support through Brisbane Domestic Violence Service. QPASTT advocated for the student to leave class to respond to her housing circumstance and to be considered for additional support with schoolwork. QPASTT was also able to raise the school's awareness of safety concerns with certain family members to ensure the student was protected.

Finally, STARTTS in Schools is an exemplar program providing an interface between schools and STARTTS' programs and services and promoting systematic changes at the school level to improve the learning environment and healing outcomes for children and young people of refugee backgrounds. The evaluation of that program demonstrated important outcomes and can be found here (STARTTS in Schools Evaluation Report).

Partnership Questionnaire

An online questionnaire (Appendix 7.1 and Section 2.5.3) was designed to evaluate (a) the effectiveness of PASTT and FASSTT engagement with these third-party organisations; and (b) how this engagement helped external organisations to deliver against the PASTT program objectives. A survey link was distributed by each FASSTT agency to their partners and relevant third-party providers.

A total of 85 stakeholders responded and completed the questionnaire. These participants were largely from New South Wales (43%) and Victoria (39%) with smaller proportions responding from Queensland (7%), Western Australia (5%), and the Australian Capital Territory (2%). The duration of their engagement with FASSTT agencies ranged from less than 5 years (38%), to more than 15 years (19%) (**Figure A1**, Appendix 7.2). Respondents also covered the spectrum of PASTT-related services and referral pathways (**Figure 24**) and interacted with FASSTT agencies in varying frequencies of engagement ranging from every day to once per year or less (**Figure A2**, Appendix 7.2).

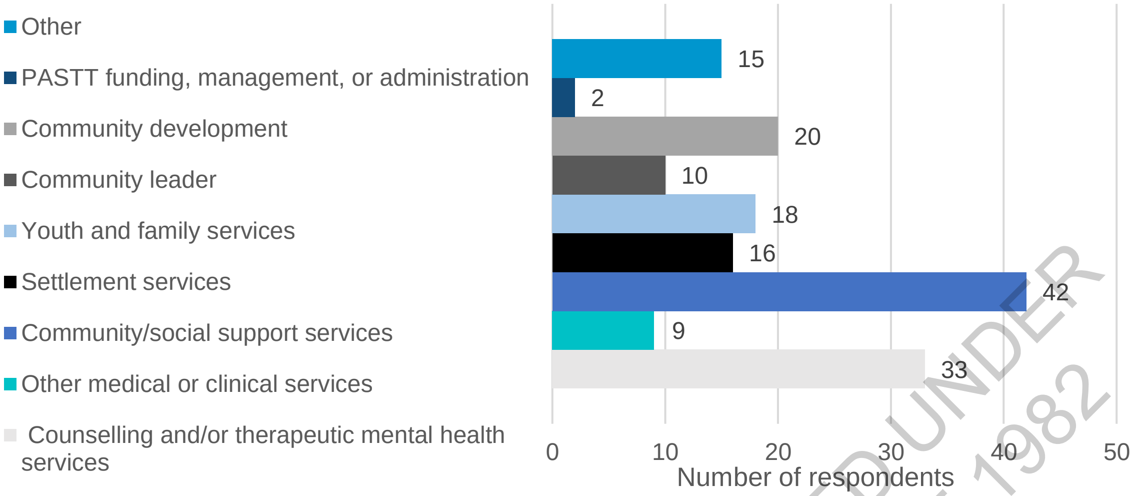

Figure 24. *Roles of stakeholders completing partnership engagement questionnaire (n=85)*

Stakeholders overwhelmingly reported satisfaction with their involvement with FASSTT agencies and PASTT activities, rating this 90 out of 100 (median score) on a sliding scale (from 0-100). **Figure 25** displays all satisfaction ratings.

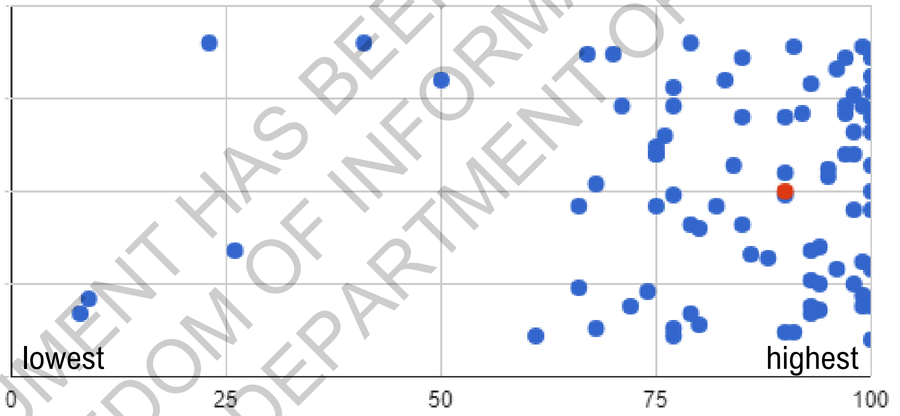

Figure 25*. Satisfaction of third-party providers with FASSTT agency engagement and collaboration (0: not at all, 100: yes, most definitely, blue dots: individual responses, red dot: median score)*

Third-party providers commented most positively on:

- The agency leaders, staff members, and counsellor advocates working within PASTT, and their knowledge, understanding and professionalism: *"they are absolute experts in their field, very knowledgeable about the sector, and are passionate about supporting the community"* – **survey response 50, third-party provider**
- The high quality of training and sector development received
- The approachable, responsive, and collaborative nature of agencies: *"individuals who are easy to approach and connect the sector with their appropriate staff"* - **survey response 76, third-party provider**
- The adaptability of services provided
- Shared values and goals between third-party providers and agencies
- Open and regular communication between third-party providers and agencies

However, despite many positive comments about engagement and collaboration, some stakeholders were considerably less satisfied with their involvement, reporting mixed quality of interactions with the agencies. These negative comments mostly equated with the lower satisfaction scores observed in Figure 25 and were not restricted to one FASSTT agency. Common reasons for the lower satisfaction scores given include:

- Extensive waitlists and wait times for PASTT services resulting in third-party stakeholders giving up on referring clients (most common frustration of respondents): *"At times there are long waiting lists that means the people we refer are left for periods of time without much needed counselling support" -* **survey response 70, third-party provider**
- Perception by third-party providers that FASSTT distrusts non-refugee specific services; sense that the FASSTT agency sees itself as the only legitimate provider and only source of expertise regarding health issues in those of refugee background; perceived lack of real willingness to acknowledge the work of other services in the sector; unclear expectations of partnerships: *"Overall there are many situations where that [FASSTT agency] operates very collaboratively with settlement services and other health services. However historically there is a sense that that [FASSTT agency] and the public mental health services do not integrate as well as they could*."- **survey response 42, third-party provider**
- Some instances of breakdowns in communication or feedback to referrers and third-party providers about the care and outcomes of individual clients: *"staff have reported breakdowns in communications about mutual clients on occasion"-* **survey response 78, third-party provider**
- FASSTT having a monopoly on the sector and lacking transparency associated with this; sometimes FASSTT works in a silo, especially at a strategic or system level: *"Feedback I have received from stakeholders is that [FASSTT agency] individual staff, especially clinicians and other frontline staff, work very collaboratively and closely on individual projects with partners. However, at a strategic level or in terms of collaborating with state health services overall, there is a sense that [FASSTT agency] does not engage as proactively as it could be expected to."* **- survey response 42, third-party provider**
- A perception by third-party providers of FASSTT agencies sometimes working outside of their scope or not understanding the context e.g., in child development

While communication about individual clients, PASTT activities, and general service delivery was considered to be a strength of third-party provider engagement, several external stakeholders reported frustrations with communication of PASTT priorities, processes, funding, and outcomes at the broader level. This encompassed a lack of knowledge about who was responsible for setting PASTT priorities nationally, how funding was allocated to agencies each year, what services were funded from the program (as opposed to other sources), and how/if outcomes have been evaluated. While FASSTT agencies and the government have processes in place to ensure transparency and accountability, these key messages are not being consistently communicated to key stakeholders (e.g. state health department). This was perceived as a barrier to local level governments and organisations being able to strategically plan their activities to support FASSTT agencies in their respective states and territories, fill service gaps, and reduce potential duplication of services.

Finally, third-party stakeholders were asked to rate how much they felt their engagement with PASTT and FASSTT agencies enabled them to deliver on the program's six key objectives (**Figure 26**). Responses were mixed, but generally positive impacts of engagement with PASTT were seen across all objectives. PASTT had the clearest impacts on external providers being able to (1) improve refugee psychosocial health and well-being; and (2) provide community education and advocacy. Delivery of regional and remote services was considered least impacted by PASTT engagement. This is consistent with the findings observed for regional and remote PASTT delivery in Chapter 4, and lack of third-party providers in these regions.

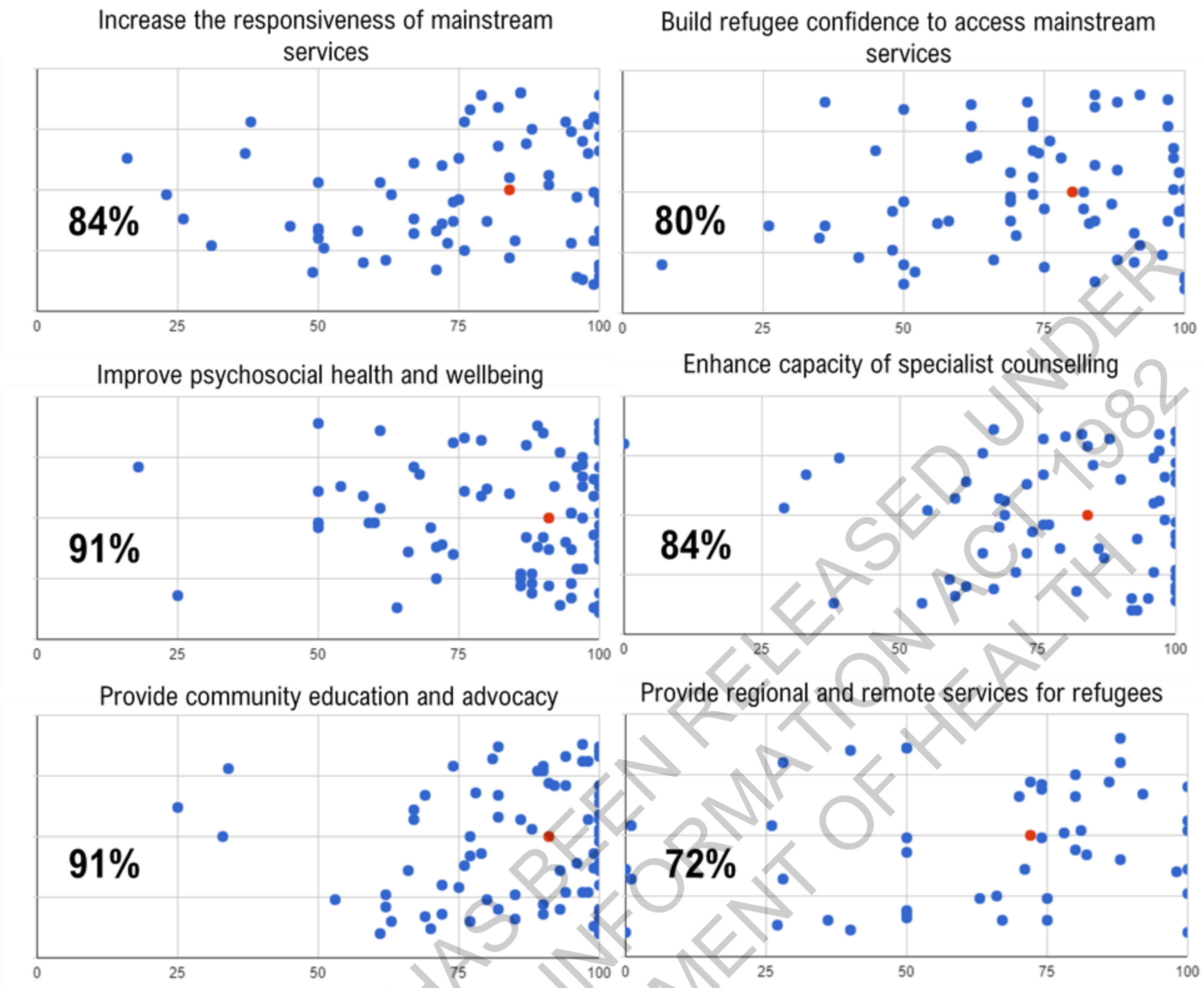

__Figure 26__. Visual representation of stakeholder's perceptions of PASTT's impact on helping them to deliver against the six objectives (0: not at all, 100: yes, most definitely, blue dots: individual responses, red dot/%: median score)

5.4 Community-level outcomes

The following section details findings related to PASTT outcomes at the community level. These findings were derived from qualitative interviews, quantitative data reports, performance reports, existing evaluations, and community case studies provided by FASSTT agencies. The qualitative interviews with the PASTT stakeholders were the primary data source. The section is divided into four parts: (1) essential role of community engagement, (2) community-capacity building programs, (3) education and advocacy activities, and (4) benefits of community engagement. Some illustrative quotes from the participant interviews are provided to explain important aspects of community level outcomes, with additional quotes provided in Appendix 9. Narrative case studies detail the outcomes of programs and were developed and provided by the FASSTT agencies.

Overall, there was a strong perception that community capacity building programs lead to positive impacts on individual clients which then flow into the community. Key findings related to community-level outcomes are summarised and presented in Section 5.5 .

It should be noted that due to large heterogeneity of communities, agencies' engagement approaches, and programs delivered across the country, the outcomes at this level were not well captured at a national level and may need to be considered at the agency level in future evaluations.

5.4.1 Essential role of community engagement

Because of their potential for cost-effectiveness and working at scale, interventions that target whole refugee communities are crucial. While scarce, previous research has shown community-level interventions can reduce isolation, increase support networks, improve communities' social capital, and positively impact psychosocial wellness and mental health[39]. Consequently, while individual therapy is an important element of PASTT, work that focuses on and with the community offers another powerful tool that can complement and enhance counselling. FASSTT agency stakeholders described it as such:

> *"…as much healing can take place in those – some of those community sessions – for some people because they won't access other therapeutic opportunities, but really powerful healing can take place in in the community sessions."*
> ***Interview 14, Clinical/counselling services, FASSTT***

> *"It's offering a space where they're able to share on a deeper and vulnerable way and start to change maybe some of the cultural experiences of shame and hiding what's going on."*
> ***Interview 16, Rural and regional services, FASSTT***

In particular, community work contributes to rebuilding fractured and lost social relationships and structures. Close collaboration with communities was continuously emphasised as essential by FASSTT agencies. It was recognised as integral to trauma-informed care at the individual, group, and community level. Having a strong and ongoing presence in the community allowed the agencies to increase the awareness of PASTT services. Building trust was repeatedly highlighted as the fundamental pillar of commencing the rehabilitation journey. However, some community members are reportedly not ready, comfortable, or familiar with engaging with counselling sessions. Thus, community-based programs offered an opportunity to expose and familiarise community members with the agencies, their staff, the services they offer, and provided an avenue for clients to engage with counselling services if needed. **It was the perception of FASSTT stakeholders that the demand for community development activities is greater than the demand for individual counselling but that the organisation is under resourced to complete these activities.**

5.4.2 Community programs, activities, and participants

Two of the key objectives of PASTT are to (1) build the confidence of refugee communities to access mainstream health and related services through capacity building activities; and (2) provide community education and advocacy to overcome any barriers to access and equity for the client group. In terms of these objectives, FASSTT agencies have demonstrated significant reach, providing a wide range of community-based engagement activities and education to refugee communities.

Some indication of the reach of the community capacity building work engaged in by FASSTT agencies can be seen in the number of organisations that participated in such programs, the number of activities conducted, and the number of participants that engaged in these between 2016 and 2021 (**Figure 27**). Despite the impacts of COVID-19 restrictions on engagement in 2019-2020, FASSTT agencies were still able to perform over 5,200 activities with 584 agencies, groups, and organisations (reaching over 115,000 individuals) across Australia over the five-year period. The total participant numbers are made possible by working with a wide range of partners, chiefly refugee communities and relevant stakeholders e.g., assisting community groups in organising and delivering events. However, these figures are likely to be an underestimate as complete data from at least one agency was missing for every year except 2018-2019 and 2020-2021. Additionally, how activities, participants, and organisations were captured, categorised, and reported was not always transparent or consistent across agencies or reporting periods.

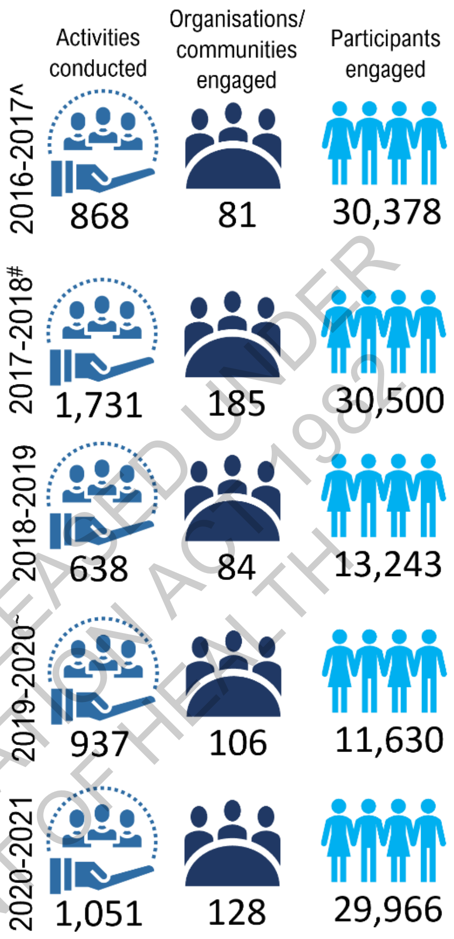

***Figure 27**. Statistics of FASSTT agency community engagement (2016-2021). ^: missing data one agency,#: missing data 2 agencies, ~: missing data 3 agencies*

Some selected examples of **PASTT-led community-based programs/activities** include:

- A drop-in homework club for young people from a refugee background
- A yoga group for women
- Community leadership courses
- Family fun days
- Men's, women's, family, and youth groups
- A LGBTIQ + refugee support group
- COVID-19 support and awareness
- Mental health literacy projects
- Storytelling by elders
- Youth ambassadors
- Musical groups and exercise groups

5.4.3 Advocacy and education activities

FASSTT stakeholders reported their agencies' advocacy and education work as an important part of community-based activities. The agencies both advocated on behalf of communities and empowered communities to self-advocate. Some examples of the agencies' advocacy and education work included:

- Contributing to and making parliamentary submissions on behalf of communities and in consultation with community leaders (e.g., QPASTT made a submission to the Queensland Parliament Inquiry into serious vilification and hate crimes and as a result was requested to present to the Legal Affairs and Safety Committee at a public hearing)
- Advocacy to the Department of Education to provide more resources to students; school and community advocacy for better support by, and structures in, external services for multi-cultural communities (e.g., increasing availability and access to interpreters)
- Advocacy to the government to share more information about international crises in the areas of ongoing and intermittently escalating conflict, and to create more places in the humanitarian program
- Education with health services and government health officials to increase communities' understanding of COVID-19, link people with COVID-19 testing, promote access to vaccines, and address misinformation
- Education with schools to assist in understanding the challenges faced by families and young people in home schooling
- Advocacy and assistance for individual clients to secure safe housing, access health services, legal services, and negotiate employment and income support
- Support and assistance with establishment of community advisory groups

5.4.4 Benefits and outcomes of community-level work

Analysis of evaluation data and stakeholder interviews indicates that there are a range of benefits of PASTT's community education, advocacy, and capacity building programs. Such programs develop communities' resilience, decrease social isolation, build strength and sense of belonging, provide a unique opportunity for developing and strengthening relationships, and expand community members social networks. This is important given that evidence suggests feeling socially connected contributes to both integration and well-being for refugee communities[59]. Engagement in community-based activities and events empowers communities and their members to self-identify issues and seek solutions. Community members were able to develop and exercise leadership skills and take on leadership roles within the community and beyond. Clients develop confidence and courage, for example, work with youth results in them being able to speak in front of peers. Finally, PASTT's community work has enabled refugee communities to be given a voice in service planning and delivery.

Community capacity building programs provide a safe, comfortable, and familiar space for community healing and addressing issues such as mental health stigma and intergenerational trauma[t]. Such programs give clients an opportunity to share knowledge, experiences, and traditions with the community and across generations via new, fun, and creative activities. These activities bring together young and elderly community members to share the main issues they believe are affecting them and engage jointly in events. One interviewee expressed their belief about the benefits of community-based events in a very passionate way:

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[t] *"A decade ago, community leaders in [location] wouldn't talk about mental health. They are actively talking, reaching out about mental health now. So, I think there have been absolutely achievements in terms of stigma reduction."* **Interview 1, Upper management, FASSTT**

> *"[when running community capacity building activities] you see energy, you see resilience, you see laughter, you see tears. I mean we trip over tears daily in a way, but [in community capacity building activities] you trip over the laughter that's got people through, and that's what needs to be celebrated. It's not always drowning in trauma, because all of these people are survivors who have come through incredible challenges."*
>
> **Interview 18, Community capacity building, FASSTT**

Community programs also provide a way to honour the wisdom, resilience, sacrifices, and strength of members which assists clients in their healing and rehabilitation. As one of the FASSTT participants working in community development said, "*being able to share and talk about and put into words those things has been a really important healing process for them, and a lot of them said they didn't want to feel that their lives had been for nothing"* - **Interview 18, Community capacity building, FASSTT**.

5.4.5 Case studies of community-level activities and program impacts

A drop-in homework club for young people from a refugee background

QPASTT established The Homework Club based on emerging community needs. It is coordinated by a young person from a refugee background, with a roster of 50 volunteer tutors. The Homework Club helps with: homework; mentoring; education and employment pathways; social opportunities; and access to QPASTT youth workers in an informal space. Benefits and healing observed include:

- Social opportunities with peers, including from different schools and different cultural backgrounds
- Connection with QPASTT staff in informal manner
- Links to other programs and activities for further social and wellbeing opportunities
- Connection with volunteers, including learning about education/work pathways, and work experience
- Study skills
- Confidence and self-agency
- Sense of community and communality - the challenges of learning in a different system and in a new culture are understood

One of the clients interviewed for this evaluation (C2) only connected to PASTT via homework club and school-based advocacy without engaging in any counselling or individual-level therapy. However, the impact of these activities on the student and his peers has been significant, including improved education and employment outcomes (see Appendix 3). C2 described the impact as such:

> *'There is so much potential in humans and you don't realise that potential until you are afforded the opportunity, or you are told that you can, or you are encouraged that you have that potential. And I have seen from personal experience, people that I would go with [to the homework club], like peers and other people that would come at the time to receive support. They would go to uni and were smashing it, getting jobs…that's what we want to see, people to be educated, law obeying citizens, paying their taxes.'*

Mental Health Literacy and Suicide Prevention Projects

The projects delivered psychoeducation and training for members of particular cultural groups, as a result of concerns being raised by those communities to STARTTS. The projects focused on increasing knowledge of basic mental health concepts and available support services and increasing confidence of community members to engage in mental health conversations in their communities to identify risk and signs of mental illness. In this way they could provide peer support to people at risk of self-harm and to refer community members to appropriate support services. Benefits and healing observed include:

- Reduction of stigma
- Reduced social isolation
- Increased peer leader support to isolated community members at-risk
- Increased referrals to support services

- Increased ability to cope with stress
- Increased awareness of self-care
- Parents better able to support their children.

Families in Cultural Transition (FICT) Program

This program uses a model of peer-facilitated conversations on sensitive topics and is an effective way to improve social connectedness of newly arrived community members, address barriers faced by refugees as they resettle in Australia, and to have a positive impact on family relationships and environment. **Figure 28** (*from: Families in Cultural Transition Evaluation Report, STARTTS*) provides thematic findings from the FICT and an extension of this program, Older People in Cultural Transition (OPICT) Program, for 2020.

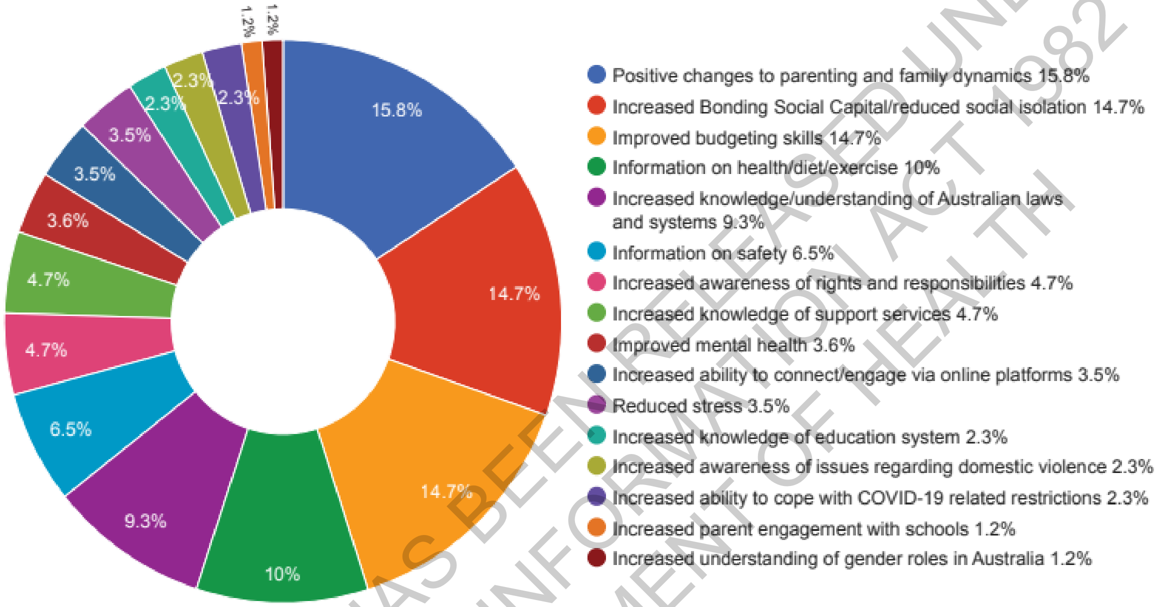

Figure 28. *Thematic findings from the Families in Cultural Transition and Older People in Cultural Transition (n=270) and Older People in Cultural Transition (OPICT) (n=96) Programs for financial year 2019-2020*

Community capacity building programs in rural Victoria

Bendigo Community Health Service and Barwon Child Youth and Family successfully engaged with refugee communities in their catchment area by developing community advisory groups to provide advice and input into the development of psychosocial and psychoeducation programs focusing on mental health and wellbeing.

Outcomes included development of a peer education mental health support program in Geelong and the development of a therapeutic group work program in Bendigo. Both initiatives led to increased community knowledge around mental health, facilitated access to mainstream services and lead to direct counselling referrals into the torture and trauma counselling programs.

Collaborating with community leaders during the COVID-19 pandemic

QPASTT provides a case study about their success in using pre-existing collaborations with Multicultural Australia, CALD faith leaders, and CALD community leaders to assess and respond to needs of community members during the COVID-19 pandemic (Appendix 4). Multi-agency and community working groups supported:

- Development of in-language fact sheets
- Building community capacity for translation in many diverse languages
- Question and answer forums with the chief health officer, and government and health officials
- Family support for online schooling
- A grassroots mental health literacy project

The outcomes of this collaboration are further described in the Appendix.

5.5 Findings

Finding O1. The available evidence indicates that PASTT is effective in achieving its aim of improving the psychosocial health and wellbeing of people who have experienced torture and trauma prior to their arrival in Australia.

Finding O2. The available evidence indicates that PASTT is effective in assisting refugees engage with Australian society including through employment, education, and social avenues.

Finding O3. The available evidence indicates that PASTT is mostly effective in its engagement with a range of third-party providers to enhance their capacity to support refugees who have experienced torture and trauma. However, to enable greater collaboration and sustainability, it will be important to address issues of trust with third-party providers; improve FASSTT involvement in system-level collaboration; and better communicate information about national and state PASTT funding, scope, and priorities to key external stakeholders.

Finding O4. The ongoing demand for training of third-party providers, and high costs of developing and delivering these services, may warrant increased funding allocation for this service activity.

Finding O5. The available evidence indicates that PASTT provides a safe, comfortable space for community healing and contributes to positive changes in refugee communities. Increased social cohesion, improved confidence and self-agency of groups and individuals, increased trust in the health system, and mental health stigma reduction have been reported.

Finding O6. An important individual and system level outcome of PASTT is the employment of former clients within FASSTT agencies and resulting ability to embed culturally appropriate and lived experience in service delivery.

Finding O7. The broad scope of PASTT activities necessitates an evaluation of impact that encompasses measurement at the client, provider, service, community, and society level using both objective and subjective measures of impact. Given this may present challenges, there needs to be nuance into how the impact of PASTT is measured and acknowledged, particularly where it is linked to achieving ongoing funding.

Finding O8. A more clearly defined national framework for classifying and reporting sector development and community engagement activities (including some pre-defined categories) would support ongoing quality improvement and evaluation activities of the PASTT program.

Chapter 6. Economic analysis of PASTT

This chapter examines the funding arrangements, costs, and financial pressures of PASTT using existing agency and program data, supported by stakeholder consultation. It also draws on published literature where appropriate. The focus of the chapter is key evaluation question two: *How efficient has the program been?* It also provides insights to key evaluation question one, discussing the suitability of current funding arrangements and operational costs.

Quantitative analysis has been undertaken based on a review of existing organisational documents including annual PASTT reports, as well as via specific requests for data on budget outcomes, cost profiles, client numbers, and waiting list outcomes. Descriptive analysis of data, including trends over the past five financial years where available, is presented. In addition, qualitative analysis has occurred after extensive consultation with FASSTT agency leadership and staff and quotes are used to support findings where appropriate. Additional supporting quotes can be found in Appendix 9.

The following sections summarise analysis completed relating to:

- Program funding
- Cost of service delivery
- Key cost pressures
- Evidence of unmet need
- Opportunities

6.1 Program funding

The Australian Government has funded PASTT for over 27 years. The continuity of PASTT funding for more than two decades has been key in enabling agencies to plan and build capacity over time, develop collaborations between each other, and maintain long-term stakeholder relationships. This continuity provides confidence in the sustainability of ongoing service delivery for clients and heath service stakeholders. The long-term investment by the government in PASTT has encouraged greater investment in refugee causes by state and philanthropic sources and drawn in other resources for policy and program development. This has generated a larger 'base platform' of refugee knowledge and experience in Australia to respond quickly and efficiently to emerging crises. FASSTT agency stakeholders strongly endorsed the overall funding model with several citing it as an international exemplar for funding specialised refugee services.

Currently PASTT is funded through the Commonwealth Standard Grant Agreement. Each of the eight PASTT agencies is contracted by The Commonwealth, represented by the Department of Health, under separate Funding Agreements. During each contracting period all agencies receive a proportion of the overall PASTT base funding budget via an agreed distribution model. This funding is released to each agency in progressive payments throughout the financial year.

Besides the agreed PASTT base funding, additional one-off supplementary funds may be provided by the government as block payments under special circumstances. For example, recent top-ups have been provided in response to humanitarian crises, natural disasters, to alleviate waitlists, and to counter increased service demands associated with COVID-19.

Amounts of base funding and supplementary top-ups since 2018 are presented in **Table 11**. Base funding amounts are largely dependent on Government policy decisions, primarily the humanitarian program intake numbers. In the 2020-21 Federal Budget, it was announced that the cap on the Humanitarian Program intake would reduce by 5,000 to 13,750 for the next 3 years. In the 2022-23 Budget it was further announced that this cap would be maintained over the forward estimates. This reduction triggered a lowering of PASTT base funding. As a temporary measure, $10 million in top-up funding is being provided in both 2021-22 and 2022-23 to maintain existing service levels and manage waitlists.

Table 11. *PASTT base and supplementary funding: 2018-2023*

PASTT Funding -GST exclusive ($mil)	2018-19	2019-20	2020-21	2021-22	2022-23
Base funding	**28.4**	**29.9**	**28.3**	**23.4**	**23.8**
Top-up funding	-	-	-	10	10
Afghan funding	-	-	-	5.2	2.7
QPASTT – flood assistance	-	-	-	-	0.2
COVID-19 funding	-	1.9	-	-	-
Social and Community Services Workers Wage Supplementation (SACS)*	2.7	3.1	3.4	-	-
Total funding	**31.1**	**34.9**	**31.7**	**38.6**	**36.7**

*SACS payments ceased in 2020-21, following the legislated cessation of the Social and Community Services Special Account.

In addition to Commonwealth PASTT funding, some agencies produce self-generated income that is used to cross-subsidise PASTT activities where necessary. Self-generated income comes from sources including philanthropic and untied donations, interest on term deposits, and revenue from delivering other services or programs. Agency budget deficits in recent years have also been supplemented with surplus income carried forward from previous years with approval from the respective agency boards.

Figure 29 summarises the combined income profile across FASSTT agencies between 2017-18 to 2020-21. The 'other income' category includes any self-generated income as well as retained earnings that have been carried forward to meet budget deficits.

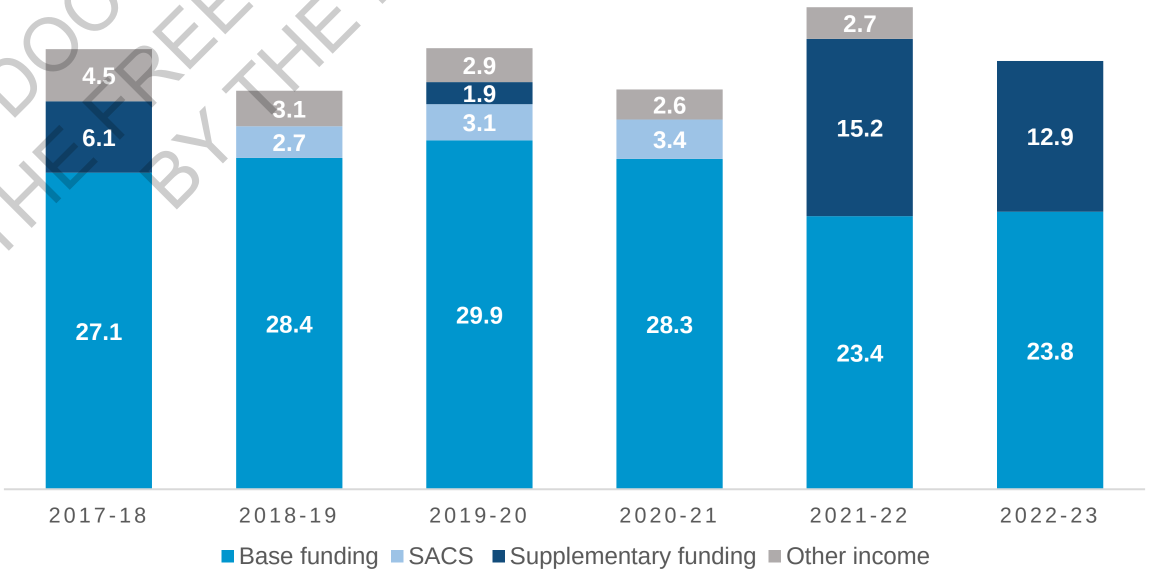

Figure 29. *FASSTT agency income ($ millions) allocated to PASTT service delivery by source: 2017-18 to 2020-21*

PASTT base funding is a critical income stream for all FASSTT agencies. In line with this funding imperative, consultations with agency stakeholders have confirmed that PASTT-funded activities sit at the centre of service delivery and are well aligned with broader organisational goals. As one FASSTT agency member described:

> *"Without PASTT we wouldn't be able to do any of the other things…our positions, that hold, the glue that holds the whole program together is PASTT funded"*
> ***Interview 22, Community capacity building, FASSTT***

Importantly, base funding acts as a consistent scaffold to build work around and leverage for further grants and tenders. In this way the PASTT investment by the Australian Government is used to leverage additional activities and services to benefit clients and communities.

6.1.1 Funding distribution across FASSTT agencies

PASTT funding distribution arrangements consider the number of refugees entering each state and territory and the minimum viability needs of each agency. To ensure the viability of smaller agencies (e.g. Melaleuca and Companion House), minimum funding levels are agreed between FASSTT and the government. This amount has been reviewed several times, most recently leading to a revision in minimum viability funding of $423,000 per annum. Consultation with FASSTT stakeholders demonstrated clear support for this practice in that it maintains equity and stability of service provision, while ameliorating issues with economies of scale often faced by these smaller agencies.

Since 2010, PASTT base funding has been allocated to each agency according to the proportion of refugee and humanitarian entrants into each state and territory averaged over the previous five years (using Department of Immigration and Citizenship settlement data). Originally, this funding allocation process occurred once across a contract lifecycle (every 3-5 years), however changes in annual settlement patterns in recent years have necessitated a move to yearly re-assessments of funding distribution. With fluctuating yearly allocations from the base funding pool, agencies have cited a lack of certainty when making decisions around planning programs or retaining staff, with perceived impacts on organisational stability and service quality. This is compounded by the unpredictable nature of top-ups, which in recent financial years have been as high as 42% of the base funding. Consideration should therefore be given for PASTT returning to longer, more predictable funding periods for base funding allocation.

6.2 Costs of service delivery

Total costs of service delivery across PASTT decreased from $39.0 million in 2017-18 to $34.5 million in 2018-19. Despite lower arrival numbers in the subsequent two years due to the COVID-19 response (see **Table 12** below), total costs increased to $35.7 million in 2019-20 and $37.4 million in 2020-21. Drivers of these increased costs are outlined in Sections 6.2.2 (Cost per client), 6.3.2 (Humanitarian intake levels and rates of engagement with PASTT), 6.3.3 (Settlement patterns), 6.3.4 (Timing of engagement), 6.3.5 (The impact of world events).

Table 12*.Total costs of service delivery (Actual) by agency: 2017-18 to 2021-22*

Agency	Actual expenses ($ millions)			
	2017-18	2018-19	2019-20	2020-21
STARTTS	15.0	13.2	13.2	13.8
VFST	11.6	10.3	10.4	11.2
QPASTT	4.7	4.5	5.3	5.3
STTARS	3.5	3.0	3.1	3.4
ASeTTS	2.5	1.8	1.9	2.0
CH	0.6	0.5	0.5	0.5
Phoenix	0.8	0.8	0.9	0.8
Melaleuca	0.4	0.4	0.4	0.4
Total	**39.0**	**34.5**	**35.7**	**37.4**

Salary-related expenses have consistently accounted for a large proportion of total costs across FASSTT agencies, ranging from 72% to 80% within 2021-22 projections (**Table 13**). An increasing overall trend in salary expenses across FASSTT agencies has been recorded, from 71% in 2017-18 to 75% in 2021-22. Increasing salary costs have been driven in part by ongoing increases in award wage rates, as well as legislated increases to employer superannuation contributions. Additional detail on wage-related cost pressures is outlined in Section 6.3.6 . Cessation of the Social and Community Services Workers Wage Supplementation (SACS) scheme has also impacted on agency salary budgets. Between 2018-19 and 2020-21, PASTT received $8.7 million in SACS in addition to their base funding. These payments ceased in 2020-21, following the legislated cessation of the Social and Community Services Special Account.

Table 13. *Salary expenses as a proportion of total agency expenses: 2017-18 to 2021-22*

Agency	2017-18	2018-19	2019-20	2020-21	2021-22
Total FASSTT	**71%**	**73%**	**75%**	**73%**	**75%**
STARTTS	67%	73%	76%	70%	72%
VFST	73%	74%	76%	77%	77%
QPASTT	69%	72%	73%	73%	75%
STTARS	73%	74%	76%	80%	80%
ASeTTS	75%	72%	71%	57%	70%
CH	80%	77%	80%	76%	80%
Phoenix	71%	71%	70%	68%	72%
Melaleuca	72%	76%	78%	65%	74%

6.2.1 Cost profiles

Activity-based cost breakdowns

Table 14 outlines the proportion of agency budgets allocated to key cost categories in the 2020-21 financial year. Direct counselling and community service activities accounted for the largest proportion of costs within each agency ranging from 44% to 65% of total costs, translating to a combined total of $18.5 million across FASSTT, when applying proportions to the 2020-21 actual expenditures in **Table 12**. Community engagement and development activities were the next largest expense category, accounting for between 3% and 21% of agencies' total costs and a combined FASSTT total of $5.4 million (29,966 participants engaged across 1,051 activities, **Figure 27**, Chapter 5). FASSTT agencies spent a combined total of $1.3 million on sector development and training in 2020-21 (8,318 participants trained across 335 sessions, **Figure 22.** , Chapter 5). Interpreting services accounted for between 5% to 10% of total costs, and a combined total of $2.2 million across FASSTT.

Table 14. *Breakdown of agency costs per category for the 2020-21 financial year*

Cost categories: FY 2020-21^	STTARTS	VFST	QPASTT	STTARS	ASeTTS	Phoenix	CH
Total direct costs	**76%**	**85%**	**80%**	**80%**	**79%**	**87%**	**85%**
Intake and assessment	3%	6%	7%	3%	6%	5%	
Counselling and community services	44%	57%	45%	65%	49%	61%	63%*
Community engagement/development	19%	12%	21%	4%	8%	8%	3%
Sector development and training	4%	5%	1%	1%	9%	8%	9%
Interpreting	6%	5%	6%	7%	7%	5%	10%
Total indirect costs	**23%**	**15%**	**20%**	**20%**	**21%**	**13%**	**15%**
Indirect cost rate (indirect costs as proportion of direct costs)	32%	18%	25%	25%	27%	15%	18%

^Cost category data was not available for Melaleuca; *Includes intake and assessment costs

Each financial year FASSTT agencies prepare their own Activity Work Plans (planned activities, outcomes, proposed budget) to outline how they will use the provided PASTT funding to deliver activities to meet the needs of local clients and communities. This flexibility granted to each FASSTT agency in using their allocated PASTT budget is a clear strength of the overall funding model. The adaptability of PASTT funding at the state-level also received unanimous support from the FASSTT agency stakeholders consulted throughout evaluation. Such a non-prescriptive approach allows agencies to allocate resources, hire staff, engage with communities, and deliver programs in the way most appropriate to their client base. It also fosters innovation and means PASTT can be highly responsive to the emerging needs of clients and communities. This ensures both early intervention and recovery focused issues can be appropriately facilitated. Maintaining this agency-level funding flexibility should be a key priority in any revision to the overall PASTT funding model. Alongside this is the need to be open to two-way dialog about the impact of such variations in funding use and associated program deliverables.

Current budgets prioritise counselling services over sector development and community work

Many FASSTT agency stakeholders consulted described how the urgency of addressing the unmet need for individual counselling and direct service provision meant that these areas were often prioritised when allocating resources in Activity Work Plans, despite the well understood importance of sector development and community capacity building activities in ensuring future sustainability. This is reflected in agency expenditures, with intake, assessment, and counselling services comprising between 47% to 66% of total costs (**Table 14**). While PASTT funding does support agencies to undertake community-based activities (and is often the only consistent source of funding available for this work), the challenges in adequately supporting communities in a holistic way within current funding envelopes was a commonly cited concern, particularly by those working in community capacity building roles. Individual counselling services are also an expensive form of service delivery, and other options may be more efficient and cost-effective. For example, group work is a culturally appropriate and effective treatment for many clients that has resource efficiencies. Community healing is also perceived to be an underutilised resource which has potential to be both effective and efficient for community recovery and early intervention.

This broader focus aligns with research which suggests that there is a need to move away from medical models of individual stress-related trauma and focus more on positive psychosocial models of change[14]. For example, building community capacity, facilitating local healing, engaging community leaders, and working with health professionals in culturally appropriate ways is more likely to facilitate lasting change, decrease stigma, and increase mental health utilisation. This approach, however, requires a long-term investment in community work, something that agency stakeholders have described as challenging to achieve within current PASTT funding allocations. Additionally, current funding has not allowed agencies to adequately adapt and respond to new communities over the long-term, or track performance data from community-led projects. Consequently, it would be useful to consider ways in which this community focused work could be better resourced and evaluated within the program to allow for long-term, ongoing community capacity building and impact.

Direct vs indirect costs

The proportion of agency budgets allocated to direct versus indirect costs is highlighted in **Table 14**. Direct costs are those directly attributed to service delivery, while indirect costs, often referred to as ‘overheads’, are those which support the organisation as a whole, without being attributable to a specific project or service. This includes costs of information technology, finance, administration, travel, and management/executive personnel.

Research from the US has demonstrated that insufficient funding for indirect costs is one of the main drivers of financial vulnerability among non-for-profit organisations[60]. The authors describe a “non-profit starvation cycle” whereby non-profits feel pressure to both underinvest in their indirect costs and underreport their true costs to funders. Similar findings have been reported in the Australian not-for-profit setting, where ‘true’ indirect costs often substantially exceed the amount that is allocated by funders[61]. Evidence suggests that insufficient investment in overheads can negatively impact the overall effectiveness of not-for-profits[62].

A study of 130,000 charities in the US found that the minimum rate of indirect costs (as a proportion of direct costs) associated with financially healthy organisations was 29%[63]. This is comparable to a recent review of Australian not-for-profits that reported an average indirect cost rate of 33%, with significant variation between 26% and 47%[61]. In comparison to these Australian and international benchmarks, FASSTT agency indirect cost rates are relatively low, with all agencies sitting below the Australian average in 2020-21 (**Table 14**). In addition, a trend of decreasing proportions of indirect costs has been observed across agencies between 2018-19 and 2021-22 (**Figure 30**). Inconsistencies in how agencies collect and report on financial data, particularly within indirect cost categories, mean that direct comparisons are not able to be made. For example, indirect costs within QPASSTT includes a regional and remote service delivery component that was not able to be separated out, resulting in slight over-estimation of indirect costs for that agency. Implementation of a consistent framework for financial reporting across FASSTT would help to support future quality improvement and evaluation activities.

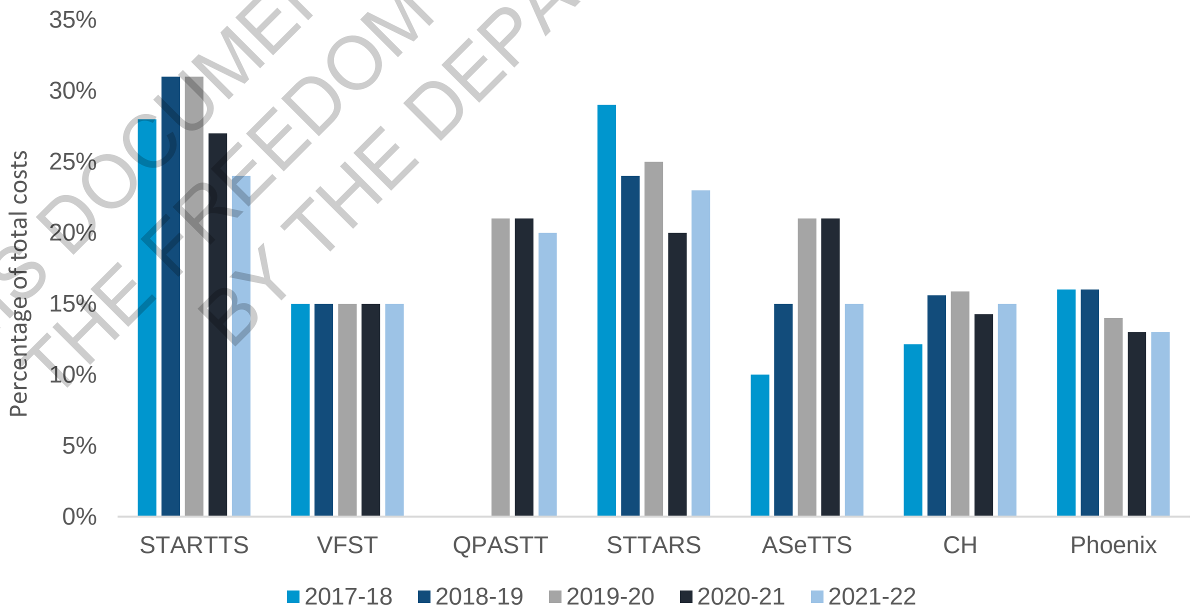

***Figure 30**. Indirect costs as a proportion of total costs by agency: 2017-18 to 2021-22*

A common concern arising from consultations with FASSTT agency stakeholders was their limited ability to invest in indirect costs within current funding envelopes, and the impact this is having on service delivery and sustainability. Activities such as administration, IT, finance, communication, co-design, learning and development, accountability/reporting, data measurement, and evaluation were perceived as crucial to support service delivery and sustainability. However, agencies only spend small proportions of their budget on these indirect activities as they perceive it to be necessary to prioritise frontline services to meet the immediate urgency of need in this area. In addition, some agency stakeholders believed that more data-driven, outcomes-focused contracting and reporting was overly burdensome and under resourced. Consideration should be given to increasing the base PASTT funding to allow for a higher proportion of spending on indirect costs, which would in turn promote longer term financial stability. Investment in national-level infrastructure across FASSTT to support and streamline activities such as communication, development, and data collection (e.g., a national reporting database) would likely provide greater efficiencies than individual agencies undertaking these in silo.

6.2.2 Cost per client

Overall cost trends

An overall ‘cost per client’ estimate can be derived by dividing total agency expenses (**Table 12**) with total number of individual counselling clients in a given financial year. This estimate should therefore not be interpreted as indicative of the average costs to provide counselling services to one individual, as it encompasses the full range of agency services including group work, community engagement, sector development, and indirect costs. For example, within these expenses agencies provided sector development/training to an average of 7,162 participants each year and engaged with 23,143 individuals via community development work annually (**Figure 22.** and **Figure 27**). Nonetheless, in the absence of complete and consistent data on the total number of clients being engaged across all activities of the program each year, this estimate is useful as a means of analysing overall trends and observing differences in relative costs of service provision between metropolitan and non-metropolitan settings.

When estimated on a ‘per client’ basis, overall agency costs have been increasing over the past five years **Figure 31** highlights the trends in cost per client by agency between 2017-18 and 2020-21. At a national level, the average cost per client has increased from $3,660 in 2017-18 to $4,344 in 2020-21. Increasing client complexity was flagged as one cause of this increased cost by PASTT stakeholders. Additional explanation around the potential cost pressures driving these costs per client increases is included in Section 6.3 below.

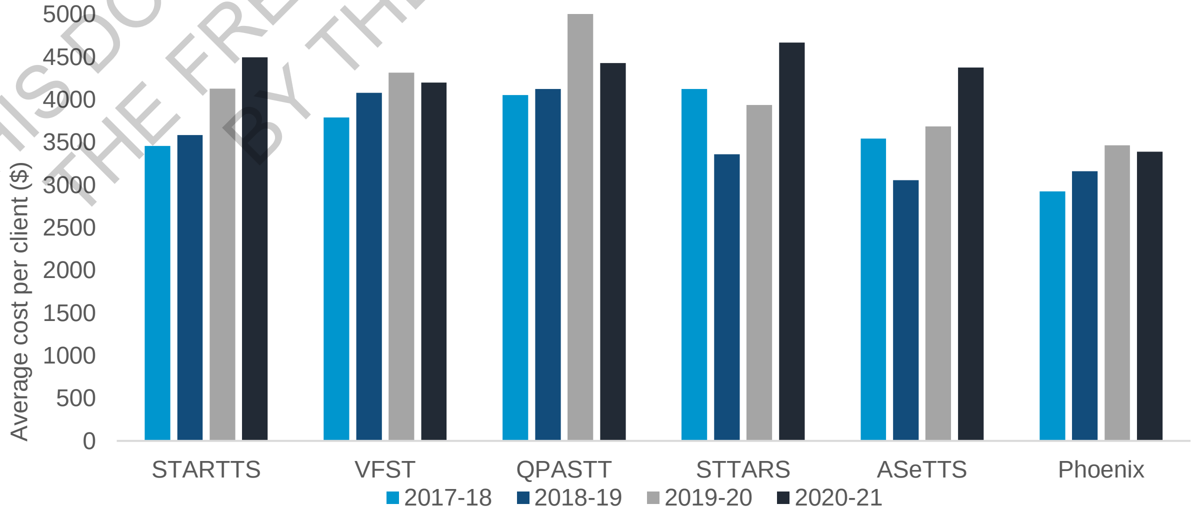

__Figure 31.__ Average cost per client by FASSTT agencies: 2017-18 to 2020-21. Cost per client figures have not been produced for Companion House or Melaleuca, as these agencies are currently funded at the “preserved minimum” rate to enable operations with relatively low client numbers.

Capital city vs regional costs

In 2019, AusHSI conducted an environmental scan encompassing all FASSTT non-capital city services and sites within NSW, Queensland, Victoria, and Tasmania. The full report, including detailed methodology, is provided in Appendix 5. Findings from this work indicated that the location-based costs of service delivery were driven by four key factors:

- Distance of site from the nearest capital city
- Type of facility: local office versus outreach
- Level of host community capacity to provide services for survivors of torture and trauma
- Additional resources required in the first 12 months of a new site

Consultation with agency CEOs when preparing this evaluation confirmed that the relative cost loadings identified in this earlier report would be consistent with current cost profiles, once scaled to reflect overall costs per client in the most recently reported financial year. For the purpose of this report, findings from the original environmental scan have been distilled to summarise differences in cost drivers between capital city versus non-capital city service delivery locations. This will allow for future funding models to approximate costs of service delivery for metropolitan versus regional and rural clients at the state or national level, without requiring site-specific calculations to be performed. **Table 15** summarises costs per client within non-capital city locations across NSW, Queensland, Tasmania, and Victoria as estimated within the 2019 environmental scan, along with respective cost loading factors.

Table 15. *Average costs per client in 2018-19: non-capital city sites as compared with Sydney, NSW*

Setting	Average cost per client ($2019)	Non-capital city cost loading factor
Base cost per client: Sydney	**3,520**	**Reference**
Average regional and rural cost per client		
New South Wales	5,791	1.65
Queensland	6,350	1.80
Tasmania	5,347	1.52
Victoria	5,775	1.64
Total	5,700	1.62

Table 16 takes the regional and rural loading factors estimated from the 2019 environmental scan (**Table 15** and Appendix 5) and applies these to the 2020-21 cost per client estimates at state and national levels. At the national level, the average cost per client within a capital city location is $3,952, compared to an average $6,400 for clients in non-capital city locations.

Table 16. *Derivation of 2020-21 average cost per client differentials across capital city sites versus non-capital city sites*

Agency	Average cost per client ($2021)	Regional and rural loading	Proportion of regional clients	Average cost per capital city client ($2021)	Average cost per non-capital city client ($2021)
STARTTS	4,495	1.65	22%	3,932	6,469
VFST	4,199	1.64	8%	4,006	6,573
QPASTT	4,430	1.80	25%	3,693	6,663
STTARS	4,670	1.62	8%	4,449	7,204
ASeTTS	4,376	1.62	0%	4,376	7,087
Phoenix	3,389	1.52	38%	2,835	4,306
Total FASSTT	**4,344**	**1.62**	**16%**	**3,952**	**6,400**

* Cost per client figures have not been produced for Companion House or Melaleuca, as these agencies are currently funded at the "preserved minimum" rate to enable operations with relatively low client numbers.

The increased costs of regional service delivery were supported with specific examples in stakeholder consultations[u]. For example, there is a need to provide specialised phone contracts and handsets that work in the regions. Due to the poor network coverage in regional areas, the phones/plans that must be obtained are generally more expensive. Additionally, specialty therapy resources cannot be shared between providers or organisations to split costs, as in metropolitan areas. Another cost that is increasing is the need to obtain accredited and skilled interpreters for the various languages spoken by the communities. Often phone interpreters have to be used, which is costly for service provision. Finally, having a physical presence in regional communities is key to relationship building with refugee communities and other service providers, but the costs of rent and travel in these areas can make this prohibitive. The issues associated with implementation of PASTT in regional areas that also explain these higher costs, and state/territory-based differences have been previously explored Chapter 4. Particular consideration for these additional expenses needs to be taken into account in future funding allocations for states/territories with large geographical areas and few established settlement communities.

6.3 Key cost pressures

Analysis of quantitative financial data and stakeholder consultations demonstrated that the current levels of base funding for PASTT are inadequate to meet current service demands or promote sustainability. This is evidenced by the increasing service costs and need for top-ups and self-generated income to maintain service delivery. Even with these additional sources, agencies are often forced to prioritise programs, services, or therapies due to limited resources. Alternatively, some agencies leverage off non-PASST funded activities to overcome this funding deficient. For example, in one agency PASTT counsellor advocates attended activities presented as part of a youth program (which was not PASTT funded) to make connections with families which facilitated relationship building and referral into the PASTT program. One FASSTT agency stakeholder voiced concerns as such:

> *"I don't think it [funding] is sustainable, and I certainly don't think it's sustainable as an expectation that we continue provide the level of services that we have provided, because we know that it's actually costing us more to deliver what we are delivering, than what we get funded for, and yet we know that there's so much more that can be done that we're not able to do."*
> ***Interview 26, Upper management, FASSTT***

While larger agencies with multiple funding streams have been able to absorb or offset some of the operating costs of their services to date, the financial viability of maintaining PASTT delivery is reaching a crisis point for other agencies. For most, the sustainability of current service levels is unlikely, given increases in both costs and demand for services. These funding issues are having downstream impacts including burgeoning waitlists and employee distress because of the need to waitlist clients. Numerous processes have been put in place by the FASSTT agencies to increase efficiencies and reduce costs (such as staffing freezes and resourcing reviews). The FASSTT agency stakeholders consulted reported any further cost reductions will likely have significant flow on effects to staff and communities.

Financial pressures are further evidenced by recent staff redundancies that have been implemented by some agencies, despite the ongoing, high demand for services. The Phoenix Centre stated that redundancies had been avoided thus far by not replacing outgoing staff who have resigned or moved into other roles within the organisation. A summary of recent redundancies since 2017-2018 is provided in **Table 17**. In addition, multiple agencies also stated that some redundancies had been avoided by not replacing outgoing staff who have resigned or moved into other roles within the organisation. These reductions in

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[u] *"[PASTT funding is flexible] but in the funding there's no consideration of the cost that it takes to deliver these types of services in the regions"* – **Interview 16, rural and regional stakeholder, FASSTT**

staffing levels have led to periods of instability for some agencies, triggering further staff turnover. This was described by one FASSTT agency member as such:

> *"...the challenge is because of that funding cut [linked to fewer entrants] it was like, the organisation became unstable. So, everything happened, then it was harder to retain staff, experienced staff. Some were made redundant, but some decided to leave because of that uncertainty around it."*
> ***Interview 20, counselling/clinical services, FASSTT***

Agency stakeholders have also described the impact these redundancies have at the client and organisational level:

- loss of counsellor advocates is problematic for clients who rely on continuity of care for therapy
- lost investment in the mentoring and capacity building of agency staff
- stress for counsellor advocates not sure if they will have employment to see clients to closure
- loss of specialised organisational knowledge and skill
- inability of agency to provide rural and regional service delivery

Table 17. *Redundancies across FASSTT agencies occurring between 2017-18 and 2021-22*

Agency	Year	FTE positions	Role descriptions	Reason for redundancy
STARTTS	2017-18	21	Counsellor/project officers (5), Group counsellor positions (5), Senior Group Counsellor (1), Family counsellors (4), Team Leader (1), ICT Support Worker (1), Project officers (3), Admin staff (1)	Reduction in funding following the end of the special provisions for the Syrian and Iraqi group
QPASTT	2021-22	3	Team Leaders, Counsellor Advocates, Community Worker, Youth Worker	Insufficient salary funds due to impact of ongoing wage increases
VFST	2017-18	7	Direct services coordinator (1), Counsellor Advocates (6), Community Liaison Workers (2)	Insufficent funds to keep up with increases in CPI and award wages. Program for refugees from Syria and Iraq involved in-depth trauma work and a sizeable number required complex and long-term interventions that meant specialist staff were needed for longer than the original funding anticipated.
STTARS	2018-19	3.1	Client service management, Finance officer, Counsellor, Executive Assistant	Agency restructure
Phoenix	2021-22	1	Not stated	Not stated
ASeTTS	2017-18	1	Complex case specialist	Restructure due to decreases in HSP and PASTT funding
	2018-19	5	Counsellor Advocates, team leaders, administrative roles	Restructure due to decreases in PASTT funding
	2020-21	3.6	Counsellor Advocates, team leaders/managers	Voluntary redundancies following restructure to adjust to PASTT funding levels
CH	2017-18	1	Counsellor Advocate	Reduced PASTT funding as a result of Syrian/Iraqi funding injection having finished

A further exploration of cost and service pressures is presented below and supported by quantitative and qualitative data where appropriate.

6.3.1 Policy context and implications

FASSTT agencies rely on PASTT base funding as the core income stream to support service delivery. However, base funding allocations are largely driven by Government policy decisions and therefore subject to change year-on-year. Recent policy decisions have caused substantial disruption to overall PASTT funding, most notably the 2020-21 Federal Budget announcement that the cap on the Humanitarian Program intake would reduce by 5,000 to 13,750 for the next 3 years. In the 2022-23 Budget it was subsequently announced that this cap would be maintained over the forward estimates. This resulted in changes to PASTT base funding levels that placed agencies under extreme financial pressure. The Government subsequently agreed that $10 million in top-up funding be provided in both 2021-22 and 2022-23 as a temporary measure to allow agencies to maintain existing service levels and manage waitlists.

In addition to changes in base funding allocations, the decision to cease the Social and Community Services Workers Wage Supplementation (SACS) scheme in 2020-21 has also had a substantial impact on salary budgets for some agencies (**Table 11** and **Figure 29**).

6.3.2 Humanitarian intake levels and rates of engagement with PASTT

All humanitarian entrants to Australia that are survivors of torture and trauma are eligible to receive PASTT services, regardless of their length of residence in Australia. As a result, the total eligible pool of clients continues to grow year on year. **Table 18** summarises annual and cumulative numbers of humanitarian entrants to Australia over the 20-year period between 2001-02 and 2020-21, along with the total number of unique clients that have been enrolled in individual counselling services over set historical windows of time.

Of the 277,539 humanitarian entrants to Australia over the last 20 years, **at least 46% have been enrolled in individual counselling services via PASTT at some point since settlement** (**Table 18**). This proportion has remained relatively consistent when considering rates of engagement over the past 15 years (46%) and past 10 years (45%). This can be considered a lower range estimate of engagement as in addition to individual counselling, client engagement with PASTT also occurs via groupwork, community engagement programs, and advocacy initiatives. However, as data is not consistently collected by all agencies on the numbers of clients engaged beyond individual counselling, this has been omitted from these estimates. Further detail about the levels of engagement across these additional activities can be found in Chapter 5 (**Figure 22.** and **Figure 27**).

Table 18. *Total humanitarian entrants to Australia since 2001-02 compared with number of unique individual counselling clients enrolled in PASTT over this period.*

Year	Total entrants	Cumulative total entrants	Individual clients accessing PASTT counselling services and relative proportion of cumulative entrant totals
2020-21	564	**5-year total**	
2019-20	13,159	65,621	40,886 62% of 5-year entrant total 28% of 10-year entrant total 19% of 15-year entrant total
2018-19	15,438		
2017-18	12,117		
2016-17	24,343		
2015-16	17,555	**10-year total**	
2014-15	13,756	144,434	64,746 45% of 10-year entrant total 31% of 15-year entrant total 23% of 20- year entrant total
2013-14	13,759		
2012-13	19,998		
2011-12	13,745		
2010-11	13,778	**15-year total**	
2009-10	13,770	211,520	97,776 46% of 15-year entrant total 35% of 20-year entrant total
2008-09	13,507		
2007-08	13,014		
2006-07	13,017		
2005-06	14,144	**20-year total**	
2004-05	13,178	277,539	126,741 46% of 20-year entrant total
2003-04	13,823		
2002-01	12,525		
2001-02	12,349		

This cumulative pool of eligible clients was a key theme in discussions with PASTT stakeholders about drivers of service demand, as demonstrated in quotes from two stakeholders.

> *"...there's a cumulative effect, so often we're seeing more clients than are represented just in the more recent arrivals, and so if our funding is reduced based on numbers of arrivals, that doesn't necessarily recognise that we have a lot of longer-term clients we are still supporting very actively."*
> ***Interview 20, Clinical/counselling services, FASSTT***

> *"…and while we've had a couple of years, you know, where the humanitarian program has been closed off, or pretty much, we've seen pretty consistent referrals"*
> ***Interview 11, Upper management; Administration and corporate services, FASSTT***

Because of this growing base of clients, there was a perception that the demand for services had increased despite low levels of humanitarian intake over the past two years (see **Figure 11**). Consequently, the number of referrals into the program is almost always beyond the capacity of current service delivery. This is evidenced by growing waiting lists (further detail in Section 6.4 below).

Impact on funding allocation

PASTT stakeholders believed that this cumulative client pool makes funding based on the previous 5-years of settlement numbers inadequate and unsustainable as these calculations do not reflect true service demands. The late engagement and long-term nature of service access adds pressure to agencies that is not captured in the funding formula. The recent arrival linked reductions in funding during the pandemic clearly demonstrate this fact where financial viability was strained trying to keep up with unchanged service demand.

6.3.3 Settlement patterns

As described in Chapter 4, an increasing proportion of humanitarian entrants have settled in regional and rural areas over the past decade, consistent with settlement and rural development policy across governments. **Figure 32** outlines the proportion of total humanitarian entrants settling in rural and regional locations within each state and territory between 2016-17 and 2019-20 (prior to the steep drop-off in entrants in 2020-21 due to the COVID-19 pandemic). At a national level, regional and rural settlement rates have more than doubled over this four-year period, from 10.8% in 2016-17 to 26.8% in 2019-20.

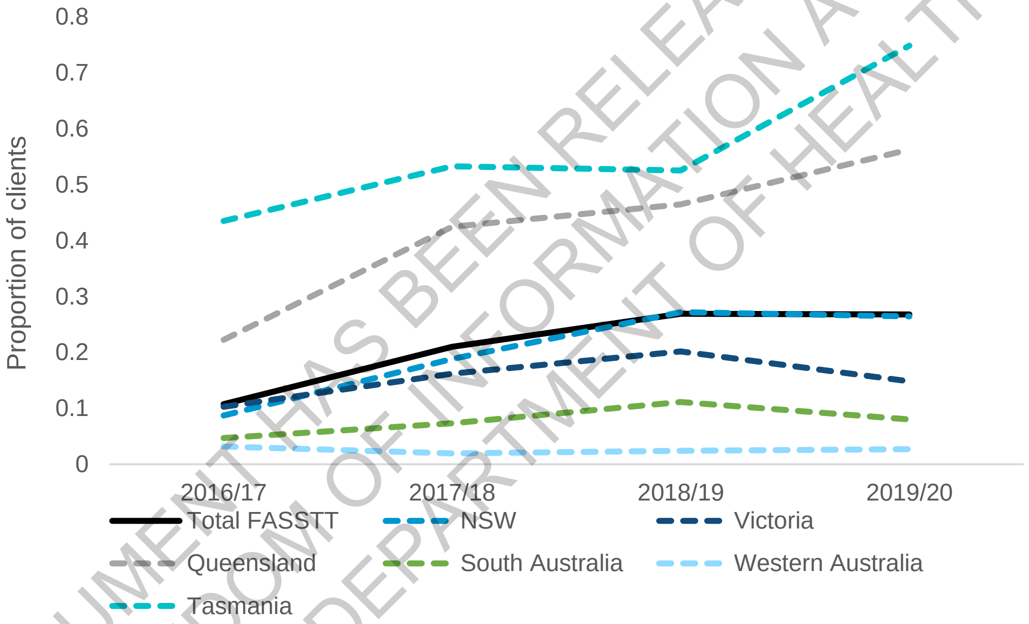

Figure 32. Proportion of total humanitarian entrants settling in rural and regional locations: 2016-17 to 2019-20

Table 19 summarises the proportion of PASTT clients who reside in regional and rural locations. Consistent with the trends observed in total humanitarian entrants (**Figure 32**), there has been an increase in the overall proportion of regional and rural PASTT clients from 11% in 2017-18 to 16% in 2020-21. Phoenix reported the highest overall proportion of rural and regional clients in 2020-21 (38%), followed by QPASTT (25%) and STARTTS (22%). Key considerations around regional and rural PASTT delivery impacting costs have been explored in Section 6.2.2 and Chapter 4.

Table 19. *Proportion of PASTT clients residing in regional and rural areas: 2017-18 to 2020-21**

Proportion of all PASTT clients residing in regional and rural locations	2016/17	2017/18	2018/19	2019/20
Nationally	11%	14%	15%	16%
Tasmania (Phoenix)	18%	21%	31%	38%
Queensland (QPASTT)	14%	24%	25%	25%
New South Wales (STARTTS)	20%	21%	23%	22%
Victoria (VFST)	0%	4%	6%	8%
South Australia (STTARS)	9%	7%	8%	8%
Western Australia (ASeTTS)	0%	0%	0%	0%
Australian Capital Territory (CH)	5%	4%	2%	2%

*Data not available for Northern Territory (Melaleuca). All Tasmania (Phoenix) regional and rural clients reside in Launceston.

6.3.4 Timing of engagement

Over the past five years, there has been a trend towards clients engaging PASTT counselling services after a longer period of time post-settlement (**Figure 33**)[v]. While 48% of PASTT clients in 2016-17 had been in Australia for less than one year, only 33% fell into this category in 2019-20 (prior to major impacts of declining arrival numbers being felt). Conversely, the proportion of clients who had been in Australia for 5 or more years increased from 22% in 2016-17 to 35% in 2019-20.

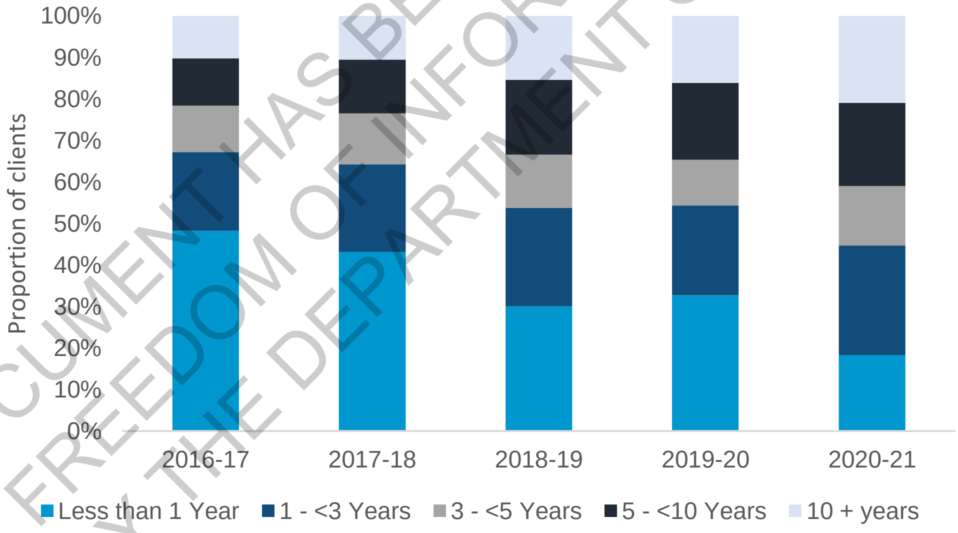

Figure 33. *Client length of residence in Australia when engaging PASTT services: 2016-17 to 2020-21*

Consultations with FASSTT agency stakeholders suggest this later engagement may be driven by a variety of factors occurring during this time including re-traumatisation from global conflicts, the COVID-19 pandemic, and increased financial insecurity. Additionally, the visibility and success of engagement work by the agencies in new communities continues to drive demand beyond settlement.

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[v] *"Our current funding formula's based on annual arrival numbers but our work is across the lifespan"* **Interview 5, Upper management, FASSTT**

Trends in the total number of hours of counselling support per client have remained relatively stable over the past 5 years (**Figure 34**). There has been a slight decrease in the proportion of clients requiring 0 to 5 hours of support, from 44% in 2016-17 to 38% in 2020-21.

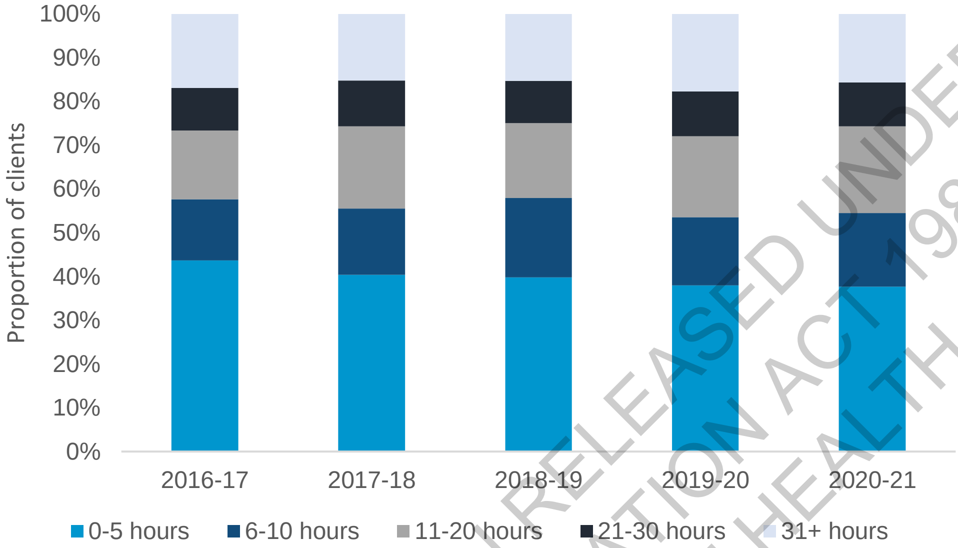

Figure 34. *Total number of hours of counselling support per client: 2016-17 to 2020-21*

An upward trend in the length of time that counselling clients remain active has been observed over the last five years (**Figure 35**). The proportion of clients active for more than two years increased from 14% in 2016-17 to 24% in 2020-21. Conversely, the proportion of clients active for three months or less decreased from 35% to 25% over this same period.

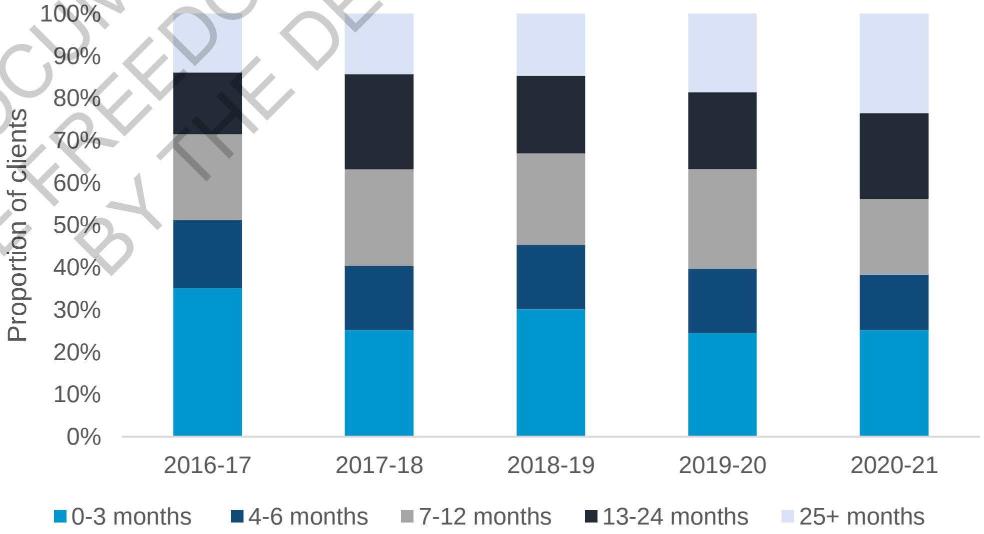

Figure 35. *Length of time that clients remain active: 2016-17 to 2020-21*

6.3.5 The impact of world events on diaspora communities

Consultations with agency stakeholders clearly highlighted that external world events were a driver of demand that brought new clients into the service and re-traumatised existing clients or those who had exited the program. For example, war, conflict, or other socio-political events often triggered a spate of referrals from existing refugee communities. Examples provided were the recent Afghan evacuation, Ukrainian conflict, and COVID-19. The retraumatising effect of such crises are forefront in case studies “F” and “B” supplied by FASSTT agencies (Appendix 4). Sometimes the best way to address this need is by working with those effected at the community level. However, funding such time-sensitive and unpredictable work is challenging. This is compounded by the fact that **base funding is designed to respond to the needs of the existing client pool (current clients, waitlisted, already settled) and has no capacity to adjust to unforeseen/unpredictable surges in demand** (such as humanitarian crises) without restricting or pausing services for existing clients[w]. Agencies often have to make difficult decisions to push waitlisted clients aside to deal with unfolding crises, which has ongoing ripple effects for the existing client base. Without having enough funding to plan, improve, and be proactive in their approach with communities, this demand will always be greater than supply.

6.3.6 Increasing cost of service delivery

One of the main challenges is that PASTT is an expensive service to fund given its complex and specialist nature, culturally appropriate approaches, focus on staff capacity building, and need for long-term community engagement. These costs are only increasing over time, which is putting agencies under financial strain. For example, the need to maintain IT infrastructure and security as well as client data management system costs is an increasing area of expenditure. Multiple agencies have needed to invest in major IT investment projects over the past three years. There have also been COVID-19 related costs which could be expected to continue, including provision of Personal Protective Equipment to conduct in person sessions, Rapid Antigen Tests, telehealth provision, and potential upgrades to ventilation in physical premises. More generally, increasing rates of inflation have been observed over the 2020-21 and 2021-22 financial years and are forecast to continue into the medium term. This will place further upward pressure on costs associated with wages as well as other essential goods and services including petrol, insurance, and travel.

Two key examples of cost increases that could be addressed in future budgets relate to interpreters and staff salaries, described in more detail below.

Interpreters

The use of interpreters has been crucial to PASTT’s appropriateness by making it easier for clients to communicate about trauma and supporting access to mainstream services. As such, interpreters are present at many service interactions. Yet, there is no longer specific PASTT budget support for providing interpreter services and agencies are required to fund these costly services out of their existing budget. This has become a major challenge under current funding levels (particularly for smaller agencies or those in rural locations) as interpreters account for 5-10% of each agency’s overall operating costs (**Table 14**). There are also discrepancies in the way these costs are reported, with some agencies classifying them as direct costs, and others as indirect costs. Interpreters, however, are an essential direct service delivery cost of PASTT and the lack of additional funding allocation for them is compromising service delivery, the number of clients seen, and the counselling sessions delivered. As a potential solution some agencies have created their own pool of ‘in-house’ interpreters who have been effective in reducing costs, but this is an unfeasible approach for all FASSTT agencies. Appropriately classifying and funding interpreter services at the national level should be a high priority in future funding allocations.

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[w] *"[recent arrivals evacuated from Afghanistan] in effect, they're on top of our cumulative load because it brings more people out of the established diaspora into the service needing assistance, it elevates our need to become much more engaged at a community level through community engagement strategies which are not well-resourced through PASTT"*
Interview 5, Upper management, FASSTT

Salaries

Given that salary-related expenses account for a large proportion of total costs across agencies, the trend of salary increases observed (**Table 13**) presents a concern for PASTT's financial sustainability. Increasing wage rates were cited as one reason for multiple redundancies across agencies in the last 5 years (**Table 17**). An indication of cost increases is that the difference is wage costs for QPASTT for an equal number of workers between 2020-21 and 2021-22 is $286,000 per annum. Consequently, staff salaries were also one of the most pressing issues raised by FASSTT agency stakeholders interviewed during the consultation process.

While there have been incremental yearly increases built into PASTT base funding allowances for staff salaries, in many cases this has not kept up with the amounts required by the respective state Social, Community, Home Care and Disability Services Industry Awards, as well as legislated annual increases to compulsory superannuation contributions by employers[x]. In addition, VFST and QPASTT are now required to pay 1.65% and 1.37% per annum, per employee (including casuals) respectively in a compulsory allocation to portable long service leave. A summary of changes to wage rates between 2017-18 and 2021-22 for selected agencies is included in **Table 20**.

In response to these increases, agencies have needed to absorb additional costs into their operations, detracting from funds available for service delivery. Furthermore, the salaries provided within PASTT funding are typically not competitive with other larger government or community service organisations which can pay above award salaries via enterprise bargaining arrangements. Similarly, there are no incentives for staff to work in regional areas, making these roles less attractive compared to other organisations. This presents further challenges in the recruitment and retainment of high-quality staff, which from consultations with stakeholders, was perceived to be one of the keys to the program's success. As such, it is recommended that future PASTT budgets provide funding for salary equity with comparable organisations and with increments that are consistent with the upward pressures being experienced.

Table 20. Wage related increases for selected agencies: 2017-18 to 2021-22

Agency	Average award and rate	2017-18	2018-19	2019-20	2020-21	2021-22	Average annual increase
VFST	Level 6 of the Victorian SCHADS Award plus Equal remuneration order (ERO)	5.8%	5.1%	5.7%	4.5%	2.5%	4.7%
QPASTT	Level 5.3 Counsellor SCHADS Award plus			3.6%	1.5%	4.2%	3.1% (projected to increase to 4.2%)
STARRS	Level 5 Counsellor SCHADS Award		7%	6%	5%	6%	6.0%
CH	SCHADS Award (average increases across agency)		7%	6%	5%	5%	5.7%
Phoenix	SCHADS Award (average increases across agency)	26.37% since 2017-18					5.3%

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[x] *"That's a real critical issue for us that there's never any indexation on any of these grants, that means that agencies are just forced to absorb wage increases, CPI increases, our insurances have gone up…"* **Interview 1, Upper management, FASSTT**

6.4 Evidence of unmet need

An analysis of trends in waiting list numbers and average waiting times was conducted as proxy indicators of demand. Across PASTT, total numbers of clients on a waiting list for individual counselling services increased from 497 in 2014-15 to 613 in 2020-21 (**Figure 36**). The number of clients waiting for longer than 6 months increased from 65 (13% of total waiting list) in 2014-15 to 151 (25% of total waiting list) in 2020-21.

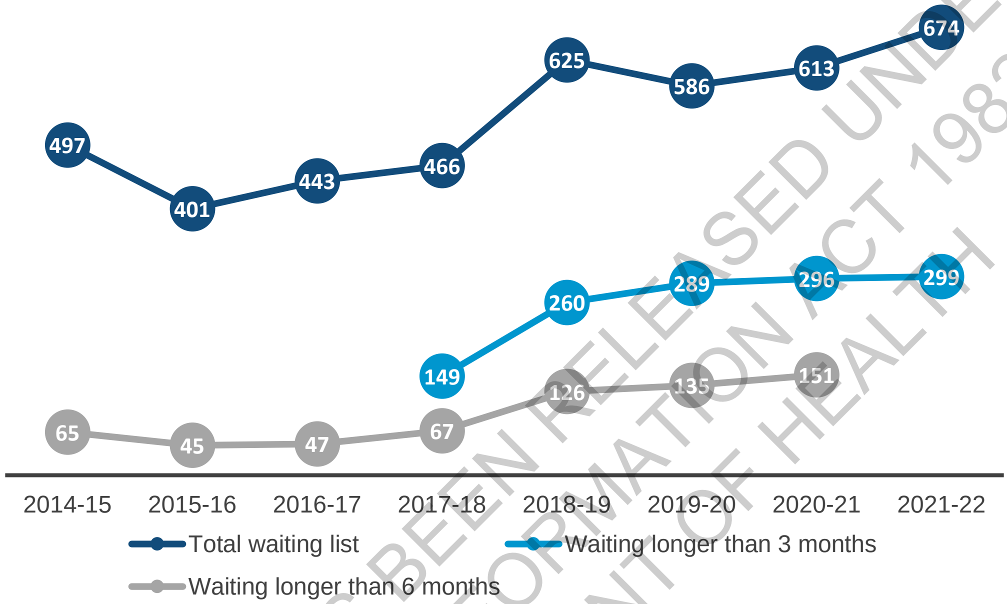

Figure 36. Whole of PASTT waiting list outcomes 2014-15 to 2020-21

Trends in the total number of clients on a waiting list for counselling services by agency is presented in **Figure 37**. Substantial recent increases were observed in VFST and QPASTT.

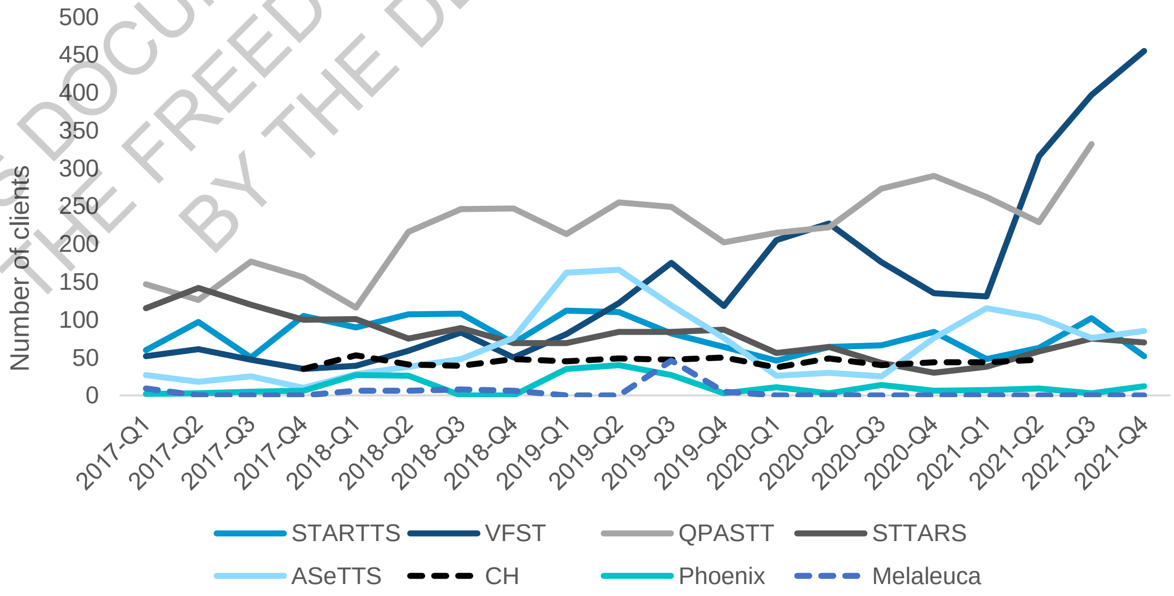

Figure 37. Total number of clients on waiting list for counselling services, by FASSTT agency: 2017 to 2021

Trends in the number of clients waiting longer than 3 months for counselling services between 2017 and 2021 is presented in **Figure 38**. Consistent with trends in total waiting list numbers, sharp increases were observed by VFST (249 clients in Q4-2021) and QPASTT (199 clients in Q3-2021).

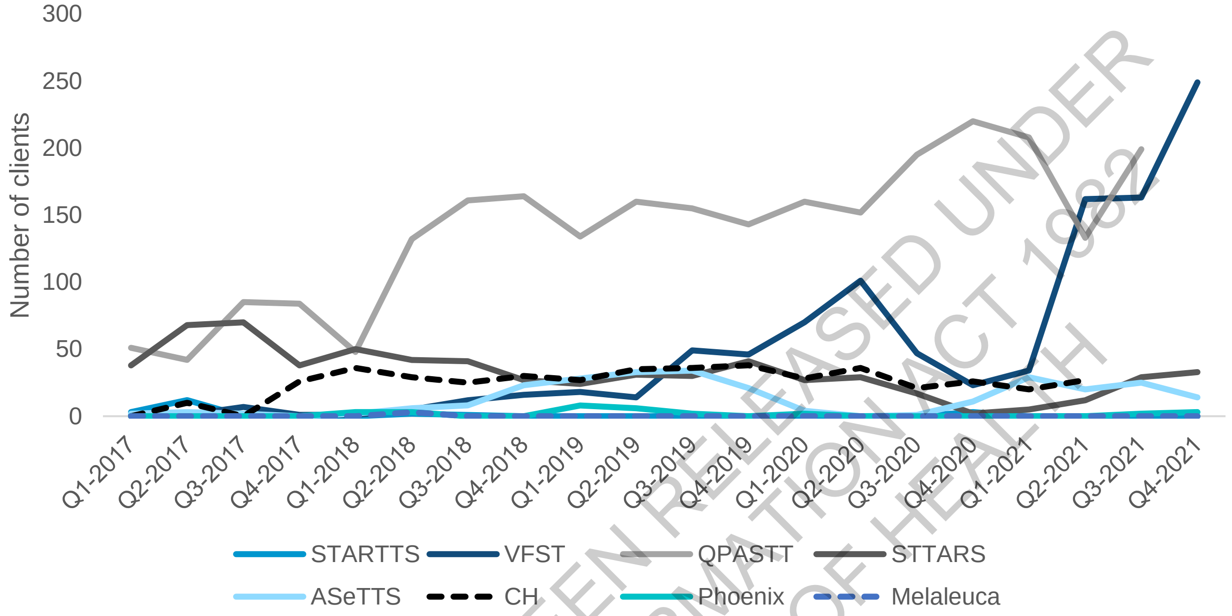

__Figure 38.__ Number of clients waiting longer than 3 months for counselling services, by FASSTT agency: 2017 to 2021

In addition to waiting lists, PASTT stakeholders also spoke about the “unseen and unknown needs” in new and existing communities. By performing community development work and engaging with communities FASSTT agencies uncover more potential refugees who could benefit from PASTT services. However, meeting this demand is always challenging. This is described as such by one stakeholder:

> *"We have a waitlist of 50 [in that region] - we could have a waitlist of 200 if we went out more, so then you have to have the balance of losing the trust of a community who have to sit on a waitlist for 6, 12, 18 months”*
> ***Interview 2, Large multidisciplinary group including upper management, FASSTT***

6.5 Opportunity to improve funding model allocations

The adequacy of the current PASTT funding formula/allocation was seen as a point of contention amongst many FASSTT agencies, but they readily admitted that a viable alternative was yet to be presented. In our analysis of qualitative consultations the following suggestions were proposed which are supported by analysis of the quantitative data:

- remove links between funding and arrival numbers, rather focus on cumulative population
- set a guaranteed minimum amount of base funding for each agency each contracted year and then top this up when required to deal with surge in demand due to crises
- return to longer, more predictable funding periods
- better account for agencies with increased rural service provision
- better account for staff salaries in funding model

6.6 Findings

Finding E1. Recent policy decisions, including reductions in the Humanitarian Program intake and cessation of the Social and Community Services Workers Wage Supplementation scheme, have resulted in significant disruption to core income streams across FASSTT agencies.

Finding E2. The current PASTT funding model and base funding allocation is not fit for purpose due to: (1) a growing pool of humanitarian entrants accessing services over a relatively long period post settlement; (2) an increasing proportion of clients settling in regional and rural areas; (3) increasing costs of service delivery, especially in relation to growing wage-related costs; and (4) the impact of external stressors including international humanitarian crises and COVID-19.

Finding E3. FASSTT agencies report a relatively low rate of indirect costs, reflecting the prioritisation of crisis-driven service delivery above long term planning and infrastructure investment. This may be indicative of financial vulnerability. Investment in national-level infrastructure for supporting services would likely provide a more efficient use of resources than agencies making investments in silos.

Finding E4. Appropriately classifying and funding interpreter services at the national level should be a high priority in future funding allocations.

Finding E5. At least 46% of humanitarian entrants have been enrolled in PASTT individual counselling services in the 10 to 20 years following their settlement.

Finding E6. There is an increasing level of unmet need within the system as evidenced by growing waiting lists.

Finding E7. There is a need for better resourcing of, and long-term investment in, community capacity building and engagement activities within the program, particularly for successful early intervention work.

Finding E8. The categorisation and reporting of agency expenses as they relate to key activities and services is inconsistent across FASSTT agencies. A consistent national framework with clear definitions for reporting expenditure against pre-defined categories would support ongoing quality improvement and evaluation activities.

Finding E9. Any new PASTT funding model should consider the cumulative eligible population, regional and rural service delivery, adequate and competitive staff salaries, longer funding durations, and balancing base and surge/crisis funding.

Chapter 7. Alignment of PASTT with best international practice

This chapter considers the alignment of PASTT with international best practice for meeting the recovery needs of refugee survivors of torture and trauma. It consolidates data from three sources (1) information compiled and provided by the FASSTT National Coordinator demonstrating how PASTT and FASSTT agencies align with The Global Standards on Rehabilitation of Torture Victims ('the standards', see Appendix 8) and the National Standards for Mental Health Services (NSMHS, see Appendix 8.1), (2) data and performance reports provided by the FASSTT agencies, (3) qualitative data from interviews with key stakeholders from each FASSTT agency, and (4) PASTT client interviews.

This chapter focusses on answering sub questions from key evaluation questions one, three, and four as outlined below.

- *Key evaluation question one: How appropriate is the PASTT model? (alignment with international best practice)*
- *Key evaluation question three: How effective has the program been? (evidence-based activities)*
- *Key evaluation question four: How can the program be developed or refined? (opportunities as identified in international best practice)*

7.1 Global Standards on Rehabilitation of Torture Victims

The Global Standards on Rehabilitation of Torture Victims ('the standards', Appendix 8) were developed and adopted by the International Rehabilitation Council for Torture Victims (IRCT) in 2020. These 17 standards were developed based on a global survey of best practice, have undergone expert technical review and political adoption via the IRCT's General Assembly, and have been shaped with regional consultation to address different local contexts. International best practice for supporting recovery and rehabilitation needs of survivors of torture and trauma is achieved when programs and their service delivery align with these standards.

FASSTT involvement in the IRCT and role in the development and promotion of the standards is discussed in the next section. A summary of evidence evaluating the alignment of FASSTT and PASTT with each of the standards is provided, along with a brief discussion of gaps and opportunities for improvement that became evident in the evaluation.

7.1.1 FASSTT agencies' involvement with the IRCT and development and promotion of the standards

FASSTT is actively represented in the IRCT governance structure through the individual IRCT membership of FASSTT agencies. FASSTT agency representatives participate in the IRCT Council and its Executive Committee. FASSTT agency representatives have also been elected to the IRCT leadership as President (Jorge Aroche, STARTTS, 2016-2020) and Vice-President (Jorge Aroche, STARTTS, 2009-2012). Robyn Smythe (STTARS) is the current elected representative from Australia in the IRCT Executive Committee.

FASSTT agencies play a leading role as international experts in torture and trauma rehabilitation, and their work (largely delivered through PASTT) is well recognised internationally. The FASSTT agencies' representatives were catalysts for the development and adoption of the standards. In the latest Annual Report (2021)[64] the IRCT specifically refers to the leading role that ASeTTS played in guiding the IRCT in developing an E-learning training course consisting of modules focused on each of the 17 standards. STARTTS is also acknowledged in the same Annual Report (2021) for an extraordinary contribution to the Torture Journal. Experts from Australia were invited to reflect on the consequences for torture survivors and the ongoing violence in Afghanistan following the Taliban's return to power in a webinar attended by 200 people which was the most well attended IRCT webinar of 2021. Lastly, there are several publications authored by the FASSTT agencies' staff in peer-reviewed international journals.

7.2 PASTT alignment with global evidence-based standards

The evidence summarised in **Table 21** predominantly indicates clear alignment of PASTT (and overall FASSTT agency policies, procedures, and activities) with evidence-based standards of care for the recovery needs of refugee survivors of torture and trauma. While in two areas, 'Care for staff' (standard 12) and 'Advocate for rehabilitation funding' (standard 14), PASTT is mostly aligned with the IRCT Standards, some qualitative interview and survey data suggests that additional actions are needed to realise these standards fully. First, policies, practices and activities addressing 'Care for staff' must be consistently implemented, especially during surges in service demand during which staff tended to compromise their own self-care time to dedicate it to front-line activities. Second, while each agency advocated for rehabilitation funding within their own capacity, it was apparent that large agencies, with dedicated staff member/s responsible for applying for additional funding, had greater capacity to seek and secure external funding. In smaller agencies, one person often had multiple roles and responsibilities which included sourcing and applying for external funding. Action is therefore needed to increase smaller agencies' capacity to seek and secure additional funding. There was also perception by some external stakeholders that agencies sometimes work in a silo, especially at a strategic or systems' level. Other opportunities for improvement exist in relation to 'Access to information' (standard 7), where access to interpreters in some states/territories and in regional and rural areas was described as variable and could be improved.

Table 21 categorises PASTT's alignment with the standards on a spectrum from strong to unclear/incomplete. Green boxes represent clear and strong alignment of PASTT with the described IRCT standard. Orange boxes represent standards which are clearly aligned but are less strongly being achieved. There were no areas in which there was unclear or complete lack of alignment with any of the IRCT Standards.

It is important to note that the standards are overarching and have been developed for rehabilitation service providers (agencies) in general, not for evaluation of one program they deliver. Hence, evidence provided in this section does not solely refer to the PASTT program but also to FASSTT agency-wide policies and structures. Additionally, the number of examples provided for PASTT's alignment with the standards does not reflect the strength of alignment.

Table 21. *Evidence to support alignment of PASTT and FASSTT with each IRCT standard*

International rehabilitation standard		Summary of evidence supporting PASTT alignment with the standards			
1. Our commitment to victims	Standard description	*Uphold the well-being and dignity of torture victims as well as professional ethical standards and principles regarding treatment and rehabilitation, including informed consent, confidentiality, do no harm, the best interests of victims, and their free choice about the services they receive, resist re-traumatisation, and apply global best practices, which are all pivotal to the work of rehabilitation centres that are independent and accountable to victims, in accordance with the principles of the UN Committee against Torture's General Comment No. 3 on the right to redress and rehabilitation.*			
	Supporting evidence	PASTT has comprehensive agency-level policies and procedures in which all staff are trained. Areas covered include: client rights and responsibilities, privacy and consent, stages of service intervention, professional practice, client engagement, and consultation processes.			
2. Independent services	Standard description	*Implement relevant structures and procedures so that rehabilitation can be provided independently, autonomously, in full compliance with applicable professional standards and ethics, and free from any external influence. In particular, rehabilitation centres should prioritise the development and implementation of structures, methodologies, and procedures that are victim-centred, evidence-based, participatory, empowering, holistic, accessible, equitable, respectful, gender sensitive, culturally appropriate, and accountable. Where funding is received from sources that could be perceived to place an external influence on the rehabilitation provider, it is essential to ensure that the organisation's mandate and the principles of victim confidentiality, transparency, and independence of decision-making are prioritised and emphasise the victims' best interests. Torture victims must be informed about measures taken to protect the rehabilitation process from external influence.*			
	Supporting evidence	Services provided by FASSTT agencies are explicitly non-denominational, politically neutral, and available for clients across the country.	Service provision that accommodates client rights was perceived by FASSTT agency staff to be of utmost importance.	Seven FASSTT agencies have received accreditation against the NSMHS; the eighth FASSTT agency (Melaleuca) is currently seeking accreditation.	FASSTT agencies offer individual counselling, group counselling, internal and external education and training, and community capacity building activities.
3. Safety of victims	Standard description	*Ensure the implementation of every possible safety and safeguarding measure for victims receiving services, including all aspects of the relationship with victims, bearing in mind that the best interest of the torture victim is a key principle of rehabilitation services. Torture victims must be informed about and input to the determination of safeguarding and safety measures.*			

	Supporting evidence	The right to safety for clients is enshrined in the FASSTT agencies' policies and procedures (e.g., *Safe Guarding at QPASTT; VFST Trauma Recovery Framework*).	Safety management processes are embedded into FASSTT agency services. For example, FASSTT agencies undertake suicide risk assessments at intake and in counselling sessions. STARTTS draft *Clinical Governance Framework 2022* references client safety as the second Pillar (Pillar B) in the service delivery framework. Clients are, wherever possible, involved in safety planning by FASSTT agencies.	All workers across all jurisdictions are screened prior to beginning employment according to vulnerable persons checks.	One FASSTT agency reported conducting on-arrival COVID-19 screening procedures for all people entering the agency's offices which included the clients.
4. Support of families	Standard description	*Ensure that the specific rehabilitation needs of torture survivors' families, in particular children and vulnerable populations, are considered an essential part of the rehabilitation process. Where resources allow, families should receive support in accordance with their needs. Where relevant, culturally appropriate community-based approaches should be employed during the rehabilitation process. Ensure that the specific rehabilitation needs of torture survivors' families, in particular children and vulnerable populations, are considered an essential part of the rehabilitation process. Where resources allow, families should receive support in accordance with their needs. Where relevant, culturally appropriate community-based approaches should be employed during the rehabilitation process.*			
	Supporting evidence	All FASSTT agencies have specific policies, programs, and interventions for working with children and families and employ appropriately qualified staff (e.g., QPASTT *Protection of Children and Young People Policy*; STARTTS *Families in Cultural Transition* program).	FASSTT agencies provide ongoing training and supervision for staff working with children and families.	FASSTT agency staff report using a holistic approach to working with trauma with a broad focus on client-specific needs including needs of the family unit. For example, QPASTT 'Community Connectors' implement the agency-developed 'Building Stronger Families' group work program in regional communities, which combines trauma recovery, psychoeducation, and parenting to empower and enable improved acculturation and adaption of parenting in the Australian context.	FASSTT agencies have strong links with primary and secondary schools and youth groups.
5. Access to Justice	Standard description	*Whenever possible, support victims' access to justice and be advocates for the eradication of torture as a part of the rehabilitation process. This includes supporting victims to document their claims in accordance with the Istanbul Protocol and file complaints and advocating with national authorities to adopt and implement national anti-torture laws and National Preventive Mechanisms (NPMs).*			

	Supporting evidence	All FASSTT agencies are independent members of the IRCT.	FASSTT agencies support the advocacy work of national agencies such as the Refugee Council of Australia and Amnesty International.	FASSTT agencies engage in advocacy work of their own by preparing submissions to government at both state and Federal levels. For example, QPASTT made a submission to the Queensland Parliament Inquiry into serious vilification and hate crimes.	FASSTT agencies offer support to enable refugee communities to self-advocate for issues of concern.
6. Intake processes	Standard description	*Establish intake processes where victims of torture can access rehabilitation services on the basis of self-referral or referral by a third party such as competent physical or mental health, social, or legal professionals, human rights defenders, faith-based, indigenous, ethnic and national minority communities, other torture victims or family members. These processes must ensure that, within available resources, torture victims have free, equal and non-discriminatory access to services, regardless of their ability to pay or legal status in the country concerned. To the extent possible, rehabilitation service providers should prioritise outreach, in particular for torture victims that are marginalised, detained, living in remote areas or lack funds for transport costs.*			
	Supporting evidence	Outreach services are provided.	FASSTT agencies have established referral pathways. Intake, assessment, and allocation processes are clear, transparent, and documented.	Transparency is prioritised, clients who are not accepted into PASTT are provided with clear reasoning for that decision and referred onto other relevant providers.	FASSTT agencies described how waitlists are managed considering the needs of clients. Individuals on waitlists are provided with at least some level of care while they wait.
7. Access to information	Standard description	*Provide torture victims with all relevant information concerning the rehabilitation services offered. Rehabilitation centres must respect and promote torture victims' agency over their own lives and the choice(s) regarding their rehabilitation. Where possible and appropriate to the service provided, reliable interpreters should be made available at no cost to the torture victim. Whenever possible, victims should be able to choose the gender of rehabilitation professionals, including interpreters. Informed consent must be obtained according to relevant professional and ethical standards before and during the process of rehabilitation.*			
	Supporting evidence	FASSTT agencies have detailed information available about services they provide, how to access their services, the scope of these services, and expectations of behaviour by both staff and client during interactions.	FASSTT agencies have written information available (online and paper-based) that is culturally appropriate, in languages spoken by clients.	FASSTT agencies utilise interpreters in providing information and during service provision.	FASSTT agencies respect and promote the clients' agency by providing client-centred services and practicing soft- and non-prescriptive approach.

<table>
<tr><td rowspan="2">8. Victim feedback</td><td>Standard description</td><td colspan="4"><i>Establish procedures and mechanisms that enable torture victims to provide ongoing feedback, including upon leaving the service, in a language they speak about the rehabilitation services they receive, for example through the use of standing service user engagement mechanisms, victim satisfaction surveys, service evaluations, focus groups and other participatory mechanisms. This feedback should be reviewed periodically and form the basis for continuous improvements to the rehabilitation services offered. Satisfaction should be clearly defined, using consistently applied standards. In addition, mechanisms whereby victims can complain and receive a prompt and satisfactory response in relation to the rehabilitation services they receive should be established. Victims should be enabled to effectively engage through measures such as provision of information about complaint possibilities and the establishment of support functions that include other victims.</i></td></tr>
<tr><td>Supporting evidence</td><td>FASSTT agencies have established feedback and complaints mechanisms.</td><td>There are formal and informal reporting requirements for feedback, including to management and FASSTT agency boards.</td><td>Feedback is gathered from clients in a variety of ways including through Client Satisfaction surveys.</td><td>Feedback is used to plan, deliver, evaluate, and improve services.</td></tr>
<tr><td rowspan="2">9. Victims' participation in rehabilitation</td><td>Standard descriptio</td><td colspan="4"><i>Promote the meaningful contribution of victims in service design and delivery, research, decision-making and governance processes of rehabilitation services through recognition of victims' experience in service development and recruitment processes, open consultative and feedback processes and/or other participative methods that are context and situationally appropriate.</i></td></tr>
<tr><td>Supporting evidence</td><td>Organisational philosophy of client-centredness means service provision is context, culturally, and situationally appropriate.</td><td colspan="2">People with lived experience of torture and trauma are employed by FASSTT agencies and represented at the Board-level.</td><td>There are extensive community consultation processes and practices, community advisory groups, and community involvement in needs assessment, service design, delivery and evaluation.</td></tr>
<tr><td rowspan="2">10. Organisational capacity</td><td>Standard descriptio</td><td colspan="4"><i>Prioritise continuous training and capacity enhancement for staff and volunteers, for example in specialised evidence-based treatment methods, trauma sensitive interview techniques, empathetic listening and anti-racism, cultural and gender awareness in accordance with relevant professional standards and ethics and international human rights standards.</i></td></tr>
<tr><td>Supporting evidence</td><td colspan="2">FASSTT agencies have processes and procedures in place to ensure staff are suitably skilled with a core focus on professional development and clinical supervision. This includes some FASSTT agencies providing clinical supervision for other FASSTT agencies and inter-agency sharing of resources.</td><td colspan="2">Relevant, recognised accreditation has been obtained for many activities and professions within the FASSTT agencies. For example, seven of eight FASSTT agencies have received accreditation against the NSMHS.</td></tr>
<tr><td>11. Staff safety</td><td>Standard description</td><td colspan="4"><i>Ensure that staff and volunteers are safe, secure and cared for and have the means to report incidents which could compromise their safety or the safety of others through reporting processes or other suitable means that ensure that these risks are documented and context appropriate measures taken to minimise them. In this regard, member centres are to ensure the adoption and implementation of appropriate policies to prevent and address discrimination, harassment and sexual and other forms of abuse.</i></td></tr>
</table>

	Supporting evidence	FASSTT agencies have polices to ensure staff safety with respect to occupational health and safety, risk management, and critical incidents.	FASSTT agencies have polices to ensure staff safety with respect to cultural safety, equal employment opportunity, discrimination, harassment, and abuse in the workplace.	Procedures regarding anti-discrimination and prevention of workplace bullying have been developed and staff are provided training regarding these procedures.	One FASSTT agency reported conducting on-arrival COVID-19 screening procedures for all people entering the agency's offices.
12. Care for staff	Standard descriptio	*Address vicarious trauma and prevention of burnout as an organisational priority for all staff. To that end, provide a robust and supportive well-being infrastructure and working environment for staff through, for example, regular supervision, peer support mechanisms, staff mentoring, psychosocial support techniques, and access to occupational health services.*			
	Supporting evidence	FASSTT agencies are aware of the potential for vicarious trauma and staff burnout and have policies and procedures in place to address these issues.	FASSTT agencies ensure counselling staff receive regular clinical supervision from dedicated clinical supervisors.	FASSTT agencies provide formal and informal methods for staff debriefing and attempt to foster a culture of care and support. Training is provided to all staff to recognise stress and access support including Employee Assistance Programs and to promote engagement in self-care activities.	
13. Share knowledge	Standard description	*Disseminate information about torture and its effects to professionals in healthcare and other relevant fields who may come into contact with torture victims. Information should include available and possible approaches to rehabilitation, the specific needs of torture victims (including early identification, assessment and timely referrals), trauma-informed care, documentation procedures according to the Istanbul Protocol and the value of providing rehabilitation to facilitate life after torture. Where security considerations allow, the dissemination of this information should be considered a critical moral and social responsibility for centres assisting victims of torture.*			
	Supporting evidence	FASSTT agencies share knowledge by participating in service delivery networks, being members of advisory committees and networks, and providing secondary and case consultation with other service providers.	FASSTT agencies develop strong, positive relationships with external services that support PASTT clients. FASSTT agencies work to upskill mainstream service providers to adopt a trauma- informed lens.	FASSTT agencies develop and disseminate resources, frameworks, training modules and research publications to support knowledge transfer in the field.	FASSTT agencies participate in conferences to share the impact of rehabilitation with national and international universities, academic institutions, and other international agencies.
14. Advocate for rehabilitation funding	Standard description	*Attempt, where possible, to establish or strengthen dialogue with states and their relevant agencies to inform them about torture and its effects and the value of rehabilitation, and to request that they provide funding to support the rehabilitation of torture victims worldwide, preferably through: a) direct funding of rehabilitation centres assisting survivors of torture in their respective countries, b) contributing to the United Nations Voluntary Fund for Victims of Torture (UNVFVT), or c) funding the IRCT's sub-granting program.*			

	Supporting evidence	The FASSTT agencies regularly make submissions to government enquiries, publish public statements regarding issues of concern, and advocate for adequate funding to continue their work.	FASSTT agencies work to build effective strategic relationships with government, non-government, and private sector organisations.	FASSTT agencies are members of advisory groups, networks, and peak bodies.	Several FASSTT agencies seek external non-PASTT funding to develop special programs or provide additional services and activities for clients.
15. Definition of quality of life	Standard description	*Apply the following definition of quality of life: the subjective well-being of individuals and their communities within their specific social and cultural context in relation to factors such as physical and mental health, family, social and community relations, culture, education, employment, economic security, exposure to physical and psychological violence and freedom, good governance and basic human rights, spiritual life, gender equality and non-discrimination, religious beliefs, legal status and the natural and living environment.*			
	Supporting evidence	FASSTT agencies have explicitly or implicitly embedded the definition of quality of life into their service delivery.		Survivor recovery needs are viewed by FASSTT agencies through multiple conceptual lenses, including the individual's history of torture and other traumatic events, risk and protective factors in the settlement/host country, and cross-cultural factors.	
16. Evaluating improvements in quality of life	Standard description	*Apply evaluation tools appropriate to their specific context. This is done with the recognition that IRCT members provide services in very different contexts, including detention, political repression, uncertain legal status, discrimination and poverty, which may have a severe negative effect on victims' quality of life. Furthermore, each member centre will determine what tools are best used to evaluate improvements in all indicators relevant to addressing the needs and improving the quality of life of the torture victims they support and communicate this to the IRCT membership. In documenting the results of their work, IRCT members are encouraged to take into account how the quality of life of torture victims is connected to the enjoyment of rights, including access to justice, international protection, redress and all five forms of reparation (restitution, compensation, rehabilitation, satisfaction and the right to truth, and guarantees of non-repetition).*			
	Supporting evidence	FASSTT agencies have a client-centred process of developing personal recovery goals with clients and tracking and reviewing progress.	FASSTT agencies use many methods to evaluate improvements, including use of the WHO-5. Agencies administer the WHO-5 in a standard way, at intake or early assessment, at or around session 5, at or around session 10, every 10 sessions thereafter, and at discharge/end of treatment.	Some FASSTT agencies have conducted research to develop more appropriate evaluation tools to use with the PASTT client population. Some FASSTT agencies have used innovations such as the use of computerised platforms that allow assessments to be conducted in the language of the client, minimising constraints regarding interpreter availability and cost.	
	Standard	*Share the results of their support to torture victims with the IRCT membership on an annual basis. This will become part of the IRCT's annual Global Impact Report, which demonstrates to the world our collective impact in the lives of torture victims.*			

17. Documenting our global impact	Supporting evidence	Each FASSTT agency publishes a publicly available annual report for the IRCT. Each agency is involved with the IRCT through meetings and events. FASSTT agency representatives have stood for election to the IRCT EXCOM and Council.

Note. Green: Clear and strong alignment with IRCT standards; Orange: Clear but less strong alignment with IRCT standards

Abbreviations. FASSTT: Forum of Australian Services for Survivors of Torture and Trauma; PASTT: Program of Assistance for Survivors of Torture and Trauma; NSMHS: National Standards for Mental Health Services; IRCT: International Rehabilitation Council Torture Victims; WHO-5: World Health Organisation-Five Well-being Index

7.3 Findings

Finding IP1. PASTT is clearly aligned with key international best practice standards as a specialist service that meets the recovery needs for refugee survivors of torture and trauma.

Finding IP2. Additional opportunities to meet standards identified in international best practice relate to: (1) consistently implementing care for staff (particularly during surges in service demand); (2) better strategic and supported systems advocacy for PASTT services and rehabilitation funding; and (3) improving access to interpreters, particularly in regional and rural areas.

Chapter 8. Findings and conclusion

The previous chapters have identified findings for the key evaluation questions. This includes nine findings for implementation, appropriateness and acceptability of PASTT; eight for regional and rural delivery; seven for outcomes achieved; nine for economic analysis; and two for alignment with best practice. This discussion and concluding chapter consolidates findings as discussed throughout the report, including an additional summary of barriers and enablers to PASTT's effectiveness.

8.1 Findings of the evaluation

8.1.1 Implementation, appropriateness, and acceptability of the PASTT model

Finding A1. Culturally appropriate approaches (e.g., community healing) and needs-based support (e.g., helping with schooling, advocacy, settlement) are equally important for improving clients' well-being as therapeutic approaches (e.g., counselling). Mainstream care was not perceived to be appropriate to meet the complex needs of many PASTT clients.

Finding A2. PASTT demonstrates high levels of appropriateness in meeting client needs and improving access and outcomes for refugee communities.

Finding A3. The three defining features of PASTT's appropriateness are: (1) delivery of a specialised culturally responsive and trauma-informed service model; (2) establishment and maintenance of a connection to community; and (3) flexibility in approach regarding how, when, and which services are accessed and delivered. Any future iteration of PASTT should seek to retain these three key features at its core.

Finding A4. There is a continued need for PASTT to build the skills and capacity of mainstream services to respond to and care for refugee clients appropriately.

Finding A5. Building and sustaining a long-term connection with communities is essential if PASTT is to reduce stigma and contribute to early intervention and prevention work.

Finding A6. The Forum of Australian Services for Survivors of Torture and Trauma (FASSTT) is effectively facilitating the funding allocation and service delivery of PASTT. However, to support sustainability consideration should be given to leadership succession planning and maintaining a successful and timely democratic decision-making process.

Finding A7. The flexibility provided in PASTT contracting agreements is a strength of current governance arrangements as it allows individual FASSTT agencies to maintain autonomy, be innovative, and respond to local needs.

Finding A8. Consideration should be given to reviewing current reporting requirements, performance indicators and evaluation criteria to align with PASTT's underpinning philosophy and adequately capture the range and type of services which may be appropriate to meet clients' needs.

Finding A9. PASTT is client-centred and satisfactorily meeting the needs of its clients for service delivery within its scope. There may be an opportunity for FASSTT agencies to better communicate with clients regarding services that the agency can and cannot provide them at the outset of engagement.

8.1.2 Regional and rural delivery of PASTT

Finding R1. Overall, the findings support a need for PASTT delivery in regional and rural communities, however the service delivery models used in metropolitan areas have not been fully realised in regional settings.

Finding R2. Balancing service demand and organisational capacity is a key challenge for regional and rural PASTT delivery. Capacity to respond is impacted by organisational factors (e.g., resourcing, staffing) and the region's geographical context (e.g. higher cost of service delivery, limited workforce, and lack of third-party providers).

Finding R3. Regional and rural communities are not homogenous so a single model to fund or deliver all regional PASTT services is not appropriate. Rather, it is important to support and encourage the development and delivery of locally relevant models of care.

Finding R4. The non-directive, flexible and adaptable nature of the PASTT program and its funding facilitates each FASSTT agency to work effectively in regional and rural areas using models of care appropriate to the local and state-based context.

Finding R5. The three major strategies used by FASSTT agencies to adapt PASTT delivery for regional and rural areas are: (1) establishing local offices to provide direct service delivery; (2) partnering with local third-party organisations to deliver PASTT services; and (3) using digital solutions.

Finding R6. FASSTT agency staff in regional and rural areas are often required to work beyond the scope of practice required in metropolitan areas (e.g., assisting refugee clients with finding suitable housing or applying for work).

Finding R7. There is a need to dedicate time and funding to training and capacity building of mainstream regional service providers and undertaking regional community development work to enable holistic delivery of PASTT in these communities.

Finding R8. PASTT funding could be better allocated or increased to address some of the current challenges in regional service delivery. However, inherent systematic challenges associated with service delivery in regional and rural Australia are likely to remain. Consequently, it may be pertinent to discuss whether the PASTT model of care needs to be re-engineered for regional services.

8.1.3 Outcomes achieved by PASTT

Finding O1. The available evidence indicates that PASTT is effective in achieving its aim of improving the psychosocial health and wellbeing of people who have experienced torture and trauma prior to their arrival in Australia.

Finding O2. The available evidence indicates that PASTT is effective in assisting refugees engage with Australian society including through employment, education, and social avenues.

Finding O3. The available evidence indicates that PASTT is mostly effective in its engagement with a range of third-party providers to enhance their capacity to support refugees who have experienced torture and trauma. However, to enable greater collaboration and sustainability, it will be important to address issues of trust with third-party providers; improve FASSTT involvement in system-level collaboration; and better communicate information about national and state PASTT funding, scope, and priorities to key external stakeholders.

Finding O4. The ongoing demand for training of third-party providers, and high costs of developing and delivering these services, may warrant increased funding allocation for this service activity.

Finding O5. The available evidence indicates that PASTT provides a safe, comfortable space for community healing and contributes to positive changes in refugee communities. Increased social cohesion, improved confidence and self-agency of groups and individuals, increased trust in the health system, and mental health stigma reduction have been reported.

Finding O6. An important individual and system level outcome of PASTT is the employment of former clients within FASSTT agencies and resulting ability to embed culturally appropriate and lived experience in service delivery.

Finding O7. The broad scope of PASTT activities necessitates an evaluation of impact that encompasses measurement at the client, provider, service, community, and society level using both objective and subjective measures of impact. Given this may present challenges, there needs to be nuance into how the impact of PASTT is measured and acknowledged, particularly where it is linked to achieving ongoing funding.

Finding O8. A more clearly defined national framework for classifying and reporting sector development and community engagement activities (including some pre-defined categories) would support ongoing quality improvement and evaluation activities of the PASTT program.

8.1.4 Economic analysis of PASTT

Finding E1. Recent policy decisions, including reductions in the Humanitarian Program intake and cessation of the Social and Community Services Workers Wage Supplementation scheme, have resulted in significant disruption to core income streams across FASSTT agencies.

Finding E2. The current PASTT funding model and base funding allocation is not fit for purpose due to: (1) a growing pool of humanitarian entrants accessing services over a relatively long period post settlement; (2) an increasing proportion of clients settling in regional and rural areas; (3) increasing costs of service delivery, especially in relation to growing wage-related costs; and (4) the impact of external stressors including international humanitarian crises and COVID-19.

Finding E3. FASSTT agencies report a relatively low rate of indirect costs, reflecting the prioritisation of crisis-driven service delivery above long term planning and infrastructure investment. This may be indicative of financial vulnerability. Investment in national-level infrastructure for supporting services would likely provide a more efficient use of resources than agencies making investments in silos.

Finding E4. Appropriately classifying and funding interpreter services at the national level should be a high priority in future funding allocations.

Finding E5. At least 46% of humanitarian entrants have been enrolled in PASTT individual counselling services in the 10 to 20 years following their settlement.

Finding E6. There is an increasing level of unmet need within the system as evidenced by growing waiting lists.

Finding E7. There is a need for better resourcing of, and long-term investment in, community capacity building and engagement activities within the program, particularly for successful early intervention work.

Finding E8. The categorisation and reporting of agency expenses as they relate to key activities and services is inconsistent across FASSTT agencies. A consistent national framework with clear definitions for reporting expenditure against pre-defined categories would support ongoing quality improvement and evaluation activities.

Finding E9. Any new PASTT funding model should consider the cumulative eligible population, regional and rural service delivery, adequate and competitive staff salaries, longer funding durations, and balancing base and surge/crisis funding.

8.1.5 Alignment of PASTT with international best practice

Finding IP1. PASTT is clearly aligned with key international best practice standards as a specialist service that meets the recovery needs for refugee survivors of torture and trauma.

Finding IP2. Additional opportunities to meet standards identified in international best practice relate to: (1) consistently implementing care for staff (particularly during surges in service demand); (2) better strategic and supported systems advocacy for PASTT services and rehabilitation funding; and (3) improving access to interpreters, particularly in regional and rural areas.

8.2 Barriers and enablers to PASTT

Table 22 presents a summary of the key enablers and challenges to PASTT's implementation and effectiveness which have been identified throughout the evaluation.

Table 22. Summary of enablers and challenges to PASTT

Enablers	Challenges
Client/community level	
Long-standing, well-developed, proactive, and collaborative relationships — Community liaison positions — Advisory boards/panels — Nourishing relationships — Resulting benefits include recruitment within agencies, self-directed referrals into the program — Leads to stigma reduction about mental health and addresses barriers to access	Complexity of work — High risk clients with highly complex needs — Reoccurring trauma — Inability to fully meet the client/community needs (recognised need to expand services to those not fully or at all supported, and waitlists) Clients' experience of lost social and professional status in Australia Time and effort to adapt procedures and programs to very diverse communities Community engagement affected by issues with confidentiality in small, poorly resourced areas
Staff level	
Highly skilled, knowledgeable, experienced, well-trained, accredited, multi-disciplinary and long-term staff who have empathy, respect and dignity for clients Employment of interpreters, bi-cultural workers, former clients with lived experience Strong culture of continuous reflective practice Having systemic approach to care/treatment	Impacts on staff wellbeing (burnout, vicarious trauma) Staff resourcing and retention issues (inability to attract and hire skilled staff; exacerbated in rural and regional areas; effects on sustainability) Demands of continuing professional development Demands of balancing competing tasks that align with core business and engaging with external stakeholders
Organisational level	
Development of efficient and effective triage and intake systems Holistic approach to service delivery Diversification - provision of a range of services in addition to PASTT Strong organisational culture; pride in being a specialised agency	The effects of organisation size and structure — Impact on task division and staff roles and responsibilities — Burden of reporting and administrative tasks — Physical space sharing with other organisations/providers, particularly in rural and regional areas Capacity — Inability to meet demand in a timely manner especially when there is a surge

Comprehensive staff support and professional development systems to protect against vicarious trauma PASTT being the core of the agencies work High standards of accountability– focus on employing skilled staff and attaining/maintaining mental health accreditation Data collection, analysis and reporting informs work, strategic plans, goals/targets Managerial and leadership support Engagement in research activities	— Tension between striving to engage with communities and inability to meet the consequent demand — Not being able to adequately engage in research activities
FASSTT	
FASSTT being a reliable, responsive, and proactive support (for agency-wide issues), and an effective and an efficient channel for knowledge, information, and resource exchange FASSTT as internationally and nationally recognised and highly regarded organisation One national collective voice stronger than eight individual state voices Cumulative experience and knowledge	Agency size perceived as determining the impact of its voice within the network Perception of some agencies that FASST is not equally inclusive for all agencies Sustainability — Inadequate succession planning and its effect on sustainability (threat to the entity should long-standing CEOs leave their agencies at the same time)
PASTT	
PASTT's adaptability and flexibility — Australia-wide but state/territory-based and locally adapted — Individualised, tailored and client-centred approach — Flexible delivery location/format — Broad parameters for access to treatment (no time frames or limits for clients to engage) — Allows soft approach to engage clients (move from other service provision to PASTT when ready) — Allows innovation and creativity in service delivery and interventions provided (e.g., neurofeedback) PASTT stability/longevity — Assists in developing other non-PASTT funded services — Results in gaining external credibility and recognition — Allows engagement in long-term advocacy activities	
Third party providers	
Promotes coordination of care with other services Builds and maintains strong relationships with external providers Provides outreach locations and visibility in other multicultural services	Perceived lack of competency/experience of mainstream providers leads to apprehension to refer clients out Perceived failure of third-party providers to recognise agencies' speciality in torture and trauma rehabilitation — Funds awarded to non-specialist organisations to service refugee clients rather than FASSTT agencies

	— Lack of interest of local health services and departments in engaging with FASSTT agencies Coordination of care often perceived as difficult (communication issues about care management, acceptance of clients referred out by third party providers under the condition that the FASSTT agency will continue provision of care)
COVID-19	
A range of activities offered online Due to individual client preferences, a small number of clients able to continue online sessions	Negative effects on clients (re-traumatisation, isolation, inability to meet face-to-face, lack of privacy for online sessions) Surge in demand for training needs from external stakeholders

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Appendix 1. Interview guide for PASTT stakeholder consultations

Introduction

Hi, my name is [________]. I'm speaking with you today because we are interested in your thoughts about the Program for Survivors of Torture and Trauma (PASTT). The information you provide to us will be used to help evaluate PASTT and to improve how it is administered.

There are no right or wrong answers and any and all information you can provide will be helpful. We won't criticise you or your opinions. Don't worry if you feel you cannot respond to some questions. It is fine to let me know you are unsure or do not know.

We will record the conversation with you if that is OK and will only share your conversation with other members of the research team or by making sure other people cannot identify your responses. We take your privacy and confidentiality seriously. I am/We are in a private room with the door closed and there are no other people present. We don't need you to use any specific details like names in response to our questions. We want to let you know that we intend that the results of the interviews will be published but we will do so in a way that does not identify you, so for example if you do use names, we'll remove those before any publications are made.

We really appreciate your time and willingness to speak with us. Do you have any questions before we get started?

<u>Section 1: Understanding implementation, barriers, and facilitators (ask these questions to all stakeholders)</u>

1. To start I was hoping you could tell me a bit about your role here at [ ] as it relates to PASTT?
2. Can you describe your experience implementing the PASTT activities/delivering services?
    a. What works well in current implementation/service delivery? (Probes: What do you mean by…? Can you tell me how…? Can you give me an example of…? How does this impact…?)
    b. What are the challenges to current implementation/service delivery? (Probes: What do you mean by…? Can you tell me how…? Can you give me an example of…? How does this impact…?)
    c. What might be some suggestions for how to overcome these challenges?

<u>Section 2: Implementation, context, and outcomes (ask questions which have not been addressed by answers in Section 1 – the key questions for all stakeholders are highlighted red)</u>

PASTT Intervention – Organisational Perspective

Ensure answer captures staff's perspectives on the evidence base for the intervention, potential barriers to frontline staff and the usefulness/adaptability of PASTT to the local context

3. Can you describe any ways you've had to adapt PASTT activities or processes to fit your local context? (Probes: what were the reasons for these adaptions? How easy was this adaptation?)

4. On a scale of 1-10 with 10 being the highest value, how adaptable is PASTT to local context?... Why did you give it that rating?

PASTT Intervention – Client Perspective/Outcomes

Ensure answer captures staff perspectives on if PASTT addresses client barriers, is client-centred/offers choice, easy to access, minimal burden, easy transitions between services/elements. Stories of care transitions for clients that may be affected by PASTT

5. Can you talk me through the process a client might go through to access and engage with PASTT? (prompts: so what happens next? what about any care transitions/referrals? exit out of service?)
6. Tell me about your most memorable client experience related to PASTT
7. How do you think PASST services address client barriers to care?
8. On a scale of 1-10 with 10 being the highest value, how would you rate the client-centredness of PASTT?... Why did you give it that rating?
9. In your opinion, what is the impact of PASTT on clients? (prompts: consider positive and negative impacts – early intervention, access to supports, well-being). Follow-up question: Why is your service in particular important in achieving these outcomes?
10. In your opinion, what is the impact of PASTT on communities? (prompts: consider positive and negative impacts). Follow-up question: Why is PASTT in particular important in achieving these outcomes?

PASTT Recipients – Organisational Characteristics

Ensure answer captures staff perspectives on organisational climate/culture, management/leadership/clinical support, communication, goals/vison, data, staffing, support systems/training, sustainability planning

11. In your experience, how does organisational culture and climate impact service delivery?
12. In your opinion, is PASTT an important priority for [your organisation]?... What makes you say that?
13. How does implementation of PASTT align with other organisational goals? What are the processes for monitoring achieving of these goals?
14. How much support do you think PASTT has from key managers, operational leaders, clinical and community partners?
15. What processes or procedures are in place related to the hiring, review, and retention of staff which impact service delivery?
16. Do you think [your organisation] expects PASTT to be sustainable? …Why do you say that?

PASTT Recipients – Client Characteristics

Ensure answer captures client demographics, health, beliefs etc that may impact on care.

17. Are their particular demographics or characteristics of clients and communities that influence the success of service delivery?

18. What strategies do you think worked best to recruit/engage with clients?

External context

Ensure answer captures current policy environment, competing services, community services/resources leveraged that can impact implementation and sustainability of PASTT

19. What are the state and federal socio-political contexts that influence implementation and service delivery?
20. What do you believe are the key drivers of service demand?
21. How adequate is the current level of PASTT funding in meeting the needs of clients?
22. Can you describe your relationship with services partners and stakeholders beyond the core PASTT program? (prompts: communication, collaboration, resource sharing, rural locations)

Section 3: Resourcing context and sustainability (ask all questions)

Implementation and sustainability infrastructure

Ensure answer captures current processes, resources, strategies and plans for implementation and sustainability of PASTT

23. Can you identify any areas of duplication – either internal or external - in the types of services and functions provided by PASTT?
24. On a scale of 1-10 with 10 being the highest value, how efficiently do you believe resources have been used by PASTT providers? …Can you tell me a bit more about that? *(Probe: Have you leveraged existing resources? Where could you gain more efficiency?)*
25. What infrastructure and resources will be needed to sustain PASTT?
26. Do you believe that implementation and sustainability are well planned for by [your organisation]…at the national level?
27. Are there modifications or adaptations that will need to be made to sustain your services over time (prompts: lower cost, different staff, reduced intensity, different settings)?

Closing questions

28. Can you suggest any ways in which the current governance or funding structure of PASTT could be improved?
29. Can you suggest any ways in which the overall PASTT service delivery model could be improved?
30. What could be the most valuable service PASST can provide in the future?
31. Do you have any questions for me?

[end of interview]

Appendix 2. Interview guide for PASTT client interviews

Introduction
Hi, my name is [________]. I'm speaking with you today because we are interested in your thoughts about the Program for Survivors of Torture and Trauma (PASTT). The information you provide to us will be used to help evaluate PASTT and to improve how it is administered.

There are no right or wrong answers and any and all information you can provide will be helpful. Don't worry if you feel you cannot respond to some questions. It is fine to let me know you are unsure or do not know.

We will record the conversation with you if that is OK and will only share your conversation with other members of the research team or by making sure other people cannot identify your responses. We take your privacy and confidentiality seriously. I am/We are in a private room with the door closed and there are no other people present. We don't need you to use any specific details like names in response to our questions. We want to let you know that we intend that the results of the interviews will be published but we will do so in a way that does not identify you, so for example if you do use names, we'll remove those before any publications are made. So, please remember to keep the discussions we have today private. Please do not share anything that is talked about today with anyone who is not present in the interview.

We really appreciate your time and willingness to speak with us. Do you have any questions before we get started?

Finally, before we start I'd just like to reconfirm that you consent to participate, and remind you that you can choose to withdraw your participation at any time. Are you happy to begin the interview?

PASST *Client Perspective.*
Ensure answer captures client perspectives on if PASTT addresses client barriers, is client-centred/offers choice, easy to access, minimal burden, easy transitions between services/elements.

- To start, could you tell me a little bit about how you became involved with the program/[insert local agency]? *(prompts: how long ago, what types of services accessed, how hear about/referred? Was it hard to access?)*

- How did you feel about the support/care/services you received from the program/[insert local agency]? *(prompts: satisfaction)*

- What did you like about the support/care/services you received through the program/[insert local agency]? *(prompts: access, tailored to them, culturally appropriate, holistic, right time, cost etc)*

- What things didn't you like about the program/ [insert local agency]? *(prompts: access, cost, barriers etc)*

- What would you have done/what would have happened if the program/[insert local agency] wasn't there?
- Do you think the program/[insert local agency] is better at meeting your support needs than other services available? Why/why not? *(prompt: accessibility, availability, timeliness, appropriateness, and type of care/support delivered)*

<Reconfirm that the participant is happy to continue participating>

PASST *Client Impact.*
Ensure answer captures client perspectives on PASST impact in terms of implementation, service, community, and client outcomes.

- Tell me about the impact that the program/[insert local agency] has had on you personally *(prompts: health, quality of life, family, connections, work, social, referrals to other services)*

Think about your **access and use of all health and community services[3]**. For example, having access to services that meet your needs when you need them like housing, finance, family, legal and health services.

- How has your access and use of these services changed since coming to the program/[agency]?
- How much do you think the program/[agency] had an impact on that change? *(prompt: not at all, a little, a lot)*

Think about your **emotional health and well-being[3]**. For example, getting mental health treatments, dealing with trauma and stress, engaging in recovery, developing communication, connection to culture and being satisfied with life overall.

- How has your emotional health and well-being changed since coming to the program/[agency]?
- How much do you think the program/[agency] had an impact on that change? *(prompt: not at all, a little, a lot)*
- Can you think of anything in your community that has changed because of the program/[insert local agency]? *(prompts: social connections, participation in events, advocacy, voices heard, services, training, family connections[3])*

PASST *Client Opportunities.*

- Can you suggest any ways in which the program/[local agency] could be improved? *(prompt: new models of care/services, access, funding, scope)*
- Do you have any questions for me?

Thank you for participating in the interview today. Please feel free to get in contact with the research team if you have any questions.

Appendix 3. PASTT client interviews: case studies

Client Case Study: C2

C2 arrived from Afghanistan in 2010 and commenced attending a local state high school. Studying in Australia was challenging, which was exacerbated by the combination of using a foreign language (which C2 was not proficient in at the time) and being surrounded by often unkind teenagers who mocked C2 for not being able to express himself very well. This was recognised by the C2's family friend who recommended going to a homework club run by one of the FASSTT agencies. Access was easy and the C2 found themselves spending most afternoons at the agency. The client recalled looking forward to the afternoons at the homework club because "*it was such a welcoming, lovely place, where you just felt like you belong, and that people respected you and you felt welcomed, and people always cared about you".*

The client formed close relationships with peers and counsellors responsible for the homework club. Although this was the only PASTT service ever accessed, C2 recalled that each time a counsellor visited the school they would check in with him about all aspects of life, not just education. The same approach and care were provided at the homework club, where children were provided with assistance with their studies but also engaged in conversations about other life aspects.

C2 accessed the local state school's services for children from non-English speaking backgrounds, but these were recognised as insufficient in meeting C2's needs. The client felt that the school staff were not sufficiently prepared to assist people from refugee backgrounds. They could not relate to the C2, did not understand the complexity of needs and circumstances he came from, and lacked empathy. This contrasted with how C2 felt about the support received from the agency, where he was always treated in a dignified manner, felt supported, heard, understood, safe, and welcomed. C2 stated: "*I'm just glad that I found [the agency]".*

Attending the homework club provided C2 with an opportunity to communicate with peers and counsellors without being judged or bullied, and resulted in great improvements in English. Further, C2's connection with the agency made him realise that to improve future life prospects he would need to change schools. This was discussed with the homework counsellor who advocated on the C2's behalf and secured a scholarship to attend one of the top high schools in the state. This led to the client being able to study at a university, and now progress a professional career and enjoy a good standard of living. This successful outcome was largely attributed by the client to engagement with the agency: *"If I had not received assistance from [the agency] it would have been a very different story".*

C2 also commented on the impact of the homework club on peers and overall agency work on people from refugee backgrounds. The assistance provided to children was seen as something that *"just gives them that extra edge – with their self-confidence, with their ability, that they can pursue their studies".* The client was very passionate about the impacts on others who attended the homework club by saying: "*There is so much potential in humans and you don't realise that potential until you are afforded the opportunity, or you are told that you can, or, you are encouraged that you have that potential. And I have seen from personal experience, people that I would go with [to the homework club], like peers and other people that would come at the time to receive support. They would go to uni and were smashing it, getting jobs…that's what we want to see, people to be educated, law obeying citizens, paying their taxes."*

C2 had an overwhelming sense of appreciation for the agency and its work, and pride to be a part of it. The client has continued a close relationship with the agency. C2 is an active and passionate advocate who has been volunteering in delivering youth activities and worked for the agency. He feels closely connected to the agency and stated that “*[the agency] has been a major part of my life and will be for the rest of my life”.*

Client Case Study: C3

C3 arrived in Australia in early 2000s but did not feel the need to use the PASTT services until almost 20 years later. The client developed a professional career, and has worked in a range of organisations where they were made aware of PASTT and the FASSTT agency delivering the program. As an active community leader, C3 supports community members and has referred some clients to PASTT. While at times C3 thought that may need some support, due to feeling burnt out from busy work and personal life, they did not think the program accepted people who arrived in Australia more than 5 years previously. There were also times when C3 wondered if they were perhaps suffering from depression, should be hospitalized, or start taking medication for mental health, but ultimately thought that *“As a [community] leader I thought I was so strong, that I wouldn’t need the support, I thought was I good”.*

An event at work triggered flashbacks related to pre-arrival experiences for C3 and a colleague convinced them to seek assistance from PASTT. C3 was hesitant but decided to try PASTT counselling services. The client said: “*At times I get emotional about things, you know, so I thought, it’s time for me to see what this is all about”.* An initial appointment was made by the client’s colleague however C3 did not feel comfortable with the first counsellor and asked to change, which happened promptly and with no difficulties. The second counsellor was thought of as *“the best; it was more like informal, (…) without even much introduction I found that I was sharing a lot more information than I could! So, the experience was really good for me. I learnt a lot of things about myself I didn’t know”.*

During the counselling sessions, C3 was able to share all aspects of life pre- and post-arrival to Australia, gained a deeper understanding of self, and managed to make changes in their personal and professional life to find a better balance and time for self-care which was largely missing before. The program’s features of being flexible, client-centred, tailored, and culturally appropriate were much appreciated by the client. C3 was grateful for the approach applied by the PASTT counsellor who made them feel safe and provided an opportunity to share sensitive information. When reflecting on how useful counselling was the C3 said “*It was helpful. I had no idea it would be helpful, and I think I as a little bit sarcastic about it, you know, because of myths and misinformation about it…counselling and many other things”.*

C3 listed a number of positive outcomes due to counselling, for example, *“it helped me with managing my anger, and building relationship with my boys, (…) setting boundaries, and communication with family, talking about feelings what we have never done before. (…) It really helped me with getting in-tune and in-touch, through that I learnt a lot about myself (…). People used to tell me I was resilient and strong, things I didn’t understand, I didn’t get the meaning of those words until then, and now I think, actually I am. (…) It helped to be an effective leader, a good parent and someone for myself. (…) I am confident but the program helped me find my inner self”.* C3 felt that the timing of accessing PASTT counselling, prior to the start of COVID-19 pandemic, was very fitting. Counselling empowered the client not only to manage their own family’s feelings and response to the pandemic but also to effectively support their community.

C3 did not seek mental health services from the mainstream health providers but reflected on a friend’s experience and knowledge from being a community leader. The mainstream health services were thought as often inappropriate, due to lack of interpreters or asking inappropriate questions, and difficult to access at the time of need due to waitlists or having to make an appointment far in advance.

C3 did not offer any suggestions for how to improve individual counselling sessions however a recommendation was made to increase awareness about the PASTT program in diverse communities. The client felt that this was especially needed in those who arrived when PASTT and the agency were not well-known in the community. A recommendation was also made to provide education and training for communities so that they can better support its members, especially those who may be reluctant to access counselling or unaware of this service and its benefits.

Client Case Study: C4

C4 arrived in Australia in 2018 and has been involved with the agency from the beginning. Pre-arrival experiences resulted in C4 feeling extremely stressed and having ongoing nightmares. This, together with the client's high blood pressure, led to feeling as if they were going to die. Through engagement with the agency C4 started to feel better – calmer and less homesick. C4 commented that the agency "*showed love and commitment"* and "*comforted and calmed"* them down. C4 appreciated that the agency "*was not offended"* by the way they was feeling or behaving. The support provided was beyond helping them with deal with post-traumatic stress disorder, and included assistance with getting child support, food and "*everything*". If the agency had not helped at the time of need C4 "*would have died*".

Organising child support was very stressful for C4. Prior to arrival, C4 thought that they would be provided with child support as they had no family or other support in Australia. However, this proved to be difficult to organise. The first staff member (from the agency) who assisted with organising child support was thought to add to this stress by "*adding confusion to the family"*" hence the client's case was later managed by another person. The second staff member was highly spoken of, and the client felt that their work "*helped family a lot".*

C4 would like the agency's work to be recognised by others because it *"makes refugee communities feel good. It makes a person come back from their stress and anxiety to be great people and do great things in society".* The client appreciated the agency's work with them and within the community. Now, the client feels strong in their family and community, and realises that they can do things for themself without relying on others. Most of all, C4 feels calm and supported by other community members who they are now supporting with what was taught by the agency.

Client Case Study: C5

C5 has been seeing a PASTT counsellor for many years. Post-arrival, the agency 'checked in' with the family and referred the client for counselling. C5 recalled being told that they need help with their mental health due to "*suffering*". The agency provided interpreting services for each session which was appreciated by the client due to their inability to communicate in English. The services were thought of as very helpful. Prior to commencing counselling sessions, the client was frequently hitting their children, reported that they "*did not care what was happening"* and thought of committing suicide. Now, it all has stopped and their mental health and wellbeing has improved so that they now "*feel really well"*.

The flexibility and easy access to counsellors was greatly appreciated by the client. C5 can call or text the counsellor at any time and receives a response. Recently, C5 lost a family member which was greatly upsetting. They did not want to show emotions in front of their children and reached out to the counsellor for support. It was possible to see the counsellor the same day, which provided an opportunity for the client to open up, cry and share personal feelings in a private situation away from the family. This made the client feel much better. C5 also reported being encouraged by the counsellor to start doing more things for themselves, for example, to start attending English classes, and to become more independent.

Client Case Study: C6

C6 started using counselling services about a year ago after hearing about the agency and their services from a community member in their church. At the time, the client was only able to engage in phone counselling due to COVID-19 lockdowns and restrictions. This made C6 feel very comfortable and, following one face-to-face session, they decided to continue with phone rather than in-person appointments. It was easy and convenient to access the agency's services and the intake process, which the client thought was really useful. Specifically, the intake process led to C6 being matched with a great counsellor of the same gender, who was not a part of their community and, which the client felt was very appropriate and comfortable with. The client appreciated that the agency took the lead in organising the appointments, which were promptly and efficiently booked.

C6 enjoyed and appreciated how the counselling sessions were run. Often, the client just wanted to "*rant*", to share their own feelings and experiences which was possible to do. C6 emphasised that the counsellor did not give out lots of information or offer unwanted advice but was able to "*read the room"* and instead listened to what they wanted and needed from each session. This was expressed by C6 as: "*sometimes I just wanted to be heard*", which was what they got out of each session. C6 reported that counselling has been very beneficial and they are feeling *"lighter*" after each session. If counselling was not sought, C6 was certain there would be a feeling of being lost, not being in a good position and being caught in the same loop of thoughts.

The counsellor always encouraged C6 to call or text if they needed to talk. However, at times the client was unable to talk about the issue/s experienced straight away. C6 had to either wait a few days for an available appointment with the regular/ongoing counsellor, or speak to whichever counsellor was available at the time. While C6 understood that there are some limitations with accessing their regular counsellor (e.g., scheduled work hours, other appointments already booked) it was considered inconvenient to wait to discuss pressing issues or to have to "*re-tell"* their story to another counsellor. The client preferred to speak to the regular counsellor and waited for an available time. However, at times, the burning issue that needed to be discussed had sometimes "*gone away"* before the next session.

While C6 thought mainstream services could had been potentially used for counselling, at the time they needed counselling using the agency's services was really convenient. At the time, C6 "*did not think clearly"* and thought that a lot of research would be needed on their part to access mainstream services. They expressed that being left to do their own research on counselling services and then approaching them would have resulted in overthinking the entire process, which could have led to a lack of engagement.

C6 has not yet accessed other services offered by the agency due to "*still processing what has happened"* in the past. However, the agency assisted with a really stressful situation on the client's behalf which was greatly appreciated. C6 has recommended the agency's services to friends within the community. While they have currently decreased the frequency of counselling sessions, C6 appreciated the ability to schedule more sessions if needed, and stated that "*it feels reassuring to know that even if I stuff up I still have someone there*".

Client Case Study: C7

C7 has been involved with the agency for about 18 months. They were initially referred to the agency by a settlement service post-arrival and found communication with the agency positive, and that it was easy to access and navigate. Counselling was the main service used, but they also received assistance with a stomach problem.

C7 found the counselling very beneficial and developed a trusting relationship with their counsellor. In each counselling session, C7 feels there is an opportunity to open up and tell "*secrets". As a result of counselling, C7 increased their self-belief and became more positive, even though "*life is not easy*" and being "*alone is not easy*". The counsellor was reportedly very encouraging (e.g., to practice English), easy to talk to, and someone who provided great advice, resulting in the client feeling very satisfied with the counselling services. The counselling sessions were thought of as very comfortable with no judgement of the client and their personal experiences.

As a result of being engaged in counselling sessions, C7 commenced studying early childhood education and completed work experience in this field. The counsellor assisted the client in obtaining employment in early childhood which is due to begin in the upcoming months once the course is finished. C7 has not been involved in other services or activities offered by the agency as up until now they have been focused on studying. However, the client is aware of group programs and activities that are available.

Overall, being involved with the agency positively changed the client. Before having counselling, C7 felt they were "*not useful for myself or my community*" but now feels more positive. Due to complex personal pre-arrival experiences, the client believes there is a lot more work to be done and many other issues to work through. Hence, C7 will continue engagement with the agency to work through these pre-arrival experiences.

Appendix 4. FASSTT agency case studies

Just a small selection of available case studies have been used in this report. Many other case studies are available from AusHSI and the FASSTT agencies to support the findings of this evaluation.

Case study of "P"

Penny* (named changed for confidentiality) arrived in Australia in mid-2021 due to persecution in her home country due to her gender identity. Penny had experienced significant trauma including sexual violence and the murder of a family member. Penny fled to a transition country where she faced harassment and had to live clandestinely to avoid danger.

Soon after her arrival in Australia Penny was referred to STTARS for counselling support due to wanting to manage her trauma symptoms including hypervigilance, panic attacks and a low mood. Penny's mental health declined further when she started to receive physical and verbal threats from a house mate in her share accommodation which re-triggered her past trauma and led to Penny feeling so unsafe at home that she started to sleep on a local beach rather than return home at night.

The first goal in supporting Penny's recovery was to respond to the immediate crisis and risk issues.

- Being a transgender woman made it very difficult for Penny to access the emergency accommodation shelters. STTARS accessed emergency relief funds to secure safe accommodation for one night for Penny while engaging in a significant amount of trauma informed advocacy with other services to enable Penny to access short term emergency accommodation where she could be reasonably safe.
- While in emergency accommodation Penny's mental distress increased and she frequently spoke of strong thoughts to end her life. During this time, Penny frequently called or dropped into STTARS office in a high level of distress. Immediate support was provided to de-escalate distress, develop safety plans and create links with state based mental health crisis services.

Restoring Safety and Rebuilding Trust

- Initially, Penny met at least weekly with a regular counsellor who supported Penny to explore coping strategies she had used in the past and increase her emotional safety through developing new coping strategies. Despite the precariousness of Penny's situation, a robust and trusting therapeutic relationship was established.
- In addition to counselling, a high level of advocacy was needed to ensure that Penny was provided with safe and appropriate accommodation which included case conferences with many other services, support letters, safety plans, multiple phone calls to stakeholders including housing providers and settlement agencies.
- Penny often required additional telephone support as she became overwhelmed at all the information that was provided to her and needed a safe space to unpack information so she could understand it better. This was particularly an issue when other services did not use interpreters.

Enhancing Agency and Control

- After 3 months of advocacy Penny was able to source safe and stable housing. Having access to a safe and predictable environment made a considerable difference in Penny's ability to engage in her recovery processes and her counsellor noticed significant improvement in Penny's mental health. Penny has commented that now she feels like 'I can get on with my life'.
- Penny was able to look for employment and has attend a number of job interviews.
- Penny has also enrolled in a TAFE SA certificate to improve her employment opportunities and has taken steps to obtain her driving license.

Processing Trauma

- Now that Penny has achieved a ‘safe enough’ environment she is able to start to processes some of her historical trauma through fortnightly counselling sessions. This allows her to tell her story, to remember, to mourn and to rebuild her life.

Counselling currently includes:

- Acknowledgement of past traumatic events and daily stressors and how these may be linked
- Normalising and validating reactions to traumatic events
- Processing traumatic memories
- Reducing guilt and self-blame
- Building skills to increase Penny’s skills in tolerating distress and regulating her affect
- Restoring her sense of dignity and purpose, and
- Exploring options to extend Penny’s social networks

Penny has demonstrated a growth in confidence and self-agency and the level of support needed has decreased. Penny is a brave, strong, and insightful survivor who gained deep insight during her therapeutic journey. A statement from February 2022 indicates Penny’s development of self-compassion and confidence:

> *“I used to blame myself and put myself down, now I look at a situation and fight for myself'*

Case study of “F”

Fatima* (named changed for confidentiality) contacted Foundation House in the days after the Taliban takeover distressed and worried asking for help to get her husband out of Afghanistan. Due to her high level of psychological distress, she was engaged immediately. The initial assessment revealed Fatima fled from Afghanistan into Pakistan as a young person. Her family applied for humanitarian protection and was granted a visa to come to Australia in 2016, when Fatima was 17 years old. Fatima married another Afghan refugee in 2019, and in early 2020 her husband returned to Afghanistan to attend support his terminally ill mother, then was unable to leave due to the Pandemic.

In her first session, Fatima talked about her worry for her husband’s safety as a member of the Hazara minority. She also felt the pressure of trying to get other extended family members to Australia.

Fatima talked about how the images of Taliban overtaking Kabul triggered memories from her childhood in Afghanistan and experiences in Pakistan. Fatima disclosed that she witnessed public executions of women in Afghanistan when she was a child and remembered the fear she felt whenever she saw a member of the Taliban. The images of the bomb explosion at Kabul airport also brought back memories of an explosion at a bazaar in Pakistan that she witnessed, which injured her younger brother. Fatima stated that she was experiencing increased nightmares and flashbacks to those memories as well as heart racing, shortness of breath and dizzy spells whenever she thought about her husband’s situation. Fatima also reported that she felt isolated and overwhelmed by the demands of looking after her 18-month-old son who was born just before her husband left Australia.

Fatima was invited to a Foundation House crisis information session during which she received information about ways to help her husband access supports to leave Afghanistan. The counsellor also linked Fatima to Refugee Legal for legal advice and support with regards to visa applications for her extended family.

Her counsellor provided psychoeducation and taught Fatima emotional regulation strategies (such as breathing and mindfulness exercises) in their counselling sessions. Fatima learned how to manage her anxiety and the importance of limiting her exposure to news and distressing media content. The counsellor also provided a space for Fatima to talk about and process some of the traumatic memories triggered by these events and linked Fatima to a community-based playgroup for parenting support and to break the social isolation.

Fatima's mental health improved over the course of the counselling sessions. She was able to manage her anxiety which helped her to be more available to her son and support her husband while he was trying to get out of Afghanistan. He eventually managed to cross the border into Iran from where he was able to board a flight to Australia. Fatima submitted visa applications for her extended family members. She made friendships and connections with other young mums through the playgroup. She reported feeling connected and not isolated any more. In her final session, Fatima stated that she felt more in control of her life again and had strategies and tools in place to better tolerate the traumatic memories from her past, manage family duties and parenting her young child. She also reported feeling energised by playgroup, her and her child enjoying being connected to other children and mums.

Case study of "B"

'B' is a 41-year-old man who is a survivor of torture and trauma. He is married with two children and arrived in Australia in 2006. His wife and children joined him a year later, after several years of separation.

B was transitioning well into life in Australia for a number of years. After watching a TV program about war in his country he experienced sudden re-traumatisation and extreme PTSD symptoms. He was referred to ASeTTS for torture and trauma counselling by his General Practitioner in 2007, shortly after being re-traumatised.

During intake and assessment B recalled his experiences of torture and trauma as a prisoner of war. B was tortured on a daily basis for a period of 6-months by prison guards and civil officers. He was continually interrogated, and forcibly coerced to provide the military with information and evidence. His physical torture included being severely beaten which resulted in serious injuries. B was also forced to strip naked, then beaten, urinated on or hosed down and left outside on winter nights were the temperature was as low as -15 degrees. In the morning after exposure to the cold he was again seriously beaten. B was during the 6-months frequently deprived of food and water, basic hygiene facilities, and medical treatment.

At the time of referral to ASeTTS B was experiencing disordered sleeping, nightmares, an array of psychosomatic complaints, anxiety, irritability, and anger and aggression which was manifesting as family and domestic violence. B had separated from his family as a result of his actions towards his wife and children.

Over the first 4-months of ASeTTS' services a comprehensive torture and trauma counselling plan was developed; this included individual, couple and family counselling supports. This included services delivered from ASeTTS offices and outreach services. B also underwent Psychiatric assessment with ASeTTS' Consultant Psychiatrist; who them provided regular psychiatric support and supervision.

After 2-years B's psychological distress and PTSD symptoms significantly reduced, his physical health had improved, his family relationships were much improved, and family and domestic violence behaviours had ceased. B was still experiencing war and torture related nightmares; however, the severity and frequency had reduced.

While the frequency of B's sessions with ASeTTS decreased over time, he accessed services for an extended period in order to reduce his sleep difficulties and continued to improve family functioning.

Case study of collaborating with community leaders during the COVID-19 pandemic (prepared by QPASTT)

Case Study Nine – Collaborating with community leaders during the COVID-19 pandemic

Shouldering up resilience of communities through justice and healing

"THE ROLE OF COMMUNITY ORGANISATIONS THAT COMMUNITIES TRUST AND HAVE CLOSE RELATIONSHIPS, IS CRUCIAL IN RESPONDING TO DISASTERS OR EMERGENCIES, IN WHICH COMMUNITY MEMBERS CAN POTENTIALLY EXPERIENCE PSYCHOLOGICAL AND MENTAL STRESS"

Context

The impacts of COVID-19 on mental health in Australia has been significant. The impact has been additionally complex for individuals, families and communities from refugee and migrant background due to a variety of factors including language and cultural barriers, low levels of mental health literacy and high levels of stigma, experiences of pre-arrival trauma, factors including racism and lack of access and equity to existing mental health services.

Resilience is defined as the process of adapting well in the face of stress, adversity, trauma, tragedy, and threats[11]. Faith and community leaders play a vital role in building community resilience to reduce the COVID-19 related equity and mental health impacts. Resilient communities are socially connected, have accessible health systems that can withstand disaster, and can foster community recovery. Due to the rapid global spread, highly infectious nature of the virus, risk of population fatalities and rapidly changing public health messaging and actions – it was anticipated the refugee background communities would be at risk. Unfortunately this risk was realised with Australian government releasing data in February 2022 that indicated that people from Culturally and Linguistically Diverse

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[11] American Psychological Association (2012) Building Your Resilience. https://www.apa.org/topics/resilience Accessed 2 March 2020.

(CALD) backgrounds disproportionately dying of COVID-19[12]. While it is indisputable that lessons must be learnt to improve health equity in Australia, these figures could have been much worse if community leaders, supported by trusted services, had not acted.

What happened

In March 2020, QPASTT joined with Multicultural Australia (MA) through the pre-existing collaborations with CALD faith and community leaders to call an initial meeting to assess needs of community members. A task force (COVID-19 Working Group) was then created as a collective response to challenges facing CALD communities, particularly communication of public health messages from Queensland Health. It was anticipated that if community members do not understand what is going on, panic could arise. Without opportunity to be consulted or able to participate in key decisions during such significant events as the COVID 19 pandemic, community members were likely to feel ignored and unworthy of consideration. If anger, exclusion, hopelessness or withdrawal resulted, this would undermine the effectiveness public health strategies, and the current and future resilience of communities. In addition, during the initial meeting concerns were raised about the broader impacts of COVID-19 on young people, families, economic wellbeing and mental health of members of refugee communities. The COVID-19 Working Group identified 6 sub-working groups to lead on key areas of collaboration, as depicted in the figure below.

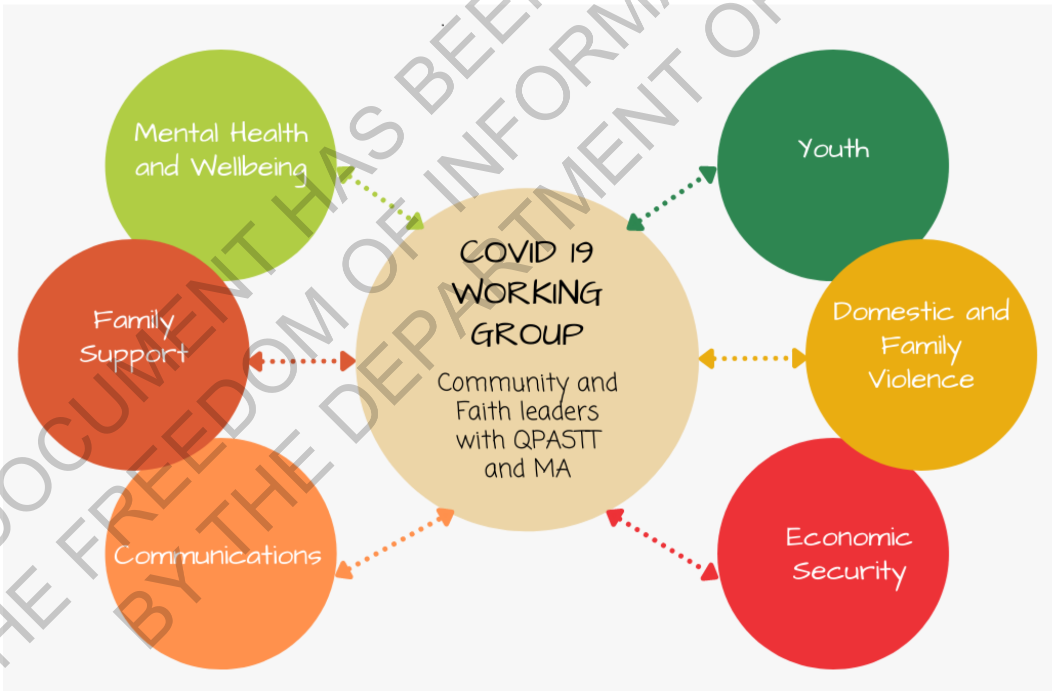

Figure One: COVID-19 Working Group with sub-working group.

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[12] https://www.abc.net.au/news/2022-02-17/abs-data-cald-communities-worse-affected-by-covid-outbreaks/100834104

What we did and why we did it

Recognising that there were 6 sub working groups within the COVID-19 Working Group, the remainder of the case study will focus on three priorities areas of QPASTT's engagement: Communications, Family Support, and Mental Health and Wellbeing.

Communication

Why: Queensland Health provided information in commonly spoken languages, however these are not the languages predominantly used by communities from refugee backgrounds. Given the complexity of the situation, the continuous spread of unhelpful information related to the virus, and the initial politicisation of the virus in the international community; obtaining clear understandable, written and verbal information in languages that our communities use was crucial.

What: The Working Group engaged in high level advocacy for the rapid production of easily comprehendible, written and verbal information in languages prioritised by refugee communities. This led to a prioritised scaling up of multi-media resources (print, radio, online etc). It also contributed to change in communication approach by Queensland Health to have visually informative and easy to read guides for topics such as public health requirements and border restriction stages.

How: The Working Group were instrumental in the creation of fact sheets in language around home school learning; increasing Queensland Government's understanding of the need for plain English fact sheets, alerts and advice; and building the capacity in community for translation work in diverse languages and dialects.

Crucially, the Working Group hosted forums with experts including the Chief Health Officer, Queensland Health officials, and Services Australia representatives for community members to hear firsthand from decision makers about COVID 19 measures and to clarify urgent queries. One of the meetings with the Chief Health Officer was organised to directly respond to a stressful rise in public racial profiling of people from refugee background. This meeting offered a particularly important occasion for community members to feel valued by health officials. The Working Group was recognised for their efforts for the community to receive timely updates of COVID-19 restrictions, lockdowns and public health alerts that were both translated and in plain English.

Family Support

Why: Home schooling become an issue to many families, with parents finding expectations particularly challenging and they didn't have sufficient resources to support their children's learning.

What: Obtaining sufficient devices and data for school aged children was essential to engage in remote learning. This included skilling up parents and caregivers on technology, and supervision of online safety and security for the children and young people in their care.

How: A massive coordination effort was arranged between community leaders, services and funders to get resources to people quickly. This was supplemented by innovations in the QPASTT Homework Club to transition from a face to face activity to an online activity whereby young people were connected by video-conference or telephone to a tutor who could provide one to one support. Additionally, QPASTT youth workers and counsellors provided therapeutic packs of activities and resources to children, young people and their parents to further reduce sense of isolation and to increase emotional regulation skills at this highly distressing time.

Mental Health

Why: The mental health of community members was highly impacted, and the leaders' mental health capacity to support was also stretched. Community leaders identified that they were providing much of the mental health responses in their own communities and requested specialist information and support in being able to better do so, as well as referral pathways for additional support. Evidence (research and anecdotal) confirms that community leaders play a key role in supporting the mental health literacy and resilience of their communities, as they are trusted sources of information who intrinsically understand the community cultural needs and preferences. Community leaders are also frequently the bridge between their community and mainstream culture framework and services access.

What: QPASTT initiated a grass roots mental health literacy project to support existing, natural and emerging leaders host conversations about wellbeing in their communities. This project was named the Community Healing to Thrive.

How: This interactive project sought to elicit community members existing knowledge of and responses to mental health issues within their communities. By embedding understanding of mental health in community members shared wisdom, experience and networks, mental health literacy and resilience strategies were situated in existing cultural frameworks and structures. QPASTT facilitators physically went to communities – the spaces and places that are culturally safe and "owned" by community such as halls and mosques - on invitation. After initiating discussion, that where possible was led by a QPASTT worker who has able to share their own cultural experience of navigating mental health concepts and systems, the intervention would then follow the community members own interests rather than a scripted model of intervention.

The Community Healing to Thrive project spread through word of mouth, after initial promotion to leaders and representative networks. The project is intentionally a brief intervention for a time limited period, with encouragement for community leaders be increase their confidence and skills to respond to the mental and emotional needs of their community. It is believed that by shouldering up leaders, this ongoing community mental health support can be done in a sustainable, and culturally relevant way. In this project QPASTT is not an expert, community members are clearly situated as the expert of their own experience, and service- dependency is intentionally avoided. The figure below depicts the Community Healing to Thrive framework.

Figure Two: Community Healing to Thrive Practice Framework

To return to the overall topic of the case study, the intention to maintain six functioning sub-working groups within the wider COVID-19 Working Group was ambitious. With great commitment and effort it was sustained for a year. During this time, policy makers and government representatives engaged with could see firsthand the importance of the work of the community leaders and the amount of time that this takes from them. After the first year of frequent, time demanding work, other services began to join this collaboration and the intensity of work was able to reduce. Leaders provided feedback that the intensity of this period of time left a toll and pointed to the need for capacity building support and resourcing.

> " DESPITE THEIR EAGERNESS AND PASSION FOR SERVING THEIR RESPECTIVE COMMUNITIES, THERE IS A LACK OF TIME, REMUNERATION, AND EXPERIENCE FOR FAITH AND COMMUNITY LEADERS AND A NEED FOR LEADERSHIP TRAINING IN DIFFERENT AREAS." (WORKING GROUP MEMBER).

Impact

In December 2021, 31 community and faith leaders joined QPASTT and Multicultural Australia in celebrating the COVID 19 Working Group's efforts and acknowledging the work achieved. This was summarised as a strong collaboration across multiple communities and generations to face all face the challenges of the pandemic. It resulted in increased understanding and advocacy of existing inequalities that were exacerbated by the pandemic namely in education, employment and access to resources. The COVID 19 Working Group was a bridge for some new relationships between community leaders and mainstream providers. For others it was an opportunity to strengthen existing relationships. By evidencing the benefit of close collaboration, the Queensland Government and mainstream providers were able to see the value in building meaningful relationship with community leaders. Queensland Health have now invited community leaders to join a new reference group, the CALD COVID-19 Health Engagement Project (CCHEP), and those that participate are able to receive an honorarium to compensate for their time and expertise.

Feedback from community leaders themselves about the experience of the COVID-19 Working Group included the following quotes:

> "WE CAN SURVIVE A PANDEMIC BECAUSE WE FEEL ARE NOT ALONE – WE CAN FACE IT TOGETHER"

> "IT WORKED WELL BECAUSE OF THE COMMITMENT FROM QPASTT AND MA AND ALL THE LEADERS AS THEY WERE WORRIED ABOUT THEIR COMMUNITY"

> "WE NOW KNOW WE CAN WORK TOGETHER TO SOLVE THE PROBLEM AND FIND SOLUTIONS "

The impact of the Community Healing to Thrive project over the initial 18-month period of its delivery includes the following:

- Over 20 "initiatives" were delivered to over 200 participants.
- Initiatives range from programs, single sessions, planning meetings – individual mentoring and one on one engagement or "adjacent sessions" have not been included in this number.
- The project team engaged with over nine different cultural communities
- The project engaged with external agencies and community organisations and associations to foster collective, social wellbeing and health. This included G11 – Mater Refugee Complex Care Clinic, Ethni, Brisbane South PHN, World Wellness Group, Multicultural Mental Health Coordinators, Queensland Transcultural Mental Health Centre, and Harmony Place.

Feedback from participants has been overwhelmingly positive as the quotes below demonstrate:

> "SINCE MY TIME IN AUSTRALIA, FOR 9 YEARS, THIS IS THE FIRST TIME SOMEONE HAS COME TO TALK TO ME LIKE THIS. THIS IS THE FIRST TIME I HAVE BEEN ABLE TO UNDERSTAND WHAT IS HAPPENING TO ME AND HOW THINGS CAN GET BETTER"

> "THIS INFORMATION HAS HELPED ME UNDERSTAND WHY OUR COMMUNITY DOES THE THINGS IT DOES [REFERRING TO TRAUMA RELATED BEHAVIOURS] AND THE IMPORTANCE OF TAKING CARE OF MYSELF"

> "IT IS IMPORTANT TO USE OUR VOICES AS WOMEN, IN THE COMMUNITY, WE ARE THE ONES THAT LOOK AFTER EVERYONE ELSE, OUR CHILDREN, OUR HUSBANDS, OUR PARENTS. WE NEED TO TALK ABOUT THESE THINGS SO WE CAN CONTINUE."

Appendix 5. Report on costs of rural and regional service provision

The 2019 AusHSI report, “Cost of service provision for survivors of torture and trauma in rural and regional locations”, can be accessed via the link below. This report contains an environmental scan and costing analysis for the Forum of Australian Services for Survivors of Torture and Trauma (FASSTT).

FASSTT report final
version 30OCT2019.

Appendix 6. Referrals into FASSTT agencies by sector

Table A1. *Referrals from other providers into FASSTT agencies (%) and nationwide (number)23*

	STARTTS	VFST	QPASTT	STTARS	Phoenix	Companion House	ASeTTS	Melaleuca
Accommodation	0.1	0.5	0.6	0.6	1.2	1.6	1.3	0.9
Asylum Seeker Support Service	0.4	0.0	0.2	1.1	2.0	1.3	3.4	5.9
Centrelink	0.0	0.4	0.1	0.1	0.2	0.2	0.2	0.0
Client - self	34.6	14.5	15.1	9.9	11.0	22.5	11.7	8.1
Client - family/friend	2.9	2.8	3.9	2.2	2.6	7.4	6.1	6.3
Community Welfare organisations	0.4	2.9	2.4	2.3	6.2	0.7	4.8	5.4
DIBP	0.0	0.1	0.0	0.4	0.0	0.0	0.1	0.0
Disability support service	0.2	0.0	0.1	0.0	0.1	0.1	0.4	0.0
Education – primary & secondary	13.2	14.8	12.1	16.1	11.1	0.5	5.1	5.9
Education – tertiary	0.8	7.0	4.5	0.6	2.2	0.1	0.5	3.6
Employment	0.4	0.1	0.3	1.3	0.4	0.2	0.5	0.0
Family Violence service	0.0	0.1	0.2	0.0	0.9	0.2	0.3	0.0
FASSTT Other	0.2	0.3	0.6	0.7	0.0	0.6	0.3	0.0
Health – allied	0.0	2.4	1.1	4.3	3.1	0.2	0.5	0.5
Health – general medical	10.0	9.6	9.1	20.4	11.8	13.7	11.0	1.8
Health – mental	1.2	4.9	5.1	3.8	2.5	0.7	2.5	1.8
Humanitarian Services program	13.0	11.0	23.0	6.8	23.1	2.4	3.5	47.1
Internal	11.4	10.6	12.7	22.9	7.0	33.5	37.0	4.5
Legal (migration related)	0.0	0.3	0.2	0.2	2.7	1.8	0.2	0.5
Legal (non-migration related)	0.2	0.3	0.1	0.3	0.2	1.8	0.5	1.8
Settlement Support	0.6	5.7	5.9	3.6	7.5	9.7	2.3	1.4
Not stated/unknown	0.0	5.1	0.0	0.0	1.4	0.0	0.6	0.0
Other services	10.4	6.8	2.6	2.5	2.8	0.7	7.4	4.5
Organisation total	100	100	100	100	100	100	100	100

Note: cells are colour coded to represent the highest (green) to lowest (red) proportions of referrals to each agency, and overall

Appendix 7. Online engagement questionnaire

Appendix 7.1 Content

Note about content: Survey items 1-4 are demographic questions to allow assessment of responses via location, service provider etc. Items 35-39 assess satisfaction and benefits of the partnership.

Introduction

The Program of Assistance for Survivors of Torture and Trauma (PASTT) has been funded by the Department of Health since 1995 to provide survivors of torture and trauma with appropriate counselling and related support services. PASTT aims to promote the physical health and psychosocial recovery of people living in Australia who have pre-migration experiences of conflict and human rights abuses, which make them vulnerable to developing mental health problems. The PASTT program model allows for providers to deliver services tailored to the needs of clients, whether this involves short, medium or long-term support.

PASTT is delivered by member agencies of the Forum of Australian Services for Survivors of Torture and Trauma (FASSTT), one in each state and territory including:

- NSW – Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS)
- VIC – Victorian Foundation for Survivors of Torture (VFST/Foundation House)
- QLD – Queensland Programme of Assistance to Survivors of Torture and Trauma (QPASTT)
- SA – Survivors of Torture and Trauma Assistance and Rehabilitation Service (STTARS)
- WA – Association for Services to Torture and Trauma Survivors (ASeTTS)
- TAS – Phoenix Centre
- NT – Melaleuca Refugee Centre
- ACT – Companion House

The Australian Centre for Health Services Innovation at the Queensland University of Technology has been contracted to provide an independent evaluation of PASTT, including the success of stakeholder engagement and any partnerships formed.

You have been asked to complete this survey as you have been identified by one of the FASSTT member agencies as supporting or delivering PASTT services. The survey aims to reflect on the partnerships established, develop a clearer idea of the success of engagement, and focus on ways to sustain collaboration into the future.

Your answers to the questions are confidential and will not be shared in identifiable form with anyone in your organisation/group or elsewhere. We will, however, be reporting the results of all aggregated surveys. All the responses will be anonymised. If you agree to participate you do not have to complete any question(s) you are uncomfortable answering. If you do not wish to answer a question you can leave it blank and move to the next question. You can also withdraw from the research project at any time by closing your web browser.

Acknowledging that you have read and understood the participant information [link to PIS] and providing responses to survey items is accepted as an indication of your consent to participate in this research project. If you would like more information about this survey, please contact Bridget Abell (bridget.abell@qut.edu.au). If you do not wish to continue, please close your browser now.

1. In which state or territory are you/your organisation currently based?
    a. New South Wales
    b. Victoria
    c. Queensland
    d. South Australia
    e. Western Australia
    f. Tasmania
    g. Northern Territory
    h. Australian Capital Territory

2. Which of the following categories best describes how you engage in your role with PASTT and/or the FASSTT member agency? (select all that apply)
    - Counselling and/or therapeutic mental health services
    - Other medical or clinical services
    - Community/social support services
    - Settlement services
    - Youth and family services
    - Community leader
    - Community development and capacity development
    - PASTT funding, management, or administration
    - Other [free-text]

3. How long have you been involved with PASTT/delivery of PASTT services? [free text]

4. How frequently do you engage, communicate, or collaborate with PASTT and/or the FASSTT member agency? (e.g. via meetings, email, phone, videoconference, referral pathways, shared clients, or in training, or resource sharing?
    a. Daily
    b. Several times a week
    c. Weekly
    d. Several times a month
    e. Monthly
    f. Several times a year
    g. Once a year or less

In this part of the survey, we will ask you some questions about your own experience and satisfaction in taking part in PASTT collaborations and activities. Please feel free to write as much as you wish in your response to the following questions.

5. What have been some of the barriers/difficulties you have experienced while participating in partnership with PASTT? *This could be at a personal or organisational level.* [free text]

6. What factors have made participation in the PASTT partnership easier for you and/or your organisation? *This could be at a personal or organisational level.* [free text]

7. So far, how satisfied have you been with participating in the PASTT partnership? (Slider scale from *drawbacks greatly exceed benefits* to *completely satisfied)*

8. Think back to when you and/or your organisation became involved in PASTT and PASTT activities. Since joining PASTT or providing PASTT activities, it has enabled you/your organisation to: (sliding scale from *not at all* to *most definitely*)
   a. Improve the psychosocial health and wellbeing of clients and refugee communities
   b. Increase the responsiveness of mainstream health and related services to the needs of your clients and refugee communities
   c. Build the confidence of refugee communities to access mainstream health and related services
   d. Provide regional rural and remote outreach services for Survivors of Torture and Trauma and refugee communities
   e. Enhance the capacity of specialist counselling and related support services
   f. Provide community education and advocacy

9. Any further comments about your experience or satisfaction working with PASTT or your FASSTT member agency? [free text]

Thank you for participating in the survey. Please click submit to ensure your answers are provided. You can then shut your browser.

Appendix 7.2 Supplementary data

Figure A1. *Duration of respondent/external agency engagement with FASSTT agency (n=69)*

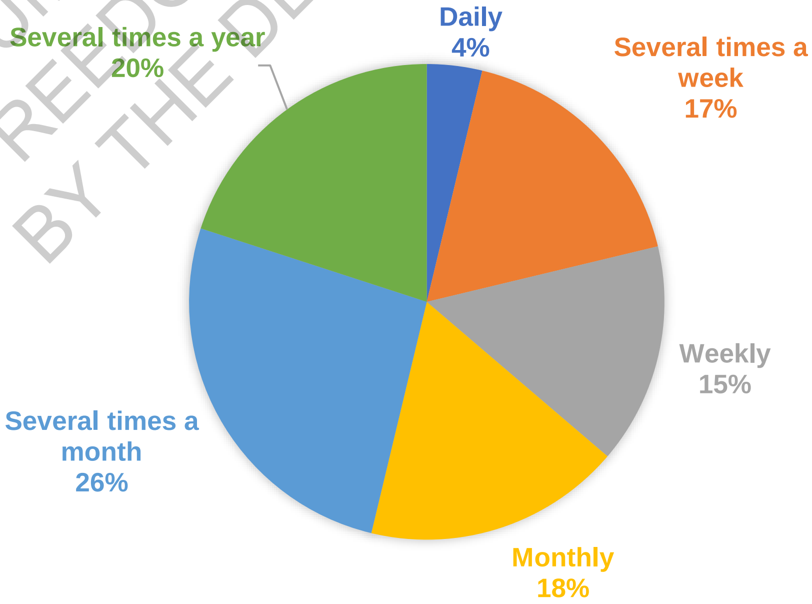
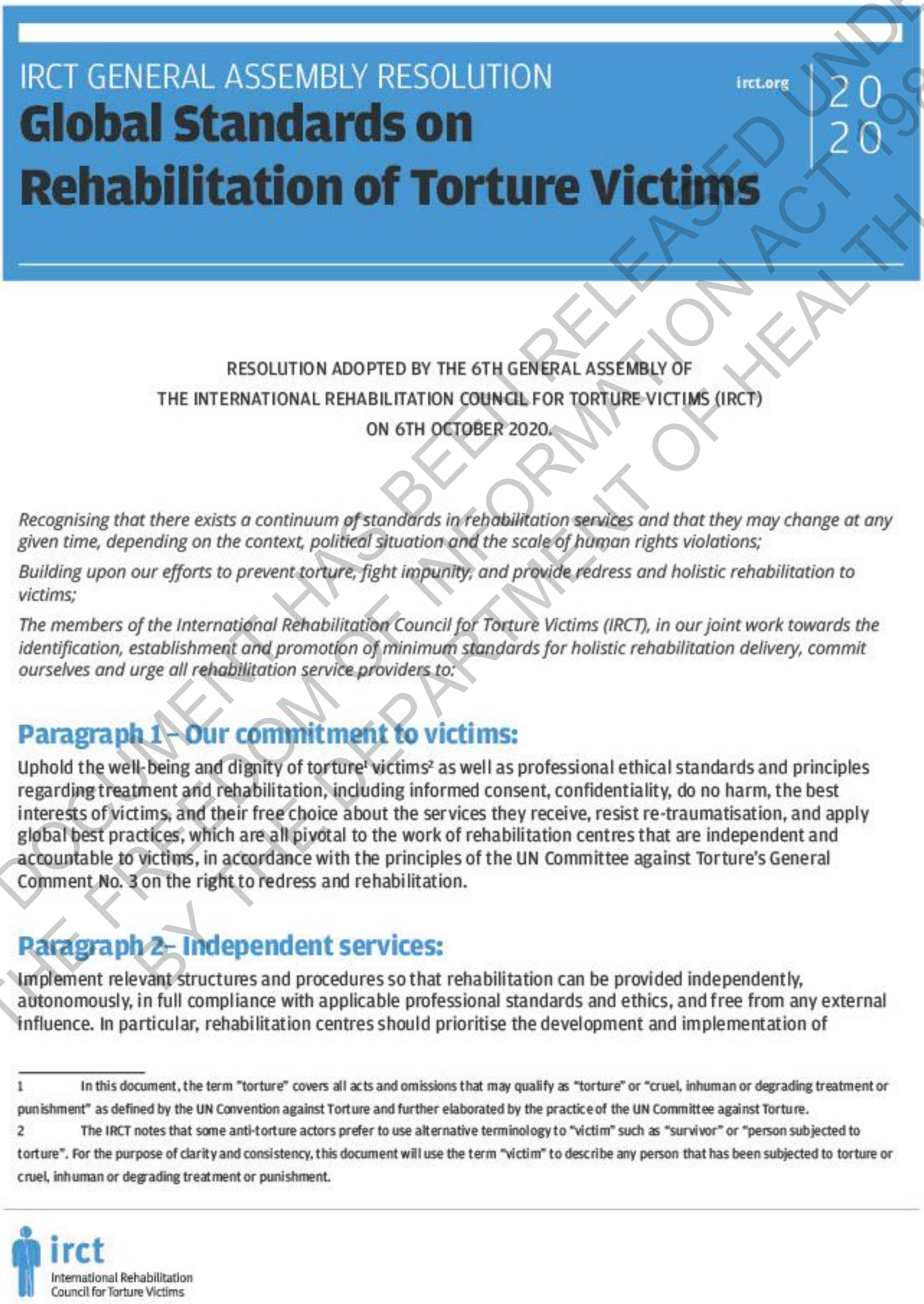


Figure A2. *Frequency of respondent/external agency contact with FASSTT agency (n=69)*

Appendix 8. The Global Standards on Rehabilitation of Torture Victims



IRCT GENERAL ASSEMBLY RESOLUTION

irct.org

2020

Global Standards on Rehabilitation of Torture Victims

RESOLUTION ADOPTED BY THE 6TH GENERAL ASSEMBLY OF
THE INTERNATIONAL REHABILITATION COUNCIL FOR TORTURE VICTIMS (IRCT)
ON 6TH OCTOBER 2020.

Recognising that there exists a continuum of standards in rehabilitation services and that they may change at any given time, depending on the context, political situation and the scale of human rights violations;

Building upon our efforts to prevent torture, fight impunity, and provide redress and holistic rehabilitation to victims;

The members of the International Rehabilitation Council for Torture Victims (IRCT), in our joint work towards the identification, establishment and promotion of minimum standards for holistic rehabilitation delivery, commit ourselves and urge all rehabilitation service providers to:

Paragraph 1 – Our commitment to victims:

Uphold the well-being and dignity of torture[1] victims[2] as well as professional ethical standards and principles regarding treatment and rehabilitation, including informed consent, confidentiality, do no harm, the best interests of victims, and their free choice about the services they receive, resist re-traumatisation, and apply global best practices, which are all pivotal to the work of rehabilitation centres that are independent and accountable to victims, in accordance with the principles of the UN Committee against Torture's General Comment No. 3 on the right to redress and rehabilitation.

Paragraph 2 – Independent services:

Implement relevant structures and procedures so that rehabilitation can be provided independently, autonomously, in full compliance with applicable professional standards and ethics, and free from any external influence. In particular, rehabilitation centres should prioritise the development and implementation of

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[1] In this document, the term "torture" covers all acts and omissions that may qualify as "torture" or "cruel, inhuman or degrading treatment or punishment" as defined by the UN Convention against Torture and further elaborated by the practice of the UN Committee against Torture.

[2] The IRCT notes that some anti-torture actors prefer to use alternative terminology to "victim" such as "survivor" or "person subjected to torture". For the purpose of clarity and consistency, this document will use the term "victim" to describe any person that has been subjected to torture or cruel, inhuman or degrading treatment or punishment.

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structures, methodologies, and procedures that are victim-centred, evidence-based, participatory, empowering, holistic, accessible, equitable, respectful, gender sensitive, culturally appropriate, and accountable. Where funding is received from sources that could be perceived to place an external influence on the rehabilitation provider, it is essential to ensure that the organisation's mandate and the principles of victim confidentiality, transparency, and independence of decision-making are prioritised and emphasise the victims' best interests. Torture victims must be informed about measures taken to protect the rehabilitation process from external influence.

Paragraph 3 – Safety of victims:

Ensure the implementation of every possible safety and safeguarding measure for victims receiving services including all aspects of the relationship with victims, bearing in mind that the best interest of torture victims is a key principle of rehabilitation services. Torture victims must be informed about and provide input into the determination of safeguarding and safety measures.

Paragraph 4 – Support to families:

Ensure that the specific rehabilitation needs of torture survivors' families, in particular children and vulnerable populations, are considered an essential part of the rehabilitation process. Where resources allow, families should receive support in accordance with their needs. Where relevant, culturally appropriate community-based approaches should be employed during the rehabilitation process.

Paragraph 5 – Access to justice:

Whenever possible, support victims' access to justice and be advocates for the eradication of torture as a part of the rehabilitation process. This includes supporting victims to document their claims in accordance with the Istanbul Protocol[3] and to file complaints, and advocate for national authorities to adopt and implement national anti-torture laws and National Preventive Mechanisms (NPMs).

Paragraph 6 – Intake Processes:

Establish intake processes through which victims of torture can access rehabilitation services on the basis of self-referral or referral by a third party, such as by competent physical or mental health, social, or legal professionals; human rights defenders; faith-based, indigenous, ethnic and national minority communities; other torture victims or family members. These processes must ensure that, within available resources, torture victims have free, equal and non-discriminatory access to services, regardless of their ability to pay or legal status in the country concerned. To the extent possible, rehabilitation service providers should prioritise outreach, in particular for torture victims who are marginalised, detained, living in remote areas or lack funds for transport costs.

Paragraph 7 – Access to information:

Provide torture victims with all relevant information concerning the rehabilitation services offered. Rehabilitation centres must respect and promote torture victims' agency in their own lives and their choices regarding rehabilitation. Where possible and appropriate to the service provided, reliable interpreters should be made available at no cost to torture victims. Whenever possible, victims should be able to choose the gender of rehabilitation professionals, including interpreters. Informed consent must be obtained according to relevant professional and ethical standards before and during the process of rehabilitation.

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[3] Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment

Paragraph 8 – Victim feedback:

Establish procedures and mechanisms that enable torture victims to provide ongoing feedback, including upon leaving rehabilitation services, in a language they speak, about the services they receive; for example, through the use of standing service user engagement mechanisms, victim satisfaction surveys, service evaluations, focus groups, and other participatory mechanisms. This feedback should be reviewed periodically and form the basis for continuous improvements to the rehabilitation services offered. Satisfaction should be clearly defined and use consistently applied standards. In addition, mechanisms whereby victims can complain and receive a prompt and satisfactory response in relation to the rehabilitation services they receive should be established. Victims should be enabled to effectively engage through measures such as provision of information about complaint possibilities and the establishment of support functions that include other victims.

Paragraph 9 – Victims' participation in rehabilitation:

Promote the meaningful contribution of victims in service design and delivery, research, decision-making, and governance processes of rehabilitation services through recognition of victims' experience in service development and recruitment processes, open consultative and feedback processes, and other participatory methods that are contextually and situationally appropriate.

Paragraph 10 – Organisational capacity:

Prioritise continuous training and capacity enhancement for staff and volunteers, for example, in specialised evidence-based treatment methods; trauma sensitive interview techniques; empathetic listening and anti-racism; cultural and gender awareness in accordance with relevant professional standards; and ethics and international human rights standards.

Paragraph 11 – Staff safety:

Ensure that staff and volunteers are safe, secure and cared for and have the means to report incidents that could compromise their safety or the safety of others through reporting processes or other suitable means that ensure that these risks are documented and that context- appropriate measures are taken to minimise them. In this regard, rehabilitation centres should ensure the adoption and implementation of appropriate policies to prevent and address discrimination, harassment, and sexual and other forms of abuse.

Paragraph 12 – Care for staff:

Address vicarious trauma and prevention of burnout as an organisational priority for all staff. To that end, provide a robust and supportive well-being infrastructure and working environment for staff through, for example, regular supervision, peer support mechanisms, staff mentoring, psychosocial support techniques, and access to occupational health services.

Paragraph 13 – Share knowledge:

Disseminate information about torture and its effects to professionals in healthcare and other relevant fields who may come into contact with torture victims. Information should include available and possible approaches to rehabilitation, the specific needs of torture victims (including early identification, assessment, and timely referrals), trauma-informed care, documentation procedures according to the Istanbul Protocol, and regarding the value of providing rehabilitation to facilitate life after torture. Where security considerations allow, the dissemination of this information should be considered a critical moral and social responsibility for centres assisting victims of torture.

Paragraph 14 – Advocate for rehabilitation funding:

Where possible, attempt to establish or strengthen dialogue with states and their relevant agencies to inform them about torture and its effects and the value of rehabilitation, and to request that they provide funding to support the rehabilitation of torture victims worldwide, preferably through: a) direct funding of rehabilitation centres assisting survivors of torture in their respective countries, b) contributing to the United Nations Voluntary Fund for Victims of Torture (UNVFVT) or c) funding the IRCT's sub-granting programme.

RECOGNISING the importance of a holistic approach to the fight against torture, which encompasses prevention, justice and reparation for victims and that IRCT members contribute to all aspects of this effort to eradicate torture;

The IRCT membership expresses our joint ambition to document and demonstrate our collective global impact on the quality of life of the torture victims we support, and therefore commit to endeavour to:

Paragraph 15 – Definition of quality of life:

Apply the following definition of quality of life: The subjective well-being of individuals and their communities within their specific social and cultural context in relation to factors such as physical and mental health; family, social and community relations; culture; education; employment; economic security; exposure to physical and psychological violence and freedom; good governance and basic human rights; spiritual life; gender equality and non-discrimination; religious beliefs; legal status; and the natural and living environment.

Paragraph 16 – Evaluating improvements in quality of life:

Apply evaluation tools that are appropriate to their specific context. This is done with the recognition that IRCT members provide services in very different contexts, including detention, political repression, victims with uncertain legal status, discrimination and poverty, which may have a severe negative effect on victims' quality of life. Furthermore, each member centre will determine which tools are best used to evaluate improvements in all indicators relevant to addressing the needs and improving the quality of life of the torture victims they support, and communicate this to the IRCT membership. In documenting the results of their work, IRCT members are encouraged to take into account how the quality of life of torture victims is connected to the enjoyment of rights, including access to justice, international protection, redress and all five forms of reparation (restitution, compensation, rehabilitation, satisfaction and the right to truth, and guarantees of non-repetition).

Paragraph 17 – Documenting our global impact:

Share the results of their support to torture victims with the IRCT membership on an annual basis. This will become part of the IRCT's annual Global Impact Report, which demonstrates to the world our collective impact in the lives of torture victims.

Appendix 8.1 Alignment between the IRCT Standards and the NSMHS

There is strong alignment between the IRCT standards and the NSMHS. Evidence for meeting the IRCT Standards was provided to the NSMHS accreditors and was formally and independently acknowledged. Below in Table A2, the IRCT Standards are presented against the NSMHS. Additionally, the below section includes NSMNS feedback to some of the FASSTT agencies' services and policies to further support alignment with the IRCT Standards.

Table A2. *Alignment of the IRCT Standards and the NSMHS*

	IRCT Standards																
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
NSMHS* equivalent	1 2 4 10.1 10.5	1 8	2	3 6 7	NE	10.2 10.3 10.4	6	3 6 10	3 6 10	2 8 9	2 8 9	2 8 9	5	NE	1	10.4	NE

*Standard 1: Rights and Responsibilities; Standard 2: Safety; Standard 3: Participation/Consumer and Carer Engagement; Standard 4: Diversity; Standard 5: Promotion and prevention; Standard 6: Consumers; Standard 7: Carers; Standard 8: Governance; Standard 9: Integration; Standard 10: Delivery of care; 10.1: Delivery of Care – Recovery; Standard 10.2: Delivery of Care – Access; Standard 10.3: Delivery of Care – Entry; Standard 10.4 Delivery of Care – Assessment; Standard 10.5: Delivery of Care – Support; NE: no equivalent

Appendix 8.1.1 Accreditation feedback to support alignment with the IRCT Standards

The accreditation review against NSMHS statements supporting alignment with the Mental Health Services accreditation standards and consequently the following IRCT Standards:

Statements against IRCT Standard 1:

"Companion House is commended for its engagement with clients based on key principles of respecting human rights and the rights to safety and self-determination. Staff readily referenced human rights as the basis for their work with refugees and asylum seekers. Clients and stakeholders reinforced this by providing numerous examples of individual experience and of program design and initiatives undertaken by Companion House. Staffs ensure that clients are at the centre of all engagements and interventions, as evidenced by interviews client and program files, minutes of meetings and publications. Clients expressed their strong view that staff at Companion House encourage individual decision making and real choices and that their rights are respected and promoted." (QIP Report 2019)

"Importantly, there was a clear resonance through the Board and staff interviews of a shared focus on clients and the importance of dealing with clients respectfully as fellow human beings. The regular checking in with clients to ensure that they are still comfortable with a previous choice, such as a consent or other commitment, is seen by staff as one of the ways of confirming client rights." (STTARS, QIP Report 2021)

"QPASTT is a dynamic and innovative organisation with a strong values driven approach to its work with clients and their communities. The Counsellor Advocate approach is innovative and recognises the importance of gaining trust in order to be able to work effectively with clients over the longer term. QPASTT is highly regarded by the many cultural communities it has engaged, and is regarded as genuinely listening and committed to responding. Clients feel that QPASTT is a safe place, with staff that can be trusted." (QPASTT, QIP Report 2019)

Statements against IRCT Standard 2:
"STTARS comply with all ethical and legal requirements for the protection of client privacy and confidentiality. Applicable legislation includes: Commonwealth Privacy Act 1988 as amended; Commonwealth Notifiable Data Breaches scheme; State Privacy Acts and Health Records Acts (Other States); Information Privacy Principals Instruction (SA); and The Freedom of Information Act 1991. Additionally, where legislation does not specifically apply, STTARS policies and procedures are consistent with the intent of the Australian Privacy Principles." (Australian Service Excellence Standards Accreditation Report 2021)

Statements against IRCT Standard 6:
*"At interview clients described Companion House intake process as detailed and client- centric - 'like they wanted to really help me'. ……Intake documentation was overall consistent in format and content………Staff were clear about eligibility criteria, the management of waiting lists and referrals for those clients who required services by another agency. Waiting lists for counselling are effectively managed and strategies are in place to risk-manage clients through telephone contact and through Companion House coordinating other resources as required." (*QIP Report 2019).

Statements against IRCT Standard 8:
"Review of the policy, procedures and records shows that there are multiple processes in place for consumers to express compliments, complaints, and grievances regarding their care and for these to be addressed by MRC Tas Phoenix Centre appropriately

Interviews with consumer representatives, facilitated by the interpreter, unanimously confirmed that there is awareness of how to give feedback and make a complaint and that they feel confident to do so."

Statements against IRCT Standard 10:
*"Staff receive a thorough induction and are well supported. Clinical supervision is in place and the well-being of staff is given priority. The organisation's commitment to continuous quality improvement is demonstrated by the review of the supervision system this year and the introduction of improved scheduling and other enhancements. Staff at interview displayed both passion for their work and competence. "(*STTARS, QIP report 2021)

*"There is a strong evidence base to the work as shown by the references in the comprehensive Clinical Services manual. There is a thorough and well-paced induction for new staff. There are well-developed systems for line supervision and clinical supervision. There is a schedule of Offline weeks (no client work) when regional staff attend head office for training and other developmental activities." (*QPASTT, QIP Report 2019).

Statements against IRCT Standard 12:
"STTARS has high staff retention as well as significant numbers of staff (and Board members) returning to the organisation after experiences elsewhere. This indicates a positive workplace culture, which was confirmed in interviews. …There is a strong commitment to risk management which is appropriate given the history and vulnerability of the clients." (STTARS, QIP report 2021)

"Another key factor in the organisation's success is the flexibility and commitment of staff and strong collaborative and positive teamwork observed across all roles in the organisation. Staff are supported in through ongoing training, quality clinical and administrative supervision, access to EAP and communication systems are very effective with multiple formats used to ensure information flows and collaborative planning that enables continuity of care for clients." (STARTTS, 2022.)

Appendix 9. Selected stakeholder quotes

The quotes provided in Table A3 below come from interviews, conducted by the AusHSI team, with a broad cross-section of key stakeholders from FASSTT agencies and external organisations, as described in Section 2.5.1 . Those interviewed were engaged in a variety of roles and at several levels in the organisational hierarchies of the agencies. Specific attributions for quotes are not provided as they are intended to be understood as supplementary examples informing the key findings described in the above report.

Table A3*. Selected stakeholder quotes to support findings.*

Chapter	Theme	Selected quotes
Appropriateness and acceptability of PASTT	Appropriateness of PASTT	"The PASTT program gives us that flexibility to support people in a way that they need to be supported to feel safe." 'It's [session focus] completely up to the client.' "Advocacy is a – a – way to sort of meet people where they're at, (...) walking with them and (…) building a relationship, which is so important (…) in trauma recovery." "[Our specialisation] is to be able to rock'n'roll with the challenges of finding an interpreter, finding bicultural links and community leaders." "Our clients whose human rights have been deprived due to torture, trauma and human rights violation, these clients are basically now with us having the opportunity to be the leader in the session, to be the one who is able to tell us what they need, and to voice their opinion. And that on its own is therapeutic and gives them more strength and capacity to tell us where they want to go." "We had to adapt the way we worked when we started to see people from [location], we had to adapt again when we started to see people from [different location] and...so with every new wave, there will be challenges...but it would be overstating it if we said we've never seen anything like this before because in fact we have and we just have to develop the experience to adapt what we need to do and the model that we are using, so there will be challenges but I don't think they are insurmountable challenges." "PASTT for me is more a structure to work within of the way of being and to kind of outline general goals and general stages and ways of assessing and engaging…" "So, for example, Ukrainian crisis at the moment, we were referred yesterday I think an 86- or 96-year-old, so someone who came out to Australia at the end of World War 2, traumatised then, has been fine, lived a full life, seen what's happening in Ukraine, been triggered...there's not many programs that have that broad level of accessibility."

		"Authentically genuine co-design process." “We've got the flexibility to say, does this person need one to on or do they need more group. Or do they — really being based around what each person needs, is probably one of the big strengths of PASTT. And that's focussing on — and everybody uses the words because they're trendy, we're person centred, we're client centred. But this program allows us to really do that. So, every assessment is starting with the person and that really holistic view. We don't see they've got this diagnosis or this illness, so what is the whole situation. What's the background, what's the supports around them, what are their goals and aspirations, what are they hoping to get out of the service and then to tailor it around that…Because I think it — it is that holistic and population-based approach that's really important.” "I certainly really highly value the support we get from the other FASSTT agencies, I think as a smaller agency there's no way we would be able to do this work without the support of the network, it's just been incredibly valuable." "Collectively, we are much more convincing and much more powerful than we would be as eight individual organisations." "There is a lot of sharing of intellectual property and that is always been incredibly generous… overwhelmingly from the bigger states to the smaller states." "I think it's probably because we are not competitors that we can very genuinely be very generous with each other."
	Challenges- reporting and outcomes and balancing demands	"We have significant quantitative aspects of the work that we do, that are not followed. (…) We have to, have the chance to – to – to be able to (...) present the qualitative aspects of our work. In a non-quantitative way. (…)” “I hate it every time data time comes around. I love data, but... I’d love to see some enhancements in our data system. It’s probably not relevant for the Department, but I think what I talked about in terms of the continuous improvement and accreditation, I think that’s so critical and being able to demonstrate – I don’t know if you’ve had a look at the stuff we’ve put up – but in terms of client outcomes and things like that, we can only really give you qualitative data and I would love to develop some systems and things that not just demonstrate to us and the department, but also you can share that with people and with communities about the things that they’ve been able to contribute to and the outcomes for them. Yeah, I’d love to be able to. So, I just think there’s so much opportunity there to do some things but to do that now would mean that I would have to cut the counselling, and that is going to hurt people in the immediate term and won’t be effective. I think that probably sums it up.” "I think some of the targets don't really make sense in terms of breaking it down into actual money and they're a little historical." "So, funding changes that have occurred with PASTT over the years haven't necessarily been reflected in changes in our targets. So, we will be looking at trying to negotiate a lower target but then you've got the issue 'well what happens to all those people in the community who need the service if we reduce the targets' because the needs are still there."
	Challenges – FASSTT governance	"While there's this line that we are all equal parties [in FASSTT], we're not, like, I'm going to be honest" "If we are saying we all have equal voice [in FASSTT], how do we ensure that we all do have equal voice."

	Acceptability	"[The client] said to me, 'I can't believe. This is the first time I feel,' – even though before coming here she was in another – in a transitional country, which also offered some support for her, prior to, she had to escape her country. But she said, 'This is the first time I feel someone has listened to me.' - like, not me, I'm talking about the organisation."
Regional and Rural Implementation of PASTT		"The cost for the number of clients that need servicing can sometimes be disproportionate compared to servicing clients in metropolitan [location]." "...just don't have the same economies of scale in rural and regional settings and that's always a factor." "[Each rural/regional community] carries its own set of circumstances...the reality is that rural and regional isn't one big group, it's a number of different areas that have their own aspects to work with and that we've needed to develop strategies to support people in those areas." "For us to spend money establishing offices in rural locations would just take money away from service delivery." "[When the number of clients is] relatively small in multiple areas, then it pays to build capability of the local community health centre or whatever the case may be." "The time needed to do the sort of community development work, the connections with communities, it's so much harder up there." "There's so much work that needs to be done to upskill and really get [3rd party providers in rural and regional areas] to probably see how their service could be a bit more responsive to our families." "We deliver a number of different, I guess, services and programs, yet, you know, the needs of refugee communities in regional areas go beyond that scope and housing is an example, or employment might be an example, and they're two areas that [the organisation] traditionally, you know, is not really involved in, particularly housing, yet the staff there will be called by the local community about, you know, 'I'm stuck, I need housing', so they get involved in all these areas mainly because they are trusted in that part of the world and I think that can be quite a challenge for them to juggle these many needs." "[Talking about PASTT service delivery in rural and regional areas] But we have a commitment to being flexible and providing an equity of access when that's possible but that, again, that's an additional cost, and additional resources are needed." "With the [rural and regional] service providers, it's just unbelievable what you can achieve in those relationships when you are there." "When relationship building is based on being present and reliable and predictable, that gets really undermined with a fly-in, fly-out model, whether that's with direct service delivery or management as well." "Because in the regions, [FASSTT agency staff] have got to do it all themselves, schools are kind of clueless, health services are clueless, haven't used an interpreter before, there's nothing like a, you know, legal office that might help you, or a migration agent, nup, none of that."

		"...we need to actually make a decision, um, do we provide an adequate service in the regions or do we provide as much as we provide in the metro areas, and I think that, I don't think that we're gonna be able to do the latter, but I don't think we've reached the former either."
Outcomes achieved	Client-level	"…even physically their presentation was very closed and extremely hyper-vigilant, extremely anxious, um, you know, a couple of, you know, like, quite fidgety, quite, you know, and just through the process of gradually providing support and stability, even just in their physical presentation you could see their recovery because they could actually engage, their body language was more open, they could make eye contact more, they could – so even just that initial, um, part of the journey where they learn to feel safe and trust and even physically sort of be able to open up and reduce anxiety enough to engage in that, you know, counselling experience, you know? I've had, you know, a few clients with that presentation, um, yeah, yep." "[the client] said that (...) if it was not for the counsellor in the time and the space that she built in – in counselling, where she felt safe and accepted and not judged and where the trauma, and the impacts of trauma and the mental health were normalised(...). She got a sense of this environment being somewhere where she could be free and safe and – and she wasn't crazy. (...) she wanted to then offer that to others. She wanted to show others that she'd come from a place where she thought she was crazy and nuts. And she was labelled as that all along. She wanted to offer hope, that hope of not being damaged." "…many clients have that experience of that trust first time in many years, and safety at [FASSTT agency] and feeling, like, homely at [FASSTT agency]. Um, and coming to [FASSTT agency] for that one smile in their, like, face. So, like, those kind of comments and those kind of, yeah, positive feedback constantly comes to us."
	Health provider and service-level	"It's been a push to get them [mainstream mental health services] to see our clients." "[Talking about 3rd Party providers] I've had a few very difficult and one very disastrous outcome with psychotic [client] who can't manage has to be seen urgently, they were so slow to pick it up. Eventually engaged with him and he did suicide in their service, and I think it was that slowness, not understanding our level of trauma." "[Talking about conducting 3rd party provider training] We're more confident about making referrals to those agencies." "If we can train more people, ah, mental health professionals, about how to work with refugees, then I think the community is actually trauma-informed community, trauma-informed society and I think that's what we need." "[Talking about resource development for 3rd party providers] In a sense, they're produced in a very cost-effective way, like, if the department was going to contract people to produce that, it would probably cost them much much more than having the expertise on tap that can be drawn in to produce those resources." "When I think about the training that we have done, we get incredible feedback from people about the impact that it's made... We do a lot of advocacy... I talk to people from the fire department through to the police station, through to the local GP service. Things like that around trying to support them to be more culturally aware... through to systems things." "If there is one frustration at a strategic level, it is related to the relationship between [state] health and the Commonwealth. For example, there is no engagement between the responsible Commonwealth bodies and [state] health. We do not even know who [in the Department] is responsible for PASST."

		"[from the outside] there appears to be little accountability for which funding (i.e. state vs Commonwealth) is used for what services or programs. Thus, the agency could be being funded twice to provide the same service."
	Community-level	When speaking of community capacity building activities: "It [individual counselling] is a bit like a needle in a haystack." "And really what we want to be able to do is build capacity of communities to be able to support the members of their communities better themselves and be able to identify people who should be referred to our organisation early, rather than to that crisis point." "So, we think we do quite a lot around that and as an agency. For example, we just recently supported the Disability Royal Commission down here. I'm meeting with someone around mental health assessments this afternoon. It's a whole range of those things, and I know they're at a bigger level but that's also about having a voice there that's reminding people that you actually need to be mindful of multicultural communities in these processes, because at the end of the day if you put a system in place and it's not had that cultural lens over it, it won't work... I know that's a really high-level kind of example but hopefully the long-term benefit of that is that the work's been done right at the front end so that we're not having to pick up the pieces, and hopefully that makes it more accessible for people."
Economic analysis	Funding	"It's really difficult not knowing how much funding we're going to have year-to-year." "We don't see it as, really, such a positive thing to be working with people forever and we want to find ways that will help them to meet goals that have been established as part of the counselling process." "If we took PASTT funding in isolation there is no way we could go anywhere near meeting the needs of clients." "So, for example, what's happened is we've had an increase in the rate of referral. If your rate of referral increases but you don't have a corresponding increase in funding levels, then what happens is you have a longer period of time before you're able to comprehensively respond to referrals. You can respond around, you know, are they an appropriate referral to us, if not, refer them out. But if they are appropriate for us but you don't have the resources to employ the staff in order to deliver that service then there becomes a wait." "There's never been leftover capacity (...) we're just delivering services as strategically and thoughtfully as we can." "(...) and I mean, I'm a realist, you're never gonna get enough money, to be able to provide a perfect service, that's fine, but I guess it's about being able to have funding that is responsive to those sort of increasing requests for the service." "...through training we're also hopefully building the capacity of other agencies to respond, um, perhaps in a more culturally competent or a culturally inclusive way to perhaps also increase that sustainability of – of PASTT funding because we can also have those partnerships." I actually think the way that PASTT funding works, it's — you know, I keep hearing it's absolutely unique in terms of the department says, we've got this much money, how do we split it amongst you. But there's huge commitment between the services with that principal, that the funding goes where it's most needed and it's based on client need. Um, and it actually works [laughs]."

		“Things are stretched, you know, people are spread thinly, to some degree (…) and I think there's definitely, a need for more [funding].” "We always have fights, like you know, but, that we'll have fights every year about funding and we kind of go back over old ground and, yeah, but we have a formula for how we recommend funding is distributed and there's always people unhappy at the end of that but then there's always a shrug of shoulders that basically says the formula is actually the best that we've got and it's not perfect.” "I’ve worked in related fields for a long time, and I think we go through lots of cycles of talking about how can we make contracts longer, funding more stable and so on. Ideally, I would love it if PASTT went, we recognise you need this level of base funding that’s got nothing to do with who’s coming, who is not coming, and you get top-ups on that. To have five-year contracts would be good and to know that you’ve at least got X, and then if you’ve got an increase in people newly arriving, that gets topped up. So, definitely not the, here you go, here you go, oh we haven’t had people arrive. Boom. We’ll actually reduce that. That doesn’t help with anything. So longer contracts, increased funding generally I would say, but yeah. Definitely having some stability and certainty... " “The issue is that [state] health has no insight about the Commonwealth’s planning for PASST…it seems that funding levels regularly change. The process is not transparent and therefore it is unclear what the Commonwealth’s priorities are, and what they are funding.”
	Demand/waitlists	“We are also – like, you know, sometimes we have to work to create a demand, for example, ah, we are running, um, mental health promotion groups at the ground level, um, and also we are – we are doing community development capacity-building programs so that these communities actually understand that they need to seek, um, counselling support, you know.” “The demand is constant, it just depends on what the urgency of different groups might be.” “We're not able to meet the demand on our services. (…) Um, I don't know if it's a particularly, um, [location deleted] thing, or COVID, or, or what, but we, you know, I – what keeps me awake at night is that we haven't had arrivals for the past two years into [location] really, except for the recent Afghan evacuees. Um, our referrals actually went up, they didn't go down.” “I don't know how, how we're going to be able to cope once arrivals really start again. Um, so yeah. We, you know, I – I'd put our statistics in, in what I'd sent through, so they're all there. But, um, yeah. We just, we're just not able to meet demand. Like currently our waitlist is sitting at over [number] now. Um, it's, it's not ethical for us to have more people on a waitlist that we're not going to get to for a very long time.”
	PASTT being the core work	“The PASTT-funded activities are bread and butter to the organisation.” "Without PASTT we wouldn't be able to do any of the other things…our positions, again, that hold, the glue that hold the whole program together are PASTT funded." “[PASTT] is who we are.”

	Cost pressures	"Because we do try and run it so leanly, I guess, to deliver great value to the Commonwealth, it has meant that we haven't been able to invest as much in some of those back office supports that are really necessary for the ongoing stability, so data, finance systems, IT systems...." "[Back office supports] has an impact, then, on the work, like it has an impact on the efficiency and effectiveness of the counsellors..." "(…) the funding hasn't increased to fully cover those increasing staffing and running costs, right, it costs more to put petrol in the car, it costs more to keep the lights on and all those sorts of things…." "(…) there also needs to be a recognition in that funding that you need management structures, that you need staff support structures in place in order to ensure that the best quality service is being delivered. Even just, sort of, the accountability requirements, you've got to have a sophisticated database system now to be able to report all the time, you've got to have a well-functioning finance area to be able to stay on top of all the accounting requirements and financial requirements and somebodies got to pay for those...." “The majority of your costing is your salary, that will be a big impact on the budget. (…) So that’s one of the biggest, and obviously now with the COVID, technology demands are really high up, so everyone needs a laptop, everyone needs a phone for work at home, and those things have really gone out the roof, so yeah.”
Findings and discussion	Summary of barriers	"We can sustain as an organisation but it's not providing the level of care that we would see our clients needing or we wish to provide." "I think our dependence upon [PASTT funding] is perilous because it's very much at the whim of whoever is in power at government." "I might be differing from the opinion of my colleagues in FASSTT…but I think there is significant risk in assuming [PASTT funding] will be there forever." “Because of the number of challenges we have, everything with the cohort, with interpreters, with the number of demands and KPIs and deliverables, and I think that retaining people is an issue that could affect sustainability.” "...But if the three [CEOs and the National Coordinator] leave in the same year, for instance, I think it would fall apart, to be honest, it's in danger of falling apart." “We are obviously competing against government services who are able to offer a lot more attractive salaries and probably a lot more attractive professional development ... (…) So, I think there’s a bit of competition with salaries. We pay under the SCHADS award, which is a level five. That’s not competitive with a lot of the other community service organisations either, because they’ve got their own infrastructure and size and so on, they’re able to have enterprise bargaining arrangements. They can pay above award salaries." ‘[we are] constantly shifting priorities and try and do everything (…) still we do achieve our KPIs, it’s probably not 100% in terms of quality, but we do meet the KPIs.’

		Hidden cost of inability to see referred clients - “internalised guilt and burnout" "The waiting list…has its own weight and its own cost in management and the people feel about it which is an important part of service delivery." "The waiting list is a stressful thing full of people who want services that we don't provide fully." "How do we triage and fix these problems so that we don’t' have very distressed staff supporting very distressed people." "That has an emotional and psychological impact on people [staff] and I don't think that there's anything this evaluation can do to address that but for me it's a day-to-day challenge for us to manage the distress associated with that and also have any kind of meaningful response." "There’s basically a whole field of vacancies out there where they could easily go to. So we’ve had a counsellor leave, but I’ve also got two other counsellors that are actively being approached by other agencies for work." "I know one of the big objectives of PASTT is to be able to support services so that people from background don’t have to stay in our service and can access all of those other services, but when you’ve got so much turnover in some of those services, the only capacity to give short bursts of training. You’re almost chasing your tail sometimes because by the time they start to build a bit of capacity, they lose it because of turnover or because of other priorities." "We might be supporting someone who could potentially be supported by another mental health service after a while, but as I said, there’s blockages there. So, people can’t move on… there’s certainly a lot of services that would say that they provide a trauma informed practice, but they’re not experienced and specialised in delivering trauma informed recovery practice with people from refugee backgrounds. They’ve fled wars and so on… I think there are services who are genuinely wanting to develop their practice to be able to better engage with communities… most of the feedback we get from people from communities, is that they struggle to engage with another service, and some of that is simple things. Like they don’t use interpreters…" "One of the things that I have certainly seen increase, and that’s only in 18 months, but [agency] tells me that, yep, we’re definitely seeing an increase in, is obviously access to affordable housing. It’s an incredible issue. We’ve seen increases in family violence rates. Increase in engagement – engagement’s not the right word – but child safety services involvement. So, I think there’s a lot of complexity that’s happening for people, and some of that is very retriggering of trauma. So, it’s not as clean cut as being a, oh that’s a case management thing, and we don’t do case management kind of thing. So, I think there’s a lot more – and I know that we’ve talked about this in past agencies. The level of complexity of issue and need for people, we are seeing an increase in... if you live in [location deleted] and you’re looking for a rental property, you’re probably not going to get one. People have got that stress and on top of all the COVID and everything else. Yeah, so I think there are definitely some socio-economic factors there that are making it more difficult. Certainly, access to employment in [location] is a real issue." “…and finally got it [decision/action by FASSTT network] through, which wasn't easy, it wasn't easy at all, I mean, I sort of joke that herding cats doesn't even begin to describe what the process was because there were eight organisations with eight boards not just the eight CEOs it was their boards that sat behind it and their boards would change we'd get to a point and we'd have another discussion and take it back and of course the board would be new and so you'd start the iteration all over again...”

		“Sometimes I would like to be in one of those places [bigger agencies], so I could feel more – feel safer doing my work with support around me.” "For a lot of people, it's not an area that they want to venture into because it's so…you know, with vicarious trauma and so on, it's hard work…and in government or private practice people can earn a lot of money." “One of the things that I find a bit limiting is just not having the resources to really apply some of that continuous improvement activity, that I would love to see happening, and just as a little example of that – and I think I might have briefly mentioned this when we met on the previous meeting. Being such a small PASTT service, I wear so many hats and go to so many different PASTT meetings and get so envious of the fact that they’ve got, oh you’ve got a data person. You’ve got a this, you’ve got a that...So I really want to develop some really good tools and be able to embed them in our database system, and use some really interactive ways to get feedback about people’s experience of our service, and then be able to actually work through all of that and come up with some really good recommendations, and then test them with communities and look at different ways. So, I have big dreams, but I have little time to do some of that...you don’t wait until you’re closing someone’s file to ask them what it’s been like. You need to be checking that every time you’re interacting with someone. Is it still relevant for you? Is it still useful? So, I’m trying to build a culture around doing that in real time checking." “Some of them are highly vulnerable, some of them are suicidal, some of them just released, just discharged from hospital… we are trying to do with them is hold people, to help them become better, and then once they are ready to start opening their trauma and working on their traumatic material.” “For a lot of people who come from a refugee background where they’ve held a qualification in their country of origin, and that’s not recognised here. It not only creates barriers for them, obviously in terms of their employment, but their identity and their self-esteem.” “It is a challenge sometimes to bring people from multiple communities together around a topic, and there’s some obvious reasons for that, that apply across all circumstances, but the on-cost of it is – usually for every community we engage, we’ve also got to then engage the bicultural worker, for language support and cultural context. So that multiplies, and so that sometimes means that when we’re providing some groups, we’re limited to only targeting one or two communities, and I think while we try to spread that – again, I don’t know this to be an issue – but I’m conscious that for other communities, it could be a, oh how come you’re doing that with that group, and that with that group, but there’s nothing yet for our group?” “And how do we manage that demand while still doing our everyday work with the clients that we know about? Um, there's difficult decisions that we have to make on a daily basis. (…) There's all these really ethically difficult decisions that we need to make. And that’s just the demand that we know about, there's other demand that we don't hear about and for me something I feel really passionately about is the zero to five age group, these are infants, children who can’t speak, who can’t express their vulnerability, but because we struggle to do the work that we know about it's really hard to do that work that is preventative, that really deeply and truly addresses intergenerational trauma.” “We’re always responding to the next emergency, we’re responding to the increasing constant demand, but being able to do that preventative work is really difficult.” “We know the demand by far exceeds what we can ever possibly deliver and sometimes our staff – us, because they’re passionate, they will – they will do it anyway you know, they will find ways, particularly, um, ones who are working in the

		communities, people who come from the lived experience background, they just – they just do it as community members on their weekends you know, they find ways to continue to do this stuff. (…) We know that that happens and that people go, like, people in this organisation and I’m sure in all the FASSTT organisations, go above and beyond so it's never a question of whether we’re delivering good work, it's a question of how do we have that seen and acknowledged.” "…even though PASTT doesn’t fund work with asylum seekers, as an organisation you're working with a people on a continuum of visas…"
	Summary of Enablers	‘I love that [ability to stay engaged with clients] about this place that you get to stay with people as long as they need.’ ‘[Lived experience] is afforded the place it should have had.” "The overarching, I suppose, feedback would be about the fact that the program's been in existence for the time it has been has meant that there's a great deal of expertise and capacity that's been built up." “The team are passionately committed to PASTT services and delivery…and you’ve got a lot of people who have stayed for a long time to do that.” “Flexibility to meet the needs of clients: each state can do things slightly differently.” "I don’t think that any service in Australia can compare to our services in working with refugees and mental health and that's just accumulated knowledge over more than 30 years of work." "We have really good links with all other institutions that are working in the field of [specialist intervention] in the world. And I believe we are one of the leaders in the world on using these techniques for working with trauma." “I’m really fortunate that the team that we’ve got are fantastic in the work that they do… but there’s a lot of experience in that team, but not easy to replace at all.” “We employ people and support people to actually develop really specialist practice, and we’re known for that...” “The work is great, it’s got it challenges, it is really worthwhile, and the staff…everyone who works here from that basis … it’s for the work and the clients that you work here.” “You can always walk up [to a staff member] and debrief.” “It [staff group support] is a lovely safety and I think it that is a joy in the work as well.” ‘I really appreciate the effect that we can be flexible enough to accommodate whatever they – they bring to us, and how they bring it to us. I do think it’s variable, and that’s why I’m here, because given all the challenges what keeps me here is that possibility of that relationship with those clients and what it can do for them, but not because it’s easy.’ "Nobody is here for self-interest"

	Contextual factors affecting rehabilitation	"They need to deal with, you know, good ol' Maslow's hierarchy, they gotta deal with their housing needs and all of that crap first before they get to their psychological needs." “Access to affordable housing. It’s an incredible issue.” “Huge challenges with housing and access to GPs.” “Housing, which I feel like is across Australia right now, but it's, um, really difficult for families and also the vulnerability, if housing – there's concerns, there's not really many options for people to be able to move or they’re quite vulnerable and, you know, are living in really bad circumstances and what they’re being charged as well.” “Um, in terms of how safe people feel in Australia, that impacts a lot on how they engage with trauma work. Um, and the federal policy can influence that. Sometimes it's the ability to be reunited with family members. So, if you've got family members who are still living in danger, that has an effect on it. Um, at the state level, some of the things that really impact are the availability of social housing. Um, you know, safe accommodation is an absolute basic for feeling safe enough to start rebuilding and to unpack trauma or those kinds of things. That's an ongoing challenge.” “I think one of the (…) events that took place in [location] have had very little coverage in our media here, and they've also had very little action from our government here. (…) Everybody has family, both in [location] and on the border in camps, and so they are all very, very strongly impacted. All of the [community members] have family members, and all the community members here are supporting family members. And there's horrendous violence, but it's not well known or recognised within Australia. (…) We went into schools last year, and I can remember asking – we're sitting with a large group of teachers talking about the large [community name] population within the school. And I just said, ‘How much do you observe kids being impacted by what's going on in [location]?’ And there was this blank look from all these teachers, and they just were not aware of what was happening. And I think that's happening within the general population, that news is not getting out and is not being picked up. And our government has, unlike the Ukraine where there's daily horrendous images that are traumatising to the whole population to look at, this was hidden.” "...we have to understand the entire sociocultural background but we also have understand in a way the systemic, ah, social economic system they are coming into, and we have to understand both systems and that a lot of our client’s needs are actually based on the gaps between the systems."

Contact us

Australian Centre for
Health Services Innovation

www.aushsi.org.au | contact@aushsi.org.au

School of Public Health and Social Work
QUT Centre for Healthcare Transformation, Faculty of Health
60 Musk Ave, Kelvin Grove QLD 4059

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Analysis of Suicide Prevention Trials Evaluation Findings

Summary of findings

Early and interim evaluation reports

February 2021

Summary of findings

Across Australia, there is a strong focus on innovative approaches to suicide prevention which can help reduce the number of people taking their own lives or attempting to do so. The Commonwealth Government, Victorian Government and Black Dog Institute are each making an important contribution to driving practice forward and building the evidence base on what works by funding regional trials of the systems-based approach to suicide prevention.

The systems-based approach involves a range of activities and interventions being delivered in parallel with and through diverse partners. Together, these activities aim to strengthen community and system capacity to respond to suicide. In the Australian trials, these are being delivered through regional approaches in which Primary Health Networks and other community actors are empowered to co-design and coordinate delivery of interventions in partnership with communities in 29 different locations around the country. The 29 sites consist of 12 National Suicide Prevention Trial locations funded by the Australian Government, 12 Place-Based Suicide Prevention Trials funded by the Victorian Government and five LifeSpan Trials delivered by the Black Dog Institute in communities across NSW and ACT.[1]

Collectively, these trials represent the largest and most comprehensive research effort exploring the regional systems-based approach to suicide prevention in the Australian context. There is therefore much that can be learned by collectively analysing and synthesising findings emerging from the trials, and drawing together their common themes. KPMG has been engaged by the Commonwealth Department of Health to undertake this analysis.

This document provides a brief overview of synthesised findings and observations from the early and interim evaluation reports prepared in relation to each of the three trials. These trials have been conducted on different timeframes during the period 2016 to 2021, and most had not commenced reporting outcomes at the time this analysis was undertaken. KPMG's initial work has therefore focused on identifying common themes and key learnings relating to the *establishment and implementation* of the regional systems-based approach to suicide prevention. Further analysis of findings relating to the *outcomes and impact* of the trials is being undertaken and reported on throughout 2021.

Key common themes in evaluation findings

In examining the early and interim findings from each of the three trials, there were a number of common themes which strongly and consistently emerged.

Time constraints were clearly identified as the most significant barrier to implementation across all trials, highlighting the need for realistic planning and time allocations in future suicide prevention initiatives. Effective local planning and relationship development are both considered critical for successful implementation, but these elements were found to be far more time consuming than originally anticipated in project timeframes. The evaluations indicate that implementation timeframes also need to be realistic and take into account other commitments and demands that intended delivery partners and stakeholders are already having to manage.

Building **strong and effective relationships** with a diversity of partners was highlighted as the most important enabler of successful implementation within the regional systems-based models of suicide prevention. This is hardly a surprising finding given that these models rely on coordinated action delivered by many different partners within a region or community. However, these trials have

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[1] The ACT LifeSpan Trial is not in scope for KPMG's analysis because it is proceeding on a different timeframe from the primary NSW trials.

identified several common factors that can facilitate the effective development of these relationships, including engaging potential partners as early as possible in planning processes and involving them in ongoing project governance. Allowing time for relationship building and the opportunity for partners to work through any pre-existing tensions or competitive pressures were also highlighted as important success factors, rather than expecting local partners to work together effectively straight away.

A related key theme that arose throughout the three evaluations was the importance of **engagement or 'buy-in'** for trial activities from the full range of suicide prevention partners and stakeholders considered essential to delivery. Establishing and leveraging relationships with a wide range of partners is critical to inform planning and facilitate implementation, but the extent to which these groups and individuals were engaged for the duration of the trials also affected the ease with which different initiatives could be implemented. One beneficial strategy that was identified for achieving this engagement was to identify and deliver 'quick wins' to demonstrate local progress to communities and generate momentum behind the broader systems-based approach.

All three evaluations reflected significantly on **workforce** issues, and noted that having workers with the right skill-set and characteristics for key trial coordinating roles was crucial to successful implementation. Importantly, the aspects that trial sites highlighted did not significantly emphasise prior suicide prevention or mental health expertise as a key requirement. Rather, it was highlighted that the coordinator roles are effectively community development positions – with a strong focus on relationship and capacity building. As such, strong interpersonal skills, community organising expertise and complex project management capability were generally found to be more important than sector-specific expertise. These are important learnings that can help inform both workforce planning and broader service planning for future community-led suicide prevention initiatives.

The final theme which emerged strongly across each of the trials is the importance of **adaptation and flexibility** in enabling successful delivery. This emerged in a number of different contexts which together emphasise the need for all partners in regional systems-based suicide prevention initiatives to adopt an open-minded and flexible approach. One common area where this was noted was in relation to how different project partners work together and make decisions. To enable timely and effective collective action, Primary Health Networks, state government health departments and other community partners will need to consider their existing governance structures and embrace less centralised models of decision-making. This need for adaptability and flexibility was also highlighted in relation to the initiatives and activities intended to be delivered within a regional systems-based approach. Communities were not found to universally embrace the systems-based models or accept evidence-based practices on face value, often preferring local knowledge or beliefs about what kinds of interventions would be most beneficial. This meant trial teams often needed to adapt their intended methods to align with local preferences or site-specific contexts. An important consideration for future community-led suicide prevention initiatives may be the need for investment in the translation of evidence at a local level.

Findings related to specific interventions, regions and populations

The early and interim evaluation reports did not provide detailed findings in relation to the implementation of specific interventions, or the impact of the trials within different regions or population groups. However, the evaluations identified a small number of preliminary observations which warrant mention here; these will be explored further through subsequent analysis.

In relation to specific interventions, the trials identified common challenges in implementing **initiatives aimed at primary care workers** such as GPs. This was primarily due to availability and the many other competing demands on their time, but buy-in for the underlying model and approach was also a factor. **School-based interventions** were also found to be challenging to implement where steps were not taken to create an authorising environment through state education departments before engaging with local schools.

The three trials consistently identified challenges with uptake and engagement in **interventions targeting priority populations including Aboriginal and Torres Strait Islander people, LGBTIQ+ Australians, men and veterans**. In each of these cases, early engagement in the design and development of initiatives and strong representation through shared governance were considered important enablers to participation, along with extensive tailoring to address locally-identified needs. The challenges of engaging with some of these priority populations are well known in broader mental health and suicide prevention service contexts. But it is important to understand that these can occur even in the highly localised and community-led context of the regional systems-based models deployed for these trials.

Finally, the early and interim evaluation reports did not reflect in detail on themes in relation to specific regions within each set of sites; subsequent reports may do so. However, one consistent observation across all trials was that **rural and remote locations** faced additional challenges in the process and implementation stages compared with more urbanised sites. For example, the remoteness of some sites made it challenging to attract staff with the appropriate skillset and local knowledge required to play an effective role in implementation. Effectively covering large catchment areas also required staff to undertake substantial travel, resulting in fatigue and potentially contributing to burn-out, in environments where there were generally fewer professional supports available to staff. Another challenge that was found to be particularly acute in rural and remote areas was drawing sufficient representation and input from partners and communities across large project catchment areas. The evaluations have highlighted that building strong local relationships is challenging in any context, but large and dispersed geographies reduce the capacity for consistent and face-to-face communication with some partners.

The evaluation reports raise some challenging early questions about the underlying **relevance of existing systems-based models to the Australian rural and remote context**. It was noted that both the LifeSpan and Alliance Against Depression models have been designed primarily in metropolitan contexts where there is a diversity of services, supports and partnerships already in place. Some trial participants questioned how applicable these models are to rural and remote communities which have fewer of these existing inputs to work with in delivering the systems-based approach. There were also specific observations about components of these models which would fundamentally need to work differently in rural and regional communities. For example, means restriction in relation to firearms is almost impossible in this context because rural and regional communities need access to these as part of their daily work. These are important insights that will need to be unpacked further through future stages of this analysis.

Conclusion

The key themes explored here appeared consistently and prominently across each of the trials despite significant differences in structures, locations, models, target cohorts, capabilities, partnerships and other factors. This suggests there are some key factors which exert a significant influence on the implementation of regional systems-based approaches to suicide prevention, regardless of the specific model or characteristics of the communities in which these will be implemented. KPMG will continue to unpack the issues mentioned in this summary through subsequent phases of analysis. But taken together, the early findings from the trials have already added much to our shared understanding of this emerging area of suicide prevention practice.

Disclaimer

Inherent Limitations

This report has been prepared as a summary of findings from the detailed report delivered to the Department of Health. The services provided in connection with this engagement comprise an advisory engagement, which is not subject to assurance or other standards issued by the Australian Auditing and Assurance Standards Board and, consequently no opinions or conclusions intended to convey assurance have been expressed.

No warranty of completeness, accuracy or reliability is given in relation to the statements and representations made by, and the information and documentation provided by, primary evaluation teams consulted as part of the process.

KPMG is under no obligation in any circumstance to update this report, in either oral or written form, for events occurring after the report has been issued in final form.

The findings in this report have been formed on the above basis.

Third Party Reliance

This report is solely for the purpose of providing the evaluations teams with a summary of findings of the detailed report. It is not to be used for any other purpose or distributed to any other party without KPMG’s prior written consent.

This report has been prepared to provide the evaluation teams for the three trials with a summary of findings from the early and interim reports. Other than our responsibility to the Department of Health, neither KPMG nor any member or employee of KPMG undertakes responsibility arising in any way from reliance placed by a third party on this report. Any reliance placed is that party’s sole responsibility.

Analysis of Suicide Prevention Trials Evaluation Findings

Progress Report 2

Department of Health

July 2021

Disclaimer

Inherent Limitations

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No warranty of completeness, accuracy or reliability is given in relation to the statements and representations made by, and the information and documentation provided by, primary evaluation teams and Primary Health Networks consulted as part of the process.

KPMG have indicated within this report the sources of the information provided. We have not sought to independently verify those sources unless otherwise noted within the report.

KPMG is under no obligation in any circumstance to update this report, in either oral or written form, for events occurring after the report has been issued in final form.

The findings in this report have been formed on the above basis.

Third Party Reliance

This report is solely for the purpose set out in the scope and methodology sections and for the Department of Health's information and is not to be used for any other purpose or distributed to any other party without KPMG's prior written consent.

This report has been prepared at the request of the Department of Health in accordance with the terms of KPMG's contract dated 13 October 2020 Other than our responsibility to the Department of Health, neither KPMG nor any member or employee of KPMG undertakes responsibility arising in any way from reliance placed by a third party on this report. Any reliance placed is that party's sole responsibility.

Executive summary

Building the evidence base for suicide prevention activity in Australia continues to be a focus for the Commonwealth Government. A key component of developing this knowledge is having a clear understanding of the various initiatives being implemented and tested at a local level. The three major suicide prevention trials across the country present an opportunity to delve into the activities underway or completed at 29 different trial sites. This report provides detailed information on the activities undertaken at each trial site and important details on the local context. A review of the broader suicide prevention literature is also included to supplement the primary research inputs originating from the three trials.

Progress Report 1 provided a high-level analysis of early and interim findings emerging from the National Suicide Prevention Trial (NSPT), the LifeSpan Trials and the Victorian Place-Based Suicide Prevention Trials (PBSPT). The initial intent for this phase of work was to provide an analysis of the final evaluation reports. However, due to changes in delivery timelines for two of the final evaluation reports, the focus of Progress Report 2 is to provide comprehensive site-level detail and an overview of the additional relevant research that informs the project's key research questions.

The site-level detail is best viewed using the Activity Insights Tool (Insights Tool) that is provided separately and is intended to be read in conjunction with this report. The tool articulates the various activities that can be viewed broadly at the national or state level and in greater depth at individual trial sites. This tool will continue to be developed as outcome information becomes available.

The literature review undertaken in a systematic manner for this report supplements the insights originating from the evaluation reports across the three trials. This process identified a total of 20 eligible articles that were then assessed for robustness by members of KPMG's Expert Advisory Panel. Much of the research identified examined implementation or process aspects of suicide prevention activity and predominantly used qualitative methodologies.

The findings in the literature mostly echoed the key themes presented in Progress Report 1 while also identifying some additional themes and issues which will warrant further exploration. The importance of planning and evidence and the impacts of multiple interventions within the systems-based approach are two such themes that will help guide our future work in this engagement. The implications of the research highlight the sheer complexity of suicide prevention activity in any context. The literature also underlines the lack of robust, translatable evidence supporting both individual interventions and systems-based approaches to suicide prevention. The lack of consultation and input into activities from people with lived experience of suicide was also highlighted by the research.

The gaps in the current evidence base and potential areas of focus will be an ongoing theme in future reports for this project. The next report will include analysis of the final evaluation reports (where available) and the potential policy implications of the evaluation findings and the broader literature.

Contents

Glossary

AAD/ EAAD	Alliance Against Depression/ European Alliance Against Depression
ADF	Australian Defence Force
ATSISPEP	Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project
CALD	Culturally and linguistically diverse
CI	Collective Impact
DHHS	Department of Health and Human Services (Victoria)
GP	General practitioner
LGBTIQ+	Lesbian, gay, bisexual, trans, intersex, queer
LHD	Local Health District
NSPT	National Suicide Prevention Trial
PBSPT	Place-Based Suicide Prevention Trials
PHN	Primary Health Network
QPR	'Question, Persuade, Refer' training
RSL	Returned and Services Leagues
YAM	Youth Aware of Mental Health – an education program delivered as part of the LifeSpan framework

1 Introduction and context

The Australian Government has made suicide prevention a key focus of its agenda for strengthening the physical and mental wellbeing of Australians. With Australia's suicide rate having been relatively static over the past decade and around 65,000 people a year attempting to take their own lives, there is a recognition among policymakers, service providers and the community that new approaches are needed.

There are several Commonwealth and state government initiatives that have been undertaken, are in progress or are being planned. These initiatives are adding to the national conversation about suicide and how to reduce its toll over time. Alongside broader strategic initiatives, governments and sector partners have also been exploring ground-up opportunities for reform through a series of regional and place-based suicide prevention trials. The Australian Government has funded 11 Primary Health Networks (PHNs) to lead community-driven interventions through the NSPT. The Victorian Government commissioned the PBSPT sites and the Black Dog Institute has been delivering five trials of its LifeSpan model in communities across New South Wales (NSW) and the Australian Capital Territory (ACT).

Each of these trials has adopted a regional systems-based approach to suicide prevention. This is a promising emerging approach which involves a mix of interventions being delivered through diverse local and community partnerships, which collectively aim to strengthen community resilience to suicide. Each of the suicide prevention trials has been evaluated or is currently being evaluated separately, with several PHNs also commissioning local evaluations on the activities in their region.

KPMG has been commissioned to synthesise and analyse the combined findings from these evaluations to inform the ongoing development of suicide prevention policy and initiatives. This includes undertaking a structured comparison of findings from these trials and the broader available research literature. The development and reporting of the various evaluations have different timelines for completion, directly impacting on what information is available for analysis at the time of developing this report.

This report is the second Progress Report and is intended to build on the information provided in Progress Report 1 that was delivered in November 2020. This report provides further detail on the initiatives undertaken at each trial site as well as a summary of the broad literature informing suicide prevention policy. This report is an adapted version of what was originally planned due to the delay in overarching trial evaluative information.

2 Analysis scope and methodology

The scope and methodology have not changed since the beginning of this engagement; however, the analysis timeline and the schedule of deliverables has changed due to the availability of evaluation reports required for this analysis. A summary of the updated schedule of deliverables can be found at Appendix A. The scope and methodology outlined below details the updated scope of this report and the methodology for the collection and analysis of information.

2.1 Scope

The purpose of this second Progress Report is to provide a more detailed synopsis of the local trial site activity for each trial and contrast the early evaluation findings with the broader literature on systems approaches and place-based suicide prevention interventions.

At the time of writing, the final evaluation reports for both the Place-Based and LifeSpan Trials are yet to be delivered. As such, this analysis primarily focuses on common themes and key learnings relating to the *establishment and implementation* of the regional systems-based approaches to suicide prevention, with preliminary analysis regarding *outcomes* of suicide prevention approaches in this report only based in the broader body of literature.

Future phases of work will focus on the analysis of outcomes as they become available in the final evaluation reports. The outcomes identified in these reports will be examined and reported on through subsequent phases of KPMG's analysis in 2021-22. The broader literature will also be analysed further in future phases to assess findings alongside the trial outcomes.

2.2 Methodology

The primary research inputs for this analysis were relevant selected literature on systems-based models of suicide prevention identified through a systematic literature review. A total of 20 eligible articles were identified through desktop searches and included in this review (for a full description of the literature review methodology, please see Appendix C).

As part of reviewing research inputs, members of the Expert Advisory Panel (Appendix B) undertook a robustness assessment of the articles selected for inclusion from the literature review. This assessment was undertaken using the Bond Evidence Principles, to allow KPMG to form judgements about how much weight to put on individual findings within the broader analysis. The robustness assessment key used in this process can be found at Appendix D. In developing aggregated findings and conclusions from this research, the analysis may place greater emphasis on findings from inputs which have been assessed as highly robust. Findings from inputs which have been assessed as less robust have still been included, but with appropriate caveats about the partial or preliminary nature of this evidence.

KPMG also undertook targeted consultation with PHN representatives who were directly involved in local trials. The purpose of this consultation was to validate existing information and gain additional information regarding the activities conducted in their respective regions as part of the trials. To this end, KPMG conducted a one-hour workshop with Victorian PHN representatives involved in the PBSPT in March 2021 and contacted all PHN representatives involved in the NSPT, LifeSpan and PBSPT Trials in writing throughout May 2021. As a result of the request for further information, a total of 48 additional documents were supplied to KPMG from seven PHNs. The documents varied in purpose and detail and included, for example, annual progress reports, public-facing communication materials, and evaluation reports of individual activities. The additional documents were assessed for relevance and used to refine the Insights Tool described at Appendix F.

Once this information was incorporated into the Insights Tool, KPMG provided each trial site with a list of the activities collated for their site to seek validation. A total of 10 PHNs representing 12 Trial sites provided validated information via email (as outlined in Table 10 at Appendix E). The information obtained through this process is included for reference in this report, however, will be further analysed along with the final trial evaluations in subsequent reports. We will continue to update the Implementation Matrix (and subsequently the Insights Tool) should further validated information be provided by PHNs.

2.3 Research questions

This project is addressing a series of research questions which explore the collective findings and outcomes of the trials, and the implications of these for suicide prevention policy and practice in Australia. The research questions have guided the analysis that has been undertaken to date.

Key research questions:

1. **What are the common themes occurring across suicide prevention trials, both at the overall coordination level and in relation to specific interventions, including barriers and enablers?**
2. **What themes has each evaluation drawn out that are unique?**
3. **What themes are specific to particular regions and/or population groups?**
4. **How do findings from these trials compare with broader available evidence on effective suicide prevention practice?**
5. What conclusions or recommendations can be made about interventions that are best coordinated, implemented and delivered at the regional level?
6. What questions emerged through the synthesis and analysis of evaluation findings and how might the Department seek to address these?
7. What are the implications for suicide prevention policy and implementation of regional approaches to suicide prevention in Australia?

This Progress Report provides analysis relating to the research questions in bold, above. The first Progress Report focused on key research questions 1, 2, 3 and 7. This report builds on the information contained in the first progress report regarding questions 1, 2 and 3 as well as providing insights to help address key research question 4.

KPMG will continue to build on this analysis and address the further research questions through subsequent phases of work as more inputs and findings from the trial sites become available in coming months.

3 Trial evaluation reports

Progress Report 1 provided a high-level analysis of early and interim findings emerging from the three suicide prevention trials. Considering the progress which had been made in delivering the trials at the time of these early findings being reported, the analysis presented in Progress Report 1 focused on common themes and key learnings relating to the establishment and implementation of the regional systems-based approach to suicide prevention.

In examining the early and interim findings from each of the three trials, there were several common themes which strongly and consistently emerged. This Progress Report therefore uses these identified themes as the basis for an analysis of the broader suicide prevention literature.

This report is intended to be read in conjunction with the Insights Tool described at Appendix F. The Insights Tool was developed based on the information contained in the Implementation Matrix, which provides a detailed list of activities conducted at each trial site conducted before May 2021.

The final evaluation reports from each of the three trials have not been included for analysis and synthesis in this report. This is primarily due to the NSPT final evaluation being the only final trial evaluation report available at the time of writing. Any evaluations commissioned by individual sites are also not included in this report. The evaluation reports for all three trials as well as any local evaluations deemed appropriate for inclusion will be assessed for robustness using the agreed criteria outlined in Appendix D and included in later reports.

Below is a summary of the general information collected for each trial and an overview of the inputs we have received. The unique themes identified for each trial identified in Progress Report 1 are also summarised. This information is provided in greater detail in Progress Report 1.

3.1 National Suicide Prevention Trials Evaluation

The NSPT is being delivered in 12 regions across Australia, which are overseen by 11 PHNs. This trial was initially scheduled to conclude on 30 June 2019, however was extended for 12 months in May 2018 (until 30 June 2020) to account for staggered commencement times for PHNs, and as the main roll-out of activities and services did not commence until late 2018 in many sites.[1]

As described by the evaluation team, seven of the trial sites had a focus on Aboriginal and Torres Strait Islander peoples, six on men, two on young people, two on LGBTIQ+ people and one each on ex-Australian Defence Force (ADF) members and older adults. Some focused on specific sub-groups in their chosen focus population, such as fishers, farmers and miners within 'men', and young people within 'LGBTIQ+' and 'Aboriginal and Torres Strait Islander' cohorts. [2] The approaches chosen by trial sites varied: eight trial sites adopted (and adapted where necessary) the LifeSpan approach, while two sites adopted the Alliance Against Depression (AAD) framework. The two trial sites that focused exclusively on Aboriginal and Torres Strait Islander peoples did not adopt either approach.[3]

The NSPT has been evaluated by the University of Melbourne to determine what learnings it provides about effective strategies for preventing suicide at a local level and in focus populations. The initial reporting date of December 2019 was extended to December 2020 in line with the trial extension.

To date, inputs received regarding the NSPT include:

- Interim evaluation report (October 2020)
- Final evaluation report (December 2020)
- Other documentation outlined in Appendix E.

Interim findings

The evaluation interim report identified several themes unique to the NSPT.

Aboriginal aftercare

The NSPT has included the development of Australia's first ever Aboriginal-led aftercare model in Port Augusta, providing culturally appropriate support for people in crisis. The model was developed throughout a period of extensive community consultation by an Aboriginal working group and other stakeholders, delivered by the Pika Wiya Health Service Aboriginal Corporation. Observations in the interim evaluation report were that the model has been well-utilised and effective in increasing the availability of culturally appropriate services, enhancing collaboration between clinical and cultural workers in the delivery of mental health care, and is now working with additional partners to help educate and promote best practice in Aboriginal and Torres Strait Islander suicide prevention.

Language use with veterans

ADF veterans are a target population for the Northern Queensland PHN in Townsville, which developed and trialled strategies for interventions supporting ex-service men and women. This initiative termed 'Operation Compass' builds connections with people who are vulnerable to social isolation.[4] The evaluation identified special considerations to incorporate when designing interventions for this particular community, with the appropriateness of language used in initiatives noted as a particularly important consideration. Preferred language for this cohort was highly context-specific (for example, not including references to foreign defence forces) and strengths-focussed (for example, preferring to emphasise veteran wellbeing rather than 'suicide prevention').[5]

Diversity of PHNs

The evaluation highlighted that differences between the geographical scale of the NSPT sites had considerable impacts on the planning and implementation phase. The evaluation found that distance impacted who could participate in the planning process by limiting stakeholders' ability to attend meetings and consequently affected local engagement.[6] The diversity of populations and infrastructure within large areas also contributed to significant challenges in planning activities that were well suited to the whole catchment area and in coordinating infrastructure and inputs from agencies at both the Commonwealth and state levels as well as community partners.[7]

The NSPT evaluation also highlighted that differences in expertise, leadership, organisational structure and culture across PHN sites had an impact on planning and implementation, highlighting the need to consider certain features of a site from the outset and tailor the approach to planning and engagement accordingly, as well as for the actual implementation of activities.

Diversity of organisational culture

Diversity of PHN organisational cultures and the differences in the alignment of these cultures with the community development approach were highlighted by the NSPT evaluation team. PHNs with a strong existing focus on community engagement and relationship-building enabled successful and relatively seamless delivery of the systems-based approach. Conversely, PHNs structured more as commissioning bodies required more effort to facilitate cohesive and coordinated community development.

3.2 Place-Based Suicide Prevention Trials Evaluation

The PBSPT is a key Victorian initiative to trial a place-based approach to reducing suicide in 12 communities spanning all six Victorian PHN regions. The Victorian Department of Health (formerly the Department of Health and Human Services) provides support to PHNs and the individual trial sites, encouraging each site to have locally tailored approaches.

The PBSPT is being evaluated by the Sax Institute and Southern Synergy in three phases, with individual pieces of work undertaking implementation/establishment, formative and summative evaluation.

To date, inputs received regarding the PBSPT include:

- Establishment Phase Evaluation Report (2019)
- Formative Phase Evaluation Report (2020)
- Other documentation outlined in Appendix E.

The final summative evaluation report is due to be provided to the Victorian Department of Health on 30 September 2021. Given this timeline and lack of new inputs since the first Progress Report, this section provides a high-level summary of the interim findings with some additional information provided by the six PHNs leading the local trial sites.

Several PHNs identified initiatives targeting specific focus populations that were not included in the first Progress Report. A full list of the target populations can be found in the Insights Tool. Some of the additional focus populations include:

- Men – Eastern Melbourne PHN (EMPHN) (Whittlesea) and Western Victoria PHN (WVPHN) (Great South Coast)
- Farmers, young people and health professionals – WVPHN (Great South Coast)
- People with lived experience, CALD – South Eastern Melbourne PHN (SEMPHN) (Dandenong and Mornington Peninsula).

Interim findings

The evaluation interim report identified one key theme unique to the PBSPT.

Collective Impact Framework

The primary unique theme emerging from the PBSPT evaluation related to the use of the Collective Impact (CI) model as a structured approach to collaboration. CI is primarily adopted when addressing complex social issues and stipulates five components in partnership: a common agenda; continuous communication; mutually reinforcing activities; backbone support; and shared measurement.[8] This new way of working presented challenges to both the Victorian Department of Health and PHNs, requiring flexibility and adaptability in governance. By grounding their approach in CI, the PBSPT sites had an opportunity to try a new governance model for suicide prevention initiatives and, in the process, learn about what is required for effective implementation. To this end, relationships were crucial, with the role of the site coordinator seen as particularly critical in connecting all stakeholders.[9] The lack of guidance available in using CI in suicide prevention in Australia provided a significant challenge.[10] However, despite 'teething problems' such as having little guidance on using the framework in practice to determine appropriate activities, the CI approach was deemed to be highly appropriate for suicide prevention.[11] An important factor in why the CI was seen as a potentially more suitable model is the focus on relationships and the role relationships and partnerships play in implementing complex initiatives. The impact of the CI approach needs further exploration to determine if this translates to positive outcomes.

3.3 LifeSpan Suicide Prevention Trials Evaluation

The LifeSpan trials are being delivered in four locations across NSW. A further trial site has been established in the ACT through a partnership with ACT Health but is proceeding on a different timeframe from the original core trials and is not in scope for this engagement. All trial sites have received additional funding to extend for a further 12 months to the end of the 2022 Financial Year.

The Black Dog Institute received funding from the Paul Ramsay Foundation to deliver and evaluate the LifeSpan trials in the initial four locations.

To date, inputs received regarding the LifeSpan trials include:

- Paul Ramsay Foundation - Progress Report (April 2020)
- Paul Ramsay Foundation - Progress Report (October 2020)
- Other documentation outlined in Appendix E.

The LifeSpan evaluation timeline has been adjusted to include key outcome measures. It is anticipated that the main outcome results (suicide attempts) will be available in September/October 2021. The evaluation team plans to use suicide attempt data up to the end of March 2021, which corresponds with two-years post-baseline intervention. Secondary outcome results (suicide deaths) will not be available until 2022.

The timeframe for delivering the final Evaluation Report remains unclear given the reliance on the release of multiple datasets. The evaluation team from the Black Dog Institute is providing regular updates on progress and is aware of the timelines relevant to this engagement.

Interim findings

The evaluation interim report identified two unique themes regarding the LifeSpan Trial**.**

Role of the media

The LifeSpan trials emphasised, more so than the other two trials, the role of the media in the regional systems-based approach. Encouraging safe and purposeful media reporting through training and capacity building forms a key part of the LifeSpan approach. Media, which included a newspaper campaign at one site, can also be an important channel for driving engagement and buy-in from the wider community in other trial activities. An example of this is through the promotion of training and other opportunities as part of awareness-raising campaigns, which highlights the value of approaching local media as a delivery partner, not just as a target for capacity building.

Data as a driver of engagement

An important observation arose about the value of data as a mechanism for driving and strengthening engagement between PHNs, Local Health Districts (LHDs) and other key stakeholders. In the LifeSpan trial sites, PHN and LHD staff were provided with data visualisation dashboards tracking progress in delivering trial activities as well as broader metrics relating to community need where these were available. These dashboards helped to build a shared understanding with these key partners about the nature of local issues and areas needing ongoing focus. They also helped to maintain engagement and to support a sense of momentum by providing close-to-real-time information on progress being made across activity taking place in multiple locations and through diverse partners.

4 Additional research

To enable richer responses to the key research questions for this engagement, a systematic literature review was undertaken to supplement the primary research inputs originating from the three Australian trials. This section synthesises findings from literature identified through this review. Please refer to Appendix C for a detailed description of the methodology and selection criteria that were used in identifying and analysing this additional research.

Literature review

A literature review conducted with a systematic approach provided an overarching scaffold for the conduct of this project. A literature review draws together evidence from a specified set of sources, chosen using pre-defined eligibility criteria. By clearly establishing the research questions of interest in advance, defining the inclusion and exclusion criteria to be used in selecting evidence, and undertaking structured comparative analysis of research outputs, this approach supports robust aggregation of empirical findings from multiple research projects and initiatives.

Realist Review

The realist synthesis approach has been developed in response to the specific challenges of undertaking evidence reviews in the health and human services context, among others. The complexity and diversity of factors that influence outcomes in these contexts mean interventions rarely work in the same way in all places and for all recipients.

Realist review therefore focuses on synthesising evidence and providing explanations for *why* an intervention may or may not work, for whom and under what conditions or circumstances. It is a strong complement to the systematic literature review approach because it deepens findings beyond the question of *whether* an intervention has been found to work.

This realist approach has guided analysis of both the core trial evaluation findings and broader research. This allows additional themes or items of interest beyond the primary research questions to be addressed if they emerge in the course of this project. It also guides the focus on identifying and explaining the *mechanisms* by which interventions appear to work, strengthening insights for future policymaking and investment.

4.1 Literature summary

Overarching observations regarding the body of literature

There is a lack of robust quantitative research examining *outcomes and impact* of systems approaches and multi-level interventions in suicide prevention. Much of the research identified in this review examined implementation/process aspects and/or used qualitative methodologies.

Most of the research which did examine impact and outcomes of suicide prevention activities focused on individual interventions (such as gatekeeper training), rather than addressing the impacts or outcomes of systems-based models as a whole. A small number of studies referred to the 'synergistic effects' produced by such approaches and emphasised the difficulty in designing evaluation methodologies to capture this additionality created through delivering multiple interventions simultaneously.

The sections below detail the findings from the literature identified through this review, as they reflect themes identified from the review of trial interim evaluation reports (please refer to Appendix C for further detail regarding methodology).

4.2 Robustness assessment of literature

The research literature included in our analysis was assessed for robustness by two members of KPMG's Expert Advisory Panel (Appendix B). The purpose of the robustness assessment is to extend the body of knowledge available on suicide prevention by better understanding the strength, relevance and reliability of the evidence outlined in the literature. The assessments supported our analysis by ensuring greater focus could be given to findings from more robust research.

A total of 20 pieces of research literature were assessed for robustness by members of KPMG's Expert Advisory Panel. This robustness assessment was undertaken using the Bond Evidence Principles, to establish an agreed baseline for how the various research literature articles should be weighted in the subsequent analysis. The robustness assessment key used in this process can be found in Appendix D.

Key observations from robustness assessment

Members of KPMG's Expert Advisory Panel highlighted a number of insights arising from the robustness assessments. Some insights regarding the literature as a collective provide contextual information when considering the early and interim evaluation findings and the forthcoming final evaluation reports. These include:

- The voice and inclusion domains consistently rated less strongly across the research literature (domain average = 56) – there is a clear lack of lived experience perspectives and prioritisation of clinical and 'official' perspectives.
- There is a large range of scores in the triangulation (range = 31 – 88) and transparency (range = 38 – 94) domains – this reflects diversity of size and scope of different research projects. The early and interim evaluation reports were assessed as being relatively stronger in these domains.

These insights provide an important lens when undertaking the robustness assessments of the trial evaluation final reports. Assessing the strength of these domains across those reports will inform gaps in the overall evidence base for suicide prevention.

Table 1 below describes some of the reflections from the robustness assessment and the implications for this project.

Table 1 Implications of robustness assessment results for the current project

Reflections	**Implications for this project**
System vs model components • When we talk about systems-based approaches, **what do we mean by 'the system'**? • Papers often **take a 'helicopter view'** of approaches	• Do the evaluation reports demonstrate common understandings of systems approaches? Which 'system' is being evaluated- the intervention components/domains, or the organic system of actors which exist in the trial community? • The research doesn't go into detail about what these model components/ systems approaches are.
Interacting with the system	• There are broader ways of tapping into 'systems', which involve tapping into

• The research describing **participation/involvement of community and stakeholders** provides little detail about this process.	experiences of communities and people impacted by suicide. • Need to understand the role people with lived experience have played in the current trials and what opportunities may exist for future suicide prevention activities.
Body of research • There is **no cohesive body of literature on systems-based approaches** at this stage • **Over-reliance on a small number of empirical modelling-based studies** as evidence for the effectiveness of the systems-based approach. • The **Bond Principles are not equally applicable** to every type of research paper.	• Qualitative research/ study designs dominate the literature but should not be relied upon in this context as a primary demonstration of success, particularly for a systems-based approach. • The Bond Principles provide a robust framework for assessing literature, but a low score does not exclude a research paper from being valuable for this analysis.

5 Findings in the literature

Several common themes were identified through the analysis of the interim evaluation reports. As the final evaluation reports for each trial are not in scope for this report, this section compares the findings in the literature from those identified in the first progress report. Details regarding the relative robustness of the literature have been included throughout this section to assist in understanding the findings in greater depth.

Greater detail on the specific interventions implemented at each site has been provided through consultation with PHNs and the provision of relevant documentation since the first progress report. This information has been incorporated into the Insights Tool but has not been analysed in detail. It is expected that final evaluation findings and additional documentation will provide further information and allow for more in-depth analysis in KPMG's subsequent reports. For greater detail on each theme from the early and interim evaluation reports described below, refer to Progress Report 1.

5.1 Findings in the literature based on themes in Progress Report 1

In the below sections, themes identified in the first progress report are separated into the overall coordination level and specific interventions

Overall coordination level

At the overall coordination level, five key themes consistently emerged from the three trial evaluations: time; relationships and partnerships; engagement; workforce; and adaptation and flexibility. Each of these themes and their interdependencies are summarised below and compared with findings in the literature.

Key theme 1: Time

The most prominent common theme across the three trial evaluations was the criticality of time as a resource. Actions required for implementation such as needs analysis, planning, community engagement, building trusting relationships and gaining input from key local stakeholders all took considerable amounts of time– both for those setting up the trial and for local community members. The amount of time allocated to important tasks was often underestimated leading to a trade-off between meeting project timelines and optimal implementation of interventions.

The literature described the time allocated for the administration of programs, particularly for leadership or coordinating roles, often being underestimated. Similarly, the input from key local stakeholders such as medical staff and leaders of partner organisations requires significant time. Both program specific roles and those informing local activity are critical roles that require a lot of time and energy and are often an additional component to existing full-time responsibilities. The time needed to be provided by these key stakeholders for meaningful engagement is often not recognised or reflected in planning. For example, when implementing a systems approach to suicide prevention using the Zero Suicide Framework, several working groups were established and led by senior clinical staff, who had limited capacity to commit to the role in addition to their full-time responsibilities.[12] In their article rated high for appropriateness and deemed generally robust, Turner et al. highlighted the consequences of underestimating time requirements across various roles and the impact this can have on the overall success of an intervention.

There is also further nuance to the criticality of time for engagement that needs further exploration. Engaging and gaining meaningful traction with stakeholders who do not currently see suicide prevention as part of their role is an example of where time requirements can be significantly underestimated. There may also be other factors required to engage such stakeholders beyond the time component that need to be explored in greater detail.

The theme of time, and often lack thereof, was a consistent theme from the early and interim evaluation reports and the relevant research in suicide prevention. While there is often a desire to implement a program or intervention as quickly as possible, allowing for adequate time to plan and build trusting relationships appears to be an important factor in the success of an initiative.

Key theme 2: Relationships and partnerships

All early and interim trial evaluations emphasised that a key enabler of the system-based approach and successful implementation was active involvement and buy-in from a wide range of community partners. More successful sites were those which either started with stronger existing relationships and partnerships within the community or allowed more time to build these at the commencement of the trials. The development of effective community partnerships by the central trial coordinators was important but the network model where partners in the trial were successfully collaborating with each other was just as crucial. The diversity of partners and effective engagement with partners representing a diversity of perspectives, particularly target populations, were both recognised as key features of successful trials.

In an exploration of Optimising Suicide Prevention and its Implementation in Europe (OSPI-Europe), Harris et al. highlight the importance of having fully engaged and collaborative partners when implementing complex multilevel interventions.[13] It is important to note that this analysis by Harris et al. received the maximum rating in the voice and inclusion domain in the robustness assessment, highlighting the quality of the research. The research indicated that sites that implemented the key components of OSPI-Europe, that did not establish strong relationships with partner organisations had greater difficulty in executing 'optional' or more intensive activities. This meant, for example, that sites with weaker relationships that provided suicide awareness training had greater difficulty implementing a more intensive, but sustainable, 'train the trainer' model, leading to less variation in the stakeholder groups trained and long delays in implementing training.[14] Furthermore, partnership and cross-sector working was hindered in one site by a lack of collaborative culture and "the need for formal, signed protocols and agreements to enable access to potential training recruits."[15]

The literature supports the theme from the first progress report highlighting the importance of relationships and partnerships. The suicide prevention sector is complex and challenging with a wide variety of individuals and organisations. Developing trusting relationships and formal partnerships with the most appropriate group of stakeholders is a key component for optimal outcomes.

Key theme 3: Engagement

As described above, relationships are a key to success, but the extent to which groups and individuals were engaged for the duration of the trials significantly impacted on the ease with which different initiatives could be implemented. Progress Report 1 highlighted the engagement of priority populations as especially integral to planning, implementation and integration of trial initiatives. It was also evident from the reports that this was a major challenge for many trial sites.

Hergerl et al. describe the process of transforming key individuals from passive stakeholders into active program participants in the forming of advisory and leadership groups as a significant success factor for OSPI-Europe implementation.[16] There were still challenges with developing community buy-in but the OSPI's emphasis on capacity-building, leveraging the strong reputation of the underlying evidence-based model (AAD) and the "participatory approach" to interventions were keys to strong engagement.[17] Hegerl et al. describe the success of the AAD model being in part due to the "bottom-up approach" and the level to which local engagement builds motivation and civil commitment.[18] The research from Hegerl et al. provided insightful detail on engagement, however the articles received low overall scores when assessed for robustness. A published article on the Tasmanian NSPT site that was assessed as being more robust, has shown that activities focussing on increasing engagement, education or capacity building have high levels of demand and are very feasible under a community-led approach.[19]

A Randomised Controlled Trial (RCT) of the Multi-level Intervention for Suicide Prevention in New Zealand study (MISP-NZ) found varied uptake for different intervention components (most engagement with print resources, followed by suicide prevention training and workshops), and that getting effective engagement with certain stakeholder groups such as primary care workers was highly challenging.[20] The authors posit that the level of success in overall engagement across the varying interventions significantly impacted the effectiveness of implementation.[21] This research from Collings et al. was rated as generally robust with particularly high scores in the Appropriateness (80) and Contribution (100) domains.

Several research articles identified in our review highlighted the value of engagement, strongly supporting the findings from Progress Report 1. The concept of engagement ties in closely with both key themes 1 and 2, with adequate time and healthy relationships both critical for the level of engagement required for success. Future activities aimed at preventing suicide must include engagement as a central component.

Key theme 4: Workforce

The interim and early evaluations also highlighted consistent challenges with retention of key staff with the right skills set during the design and delivery of each trial. Turnover of staff often led to disjointed relationships, loss of project momentum and a loss of confidence within the community. Staff turnover and the associated loss of relationships and knowledge was a significant barrier for many trial sites, and often cited as a major reason for slower than expected implementation. Changes in particular roles, such as coordinator roles, were emphasised as having a significant impact on the progress of interventions. The evaluations also noted the impact of significant turnover in supporting agencies and key partner organisations. Similarly, analysis of OSPI-Europe implementation revealed central coordination bodies, such as advisory groups, as having substantial impact on the ease of implementation.[22] This suggests that having the right stakeholders in central roles can mitigate the impact of staff turnover across organisations, but also that the loss of these central stakeholders can be particularly damaging to trials.

In line with the workforce theme, the competencies of staff are critical to the success of multi-component/ multi-level initiatives in the literature. A core component of implementing a Zero Suicide Framework in a mental health service in Queensland was staff training. As described by Turner et al., "an expectation is that all staff are first assessed for their beliefs, training and skills needed, which is followed by the provision of the training appropriate to their role."[23] Staff skills outside their clinical discipline prove integral to smooth implementation given the challenges of implementing complex models and interventions. An agile, collaborative and all-of-service approach to work, and "a culture that supported resilience and flexibility of the system in addressing challenges when they arose"[24] was recognised as an important factor.

The workforce theme identified in the literature emphasised the importance of skills and competency, and the influence of effective training. The interim and early evaluations focused on the negative implications of staff turnover and the resulting loss of momentum and knowledge. Both the ability of a staff member and the retention of key staff appear important to the success of suicide prevention initiatives.

Key theme 5: Adaptation and flexibility

The final theme which emerged strongly from our analysis of the early and interim evaluation reports was the importance of adaptation and flexibility in enabling successful delivery. This was noted in relation to a number of different trial components required to deliver the systems-based approach: how different project partners work together and make decisions; the mix of initiatives and activities as local priorities changed; the importance of being flexible to incorporate community priorities; and being adaptable and flexible in relation to delivering a diverse range of activities coordinated through multiple partners within a compressed timeframe. Each trial evaluation team highlighted that 'planning' and 'delivery' were not distinct phases in trial implementation leading to a continuous process of planning, reviewing and evolving activities as new insights were gained.

The fluidity of the environment appears to be an inherent feature of the community-led approach to suicide prevention and is backed up in the literature for certain components. The RCT of the MISP-NZ interventions completed by Collings et al. showed that there is a need to adapt to changing evidence surrounding suicidality when implementing interventions. [25] When MISP-NZ interventions failed to generate results seen in their previous implementation overseas, Collings et al. posit this was in part due to a divergence from the underlying model's (EAAD) focus on identification and treatment of *depression* to a focus on identification of *suicide risk* (including a broader range of risk factors) in line with more recent theories surrounding suicidality.[26] Learnings from the Tasmanian NSPT outlined in articles considered reasonably robust also highlight the need for flexibility in which interventions are chosen and how they are delivered according to focus populations' existing knowledge and skills surrounding suicide prevention.[27] [28]

Flexibility with training is another theme in the literature with Coppens et al. highlighting the need to tailor approaches to gatekeeper training between different sites based on the existing skills of particular cohorts in each context. [29] Arensman et al. also reflect the need to tailor training strategies according to existing knowledge based on the differing proportions of previous suicide prevention training across different OSPI-Europe sites. [30] As part of the OSPI-Europe program across multiple European states, gatekeeper training was directed at police officers as both an at-risk cohort and a cohort who are highly likely to come into contact with people experiencing mental illness or suicidality compared with the general population.[31] The authors of this article that was assessed as high for appropriateness conclude that approaches to gatekeeper training should be adapted based on factors such as the expectations and roles associated with police work and the characteristics of police officers in different contexts.[32]

Hegerl et al.'s exploration of the AAD approach highlights the importance of being adaptive and flexible in communications and messaging according to the target population.[33] The dual focus of the AAD model on both depression and suicidal behaviour was said to enable the tailoring of messages according to the values of the general public versus health professionals. [34] Similarly, adaptability in approaches to suicide prevention is required to target communities' experiences of suicide.[35] Exemplifying this is the difference in suicide behaviour and suicide methods across different EAAD sites in Europe, where the most common methods of suicide and characteristics of suicide according to gender substantially differed between sites.[36] Hegerl et al. suggest "setting country-specific foci in awareness campaigns and suicide prevention strategies." While these insights add considerable value, it's important to remain cognisant of the low overall robustness of this literature.

The existing health service/ system/ intervention landscape at sites is also a factor that requires flexibility and adaptation.[37] Collings et al. describe how the EAAD model was adapted from having a primary focus on depression identification and treatment in original European sites to having a more specific focus on suicide prevention in New Zealand. [38] Differing health service systems, and cultural and historical differences between New Zealand and other countries need to be accounted for to understand local factors contributing to both suicide and mental illness, meaning that prescribing a one-size-fits-all approach is not always appropriate. [39] However, it is important to note that while adaptations may be necessary to ensure interventions are contextually appropriate, consideration must be given to the impact of any changes to expected outcomes when deviating from the underpinning model. This may have been a factor in the differing results between New Zealand and the original European sites. Also suggesting there is an important role for consistency, York et al. explored Veteran-specific suicide prevention activities and describe how inconsistent definitions of suicidality between clinical services, research and education have impaired collaboration and communication across the sector.[40] The authors suggest that adopting standard nomenclature across sector stakeholders is an effective method of facilitating collaboration across diverse sites and sectors.[41] The literature outlining the different perspectives provided by Collings et al. and York et al. was rated high for appropriateness (88 for both) and considered reasonably robust.

The majority of the literature supported the findings from the first progress report that suicide prevention activity needs to be adapted to the local context and flexibility is required during the implantation phase. Tailoring training, messaging and interventions to the specific community needs and levels of knowledge is an important consideration. However, the literature also highlighted the importance of consistency in interventions and language in some situations.

Specific interventions

The following section identifies a small number of emerging observations relating to specific interventions that were common across the early and interim findings, which will continue to be refined and expanded upon as additional information becomes available.

Interventions based on engaging primary care workers

Interventions designed to train and upskill primary care practitioners such as general practitioners (GPs) have been part of the systems-based approach in most trial sites. A common challenge across all sites was reaching and engaging with these audiences due to their limited availability or willingness to participate. For example, the LifeSpan trials reported that implementing the StepCare screening tool and methods within GP practices had been challenging, with mixed uptake across sites.[42] The NSPT evaluation report similarly identified a key challenge for interventions focused on training primary carers as being: "Finding GPs who have capacity and willingness to step outside their usual day to do something different."[43] The NSPT evaluation noted that where activities for primary care workers were conducted *by* GPs, this appeared to support improved buy-in and participation.

Primary care providers (GPs) are identified in the literature as a cohort that both plays an integral part in the effectiveness of multi-component or multi-level suicide prevention initiatives, but also a potentially challenging group to engage, requiring tailored engagement and communication strategies. Similarly, Smith et al. reported that at the Tasmanian NSPT site there were challenges in engaging GPs and emergency department workers due to "organisational-level barriers within these services," and that, as a result, few activities in the PHN were targeting these workforces.[44]

Harris et al. highlight how the use of central coordinating bodies, such as advisory or working groups, can be used effectively to overcome challenges in engaging primary care providers in suicide prevention interventions.[45] Sites where advisory groups had strong links with local GP champions (and therefore a high level of sector and community influence) experienced less difficulty and took less time to recruit and train GPs than sites without advisory groups or without strong links to primary care providers. [46] The EAAD model includes a strategy of "forming connections with primary care physicians in a local community by offering advanced training" that is interactive and provides an opportunity for discussion on local systemic factors.[47] As education of primary care physicians targeting recognition and treatment of depression have been shown to be one of the most effective interventions in lowering suicide rates, effective methods of engaging this cohort in complex multi-level, multi-component suicide prevention activities is integral to the success of a systems approach.[48] This review from Zalsman et al., assessed as high in appropriateness (88) and transparency (75), emphasises the need for further investigation on methods to effectively engage not only physicians but all primary care workers.

The literature supported the notion from the first progress report that interventions based on engaging primary care workers is crucial for success in a systems-based approach to suicide prevention. The literature exposed some of the training and engagement methods that have proven more effective with this cohort. These findings should be used to inform future activities targeting this critical part of the workforce.

School-based interventions

Across the three trials, interventions focused on informing and educating young people about mental ill-health, suicide and how to get or provide help were an important component of community capacity-building. The most commonly delivered intervention was the LifeSpan Youth Aware of Mental Health (YAM) program, which is primarily delivered to Year 9 students. This was undertaken both through the NSW LifeSpan trials and in at least one NSPT site. In consultation with the Black Dog Institute, it was emphasised that delivery of these youth-focused interventions was significantly enabled by having the support and buy-in from state-wide education departments. The NSW and

South Australian Governments provided senior-level agreement for the program to be delivered in local schools, which made the roll-out of this on the ground relatively straightforward. In contrast, in jurisdictions where this authorisation had not been provided, engaging with individual schools was much more challenging.

The level of evidence supporting school-based suicide prevention programs is mixed, with some studies showing improvements in knowledge and attitudes toward suicide but no effect on suicidal behaviour, others showing reductions in suicide attempts and severe suicidal ideation, and others demonstrating mixed or negative impacts on suicidal behaviour.[49] Youth suicide screening programs also show mixed impacts on suicidal behaviour. While some improved identification in adolescents at risk this was to differing extents. Screening in school settings was found to be effective and safe in enhancing treatment referrals and service use in high-risk adolescents. Conversely, a large RCT of suicide prevention programmes implemented in Europe did not show significant effects of screening in reducing suicidal ideation and attempts. However, a combination of screening for risk behaviours in addition to psychopathology added significant value in identifying pupils with mental health problems.[50]

The current literature suggests there is a need for further exploration on the effectiveness of school-based interventions. The early and interim trial evaluation reports and discussions with the evaluation teams highlighted the importance of such interventions. The impact and outcomes associated with school-based interventions will be of considerable interest in the final evaluation reports.

Interventions targeting priority populations

Sites in all trials appear to have faced challenges designing and delivering specific interventions for priority populations. This was primarily because of the issues relating to buy-in and engagement discussed under Key theme 3, as well as the intersection and overlap of planned trial activities with existing initiatives in place within communities. Challenges were most commonly reported in relation to specific interventions targeting Aboriginal and Torres Strait Islander communities, men and young people. The NSPT evaluation also noted initial challenges engaging with veteran communities, because the focus on suicide prevention was not considered to align with their priority focus on wellbeing and upstream support for people who have served in the military.

The literature also described various interventions targeting priority populations and their relative effectiveness. The evidence was mostly in line with the findings from the first progress report, with the challenges of getting the right stakeholders involved and the difficulty of engagement from priority populations common themes. Involving people from priority populations – and particularly those with a lived experience of suicide – in the planning and development of initiatives directed towards their communities was found to increase buy-in and the likelihood of success for these specific interventions across all trials.

A number of target populations stood out in the literature, with the section below separated accordingly.

Gender

The literature highlighted that gender-based differences must be considered for increased efficacy of interventions.[51] [52] For example, Sakashita et al. found that primary care interventions alone are insufficient to reduce the suicide rate in men in their article rated high in appropriateness but low in voice and inclusion[53] They also posit that different levels of impulsivity in men and women (where men are more vulnerable to impulsivity) may explain differences in responses to screening interventions including either primary or psychiatric care.[54] Szekely et al. also propose a need for gender to be considered when designing interventions in their research assessed as high in contribution.[55] They found that the findings prior to their analysis of the EAAD program in Hungary suggest that certain interventions are less effective in reducing suicide rates for men than women.[56] Szekely et al. also infer that as motivation for seeking professional help tends to be higher among women, training GPs in isolation of other interventions is less likely to be helpful for men, meaning "effective hotline advice as a first step intervention could motivate men to utilise non-anonymous services as well." [57]

The literature supports the need for a gender lens when designing and implementing suicide prevention initiatives.

Aboriginal and Torres Strait Islander Peoples

In line with the early and interim evaluations, the literature highlights the importance of community empowerment, development and ownership in programs targeting Indigenous peoples.[58] Dudgeon et al. detail in their generally robust article how, for Indigenous people, "empowerment has come to be recognised as an important element of any strategic response that aims to address community challenges" including suicide.[59] In practical terms, this means that Indigenous leadership and engagement in all aspects of design and delivery are crucial determinants of the effectiveness of interventions, from involvement of Elders to upskilling community members to provide peer support.[60] Interventions that have proven successful in Indigenous communities are those which "have a strong foundation in community education on social and emotional wellbeing as they give communities the tools to organise their thinking about their situation and respond to it." [61] Community-specific responses also need to address community priorities: this may mean that conflicts within communities need to be addressed prior to implementation, service providers may need to pool resources and collaborate in other ways, and the physical places where people can come together need to be considered. [62]

As described in the first progress report, workshops with the evaluation teams included discussion that both the LifeSpan and AAD models may be fundamentally ill-suited to meeting the needs of Aboriginal and Torres Strait Islander communities. These models are reportedly not perceived by some as relevant to Aboriginal and Torres Strait Islander people due to the emphasis on individual-focused activities. Findings by Dudgeon et al. point towards the need to focus on the community ahead of individual needs when engaging this target population. Further investigation is required to understand this in more practical terms.

The very nature of community-specific responses also means that approaches and interventions cannot be fully standardised, nor can results be equally shared across different communities. [63] Dudgeon et al. suggest that working within a cultural framework assists in translating general population interventions to be more responsive to the needs of Indigenous peoples.[64]

The literature demonstrates the challenges in engaging Indigenous populations and provides several suggestions that should be considered in future targeted suicide prevention activity.

Veterans

Evidence suggests that differences within target population groups need to be accounted for. [65] York et al. described this when investigating the veteran community. The intersection of suicide risk factors for Veterans (such as combat experience) and risk factors specific to sub-groups within the Veteran population (such as those experiencing psychiatric disorders, Veterans experiencing homelessness, and attitudes associated with suicide) were critical factors when considering appropriate interventions.[66] The authors identify a need for targeted educational and outreach campaigns specific to target subgroups such as the elderly, women and rural/remote dwelling Veterans, and identify an associated research gap regarding population sub-groups within Veterans. [67]

The variability in risk for suicide for the Veteran sub-groups needs to be considered. The evidence suggested that this is a common theme within target populations and therefore requires another layer of adaptation and flexibility in interventions and support.

Rural, regional and remote (RRR) locations

As suggested in Progress Report 1 and supported by the literature, there are additional challenges and considerations posed by working in RRR areas. York et al describe how the implementation of evidence-based strategies in rural areas can be facilitated by a toolkit designed for service providers in rural areas, emphasising the use of telemedicine, as well as ways that existing interventions for focus populations in rural areas can be adapted for other focus populations.[68] Accessibility of suicide prevention supports and services that account for diversity within focus populations is an area of particular concern, as service provision in rural and remote areas that is already limited in comparison with urban areas.[69]

The evidence is in line with the findings described in the first progress report, with practical solutions known to improve effectiveness in RRR areas remaining absent. This area needs to be a priority for future activity so that evidence on effectiveness can be used to drive future policy and decision making.

5.2 Additional themes and findings

This review of the available literature mostly echoed the themes presented in Progress Report 1. However, there were several additional themes and issues in the literature which will warrant further exploration in the context of the final evaluation reports.

Planning and evidence

There remains an absence of accessible, robust, definitive evidence of effectiveness for suicide prevention models and multi-level, multi-component interventions. Consistent and reliable data collection on outcomes and impact is commonly hindered by limitations in both study design and methodology. This leads to the lack or variability in comprehensiveness and quality of data currently available to form baseline measurements and draw out definitive inferences. Limitations outlined in the literature include:

- Study designs that generate robust evidence, such as RCTs involving formal randomisation of intervention and control sites, are rarely conducted in multi-level and multi-component models.[70]
- Challenges inherent in controlling for the large number of potential confounding factors in real-world environments and for highly complex interventions, implemented across multiple contexts.[71]
- A lengthy implementation period (over 2 years according to Collings et al.) is required to "provide statistical power for comparison and/or to allow establishment and sufficient penetration" of interventions.[72]
- The need for accurate longitudinal data regarding suicidality to establish baselines for intervention studies is impacted by the possibility for suicide deaths and suicide-related activity (e.g. intentional self-harm) to be misclassified. [73] [74] Additionally, in some contexts including New Zealand, intentional self-harm data may only include incidents where a person is admitted to hospital, which is affected by the "availability of hospital beds, the risk tolerance of treating clinicians, and the treatment protocols of individual services." [75] [76] Finally, data sources required to perform accurate modelling of forecasted intervention effects such as population health surveys, the Medicare Benefits Schedule, PHN and LHD datasets and the Australian Bureau of Statistics vary in quality[77] and in definitions used.[78]
- The small population size of people who die by suicide limit statistical power to detect effects of interventions.[79]
- When trials are conducted over a large number of geographical regions, there can be a degree of 'contamination' where the interventions existing in different regions at baseline are different. For

example, there were "instances where community workers or professionals from the control regions were requesting and receiving the QPR training after hearing about its use in the intervention regions." [80]

These limitations and the associated lack of data available to establish effects of suicide prevention interventions on suicide deaths and attempts highlight the need for improved evaluation of activity, particularly in the Australian context.[81] As Collings et al. note, "while multilevel interventions for suicide prevention have been positioned as the gold standard, they are hugely resource intensive and as such are likely only to be funded at the government level. […] To assist policymakers and to make good use of public funding, it is essential that the evidence base around the effectiveness of multilevel interventions for reducing suicidal behaviours is robust, scientific (more RCTs are required) and reported transparently." [82]

Several potential methods of improving the evidence base are reported in the literature. Collings et al. call for "the development of reporting criteria for non-randomised controlled multilevel interventions to reduce suicidal behaviours." [83] Hegerl et al. propose further refinements of methodologies, firstly suggesting researchers and evaluators monitor for intermediate effects and precisely document environmental conditions before and during the study to allow for more robust interpretation and understanding of primary and secondary outcomes.[84] Hegerl et al. also suggest study design limitations borne from challenges of implementing comparable interventions in different contexts can be overcome by process evaluations. Where these focus on the transferability of the intervention to different systems this enables the researchers to control for and explain differences in implementation that might occur at intervention sites.[85]

Atkinson et al. reiterate the utility of systems modelling and simulation to provide "decision support capability that can help avoid unintended consequences, inform the timing and scaling of interventions, and realise the full potential of evidence-based interventions."[86] In this article that was assessed as being highly robust, Atkinson et al. also emphasise how qualitative insights about the impact of contextual factors on outcomes have broader relevance to regional commissioning of suicide prevention initiatives than simply examining quantitative impacts. [87]

Finally, Atkinson et al. suggest that embedding systems modelling and simulation in monitoring and evaluation cycles for suicide prevention interventions allows for stakeholders to a) iteratively determine the accuracy of modelling in comparison to real-world outcomes over time and how implementation can be enhanced to improve outcomes, and b) input real-time monitoring and evaluation data into models to improve future forecasting of outcomes and proactively guide decision-making.[88]

Impacts of multiple interventions within the systems-based approach

The theoretical underpinnings of the systems-based approach emphasise that positive outcomes are facilitated by the combined effects of multiple coordinated interventions being delivered in parallel.[89] This is in part based on historical evidence from other fields of health promotion and prevention, such as tobacco control and HIV prevention.[90] Some evidence points to synergistic and catalytic effects between the 'levels' of multilevel approaches. For example, public campaigns increasing awareness of the trial and its aims, and attracting interest in other activities,[91] enthusiastic participants in one activity recruiting others for additional activities,[92] or increased demand for suicide-related primary care following increased awareness prompting primary care workers to become involved in suicide-prevention activities.[93]

Some modelling-based analyses question the extent to which positive outcomes are facilitated through the combined effects of multiple interventions. Krysinska et al. estimated the effects on suicide attempts and deaths that might be expected if active components of a multi-level systems approach were to be implemented in Australia.[94] While the findings of this modelling indicated that a systems approach could reduce suicide attempts and deaths significantly (the most effective interventions being psychosocial treatments and coordinated/ assertive/brief aftercare), the authors caution that "combined effects from multiple interventions may be less than the sum of their individual effects, or synergise to create a stronger effect." [95] This is due to the potential for several factors such as "regional effects, implementation challenges, the context in which the intervention is delivered and baseline variations in terms of pre-existing programmes that may already be impacting on suicide attempts or deaths."[96] This indicates that while multiple coordinated interventions may lead to an intensification of positive outcomes, they may also combine to intensify poor results in systems where interventions are not working.

Similarly, Atkinson et al. highlight the need to account for contextual factors and system capacity, for example, rather than assume certain combinations of suicide prevention interventions will work in complementarity. Atikinson et al. used systems modelling and simulation to undertake a priori testing of the likely impact of interventions for a PHN catchment in rural NSW.[97] The interventions anticipated to have the biggest impact on suicidal behaviour were post-suicide attempt assertive aftercare, "followed closely by universally applied community support programmes and a programme aimed at re-engaging those known to the mental health system but lost to follow-up."[98] This study yielded unexpected results in the form of a slight increase in suicidal behaviour associated with implementing GP training combined with mental health education programs. The authors outline how this arises from this combination of interventions generating a demand for mental health services beyond the availability of baseline service capacity, leading to increased rates of consumers disengaging from services due to things like increased wait times and dissatisfaction with their service.[99] These results, although based on modelling, highlight both the need to consider a broad range of contextual factors before implementing suites of interventions expected to be complementary, and also the potential for synergistic impacts between interventions if these factors are identified and addressed.[100]

Limited empirical analyses also question the evidence for synergistic impacts of interventions in practice. Questions about this particularly arise when programs and projects do not sufficiently add to 'practice as usual'. Collings et al. describe how the high baseline level of investment in mental health initiatives in New Zealand such as national depression awareness campaigns, and work in primary care settings to improve identification of mental health issues, referral pathways and treatment, meant that MISP-NZ failed to reproduce the substantial effects seen in other settings.[101] Interventions appear most effective when they maximise and complement what is already in place rather than being laid over the top of pre-existing strategies or interventions. For example, Zalsman et al. report that gatekeeper training is helpful in reducing the number of suicides, provided that formalised roles and pathways to treatment are readily available,[102] while Sakashita et al. describe the necessity of systematic links among universal, selective, and indicated programs.[103]

With the present state of research, whether systems-based models generate positive impacts over and above the sum of benefits from their component interventions remains to be established. Zalsman et al. call for combinations of strategies to be assessed on both individual and population levels using robust methodologies (RCTs and similar) and examining the effect of interventions on focus populations, cost effectiveness and effect size.[104]

The research does suggest that a multi-level systems approach can be an effective way to implement suicide prevention initiatives. Importantly, this approach needs to incorporate the local environment and the broad range of contextual factors during the design and implementation phases. Further research focused on the Australian context is required to better understand the impacts of multiple interventions within the systems-based approach.

5.3 Effectiveness of interventions outlined in the literature

The literature review did not identify articles addressing all interventions delivered through the three Australian trial sites in combination. Several studies did explore impacts of multi-level or systems-based approaches to suicide prevention, but the methodologies and outcomes examined across studies varied. Szekely et al. investigated the impact of EAAD on suicide rates according to sex and found the combination of the four levels of interventions led to a reduction in suicide rates for both males and females.[105] Harris et al. explore synergistic effects between four levels of OSPI-Europe interventions and conclude that there are indeed positive interactions between certain types of interventions. However, this is a qualitative process evaluation and therefore does not explore impacts on rates of suicide or suicidal behaviour.[106] It was also rated low in the voice and inclusion, triangulation and transparency domains of the robustness assessment. Collings et al. produced the only article identified through this review which uses RCT methodology to explore the impact of a multi-level intervention on suicide rates. Collings et al. concludes that MISP-NZ did not produce significant differences in rates of suicidal behaviours.[107]

There are a greater number of articles examining the relative effectiveness of different individual interventions on rates of suicide and/or suicidal behaviour. Atkinson et al. created a systems dynamics model which shows the impact of interventions on self-harm hospitalisations and suicide deaths, with results showing assertive aftercare forecast to be the most effective intervention post-suicide attempt.[108] This was followed by (in order of anticipated effectiveness): a services re-engagement program (for people who were known to suicide prevention/ mental health services but had been lost to follow-up); community support programs; a combination of services capacity increase plus GP training and mental health education programs; hospital staff training; online services; and finally, suicide helpline services.[109] Service capacity increases; mental health education programs; and community management of severe disorders were all seen as having marginal impacts.[110] Unexpectedly, GP training plus mental health education produced a significant increase in suicides, and GP training alone also produced a slight increase in suicides.[111] The reasons for this were unclear, highlighting the complexity of measuring outcomes in suicide prevention.

Zalsman et al. conducted a systematic review of the effectiveness of suicide prevention interventions between 2005-2015.[112] Due to heterogeneity of studies, a quantitative meta-analysis was not possible, however through narrative review, Zalsman et al. conclude that there is evidence to strongly support the impact of means restriction and follow-up of people who attempt suicide; increasing evidence for school-based mental health and suicide awareness programmes (with or without combined screening); and some evidence for increased mental health service availability.[113] Limited evidence supports the use of media reporting interventions in combination with other interventions.[114] No conclusions could be made regarding the impact of public awareness campaigns, suicide prevention screening in primary care, training programs for GPs, gatekeeper training, or telephone/ helpline supports.[115] Separating the impact of certain interventions is an ongoing challenge for suicide prevention activity, making it difficult to draw decisive conclusions.

Nevertheless, some studies are able to show the impact of a single interventions. For example, Sakashita et al. found that screening interventions for depression amongst elderly people in Japan were associated with lower suicide rates.[116] Some studies in Australia have also been able to separate particular interventions to assess effect. Krysinska et al. and Pirkis et al.[117] estimate the effect of multiple intervention types on suicide attempts and deaths, finding that interventions anticipated to have the biggest impact on suicide attempts were coordinated/assertive/ brief aftercare, followed by psychosocial treatment; with school-based programs and means restriction having the lowest impacts.[118] The finding on the effectiveness of means restrictions differs from some international research mentioned previously, with local laws and regulations a likely factor. In their research, Krysinska et al. anticipated the interventions to have the biggest impact on suicide deaths were (in order of impact): GP training; psychosocial treatment; gatekeeper training; means restriction; followed by media guidelines; coordinated/ assertive/ brief aftercare; and public awareness campaigns all identified as having marginal impact.[119]

Dudgeon et al. summarise “success factors” for suicide prevention in Indigenous communities based on both meta-evaluation and community and sector consultation.[120] Although not every ‘factor’ is examined in terms of its impact on suicide and suicidal behaviour (with some addressing established risk factors for suicide), these are important to include in this report due to the disproportionate burden of suicidality in Indigenous communities and the need for tailored and Indigenous-led approaches. Success factors identified by Dudgeon et al. are summarised in Table 2.

Table 2 Success factors for Indigenous suicide prevention identified by ATSISPEP[121]

Approach	Intervention type	Intervention
UNIVERSAL/ INDIGENOUS COMMUNITY-WIDE	**Primordial prevention**	- Addressing community challenges, poverty, social determinants of health - Cultural elements – building identity, social and emotional wellbeing, healing - Alcohol/drug use reduction
	Primary prevention	- Gatekeeper training – Indigenous-specific - Awareness raising programs about suicide risk/use of DVDs with no assumption of literacy - Reducing access to lethal means of suicide - Training of frontline staff/GPs in detecting depression and suicide risk - E-health services/internet/crisis call lines and chat services - Responsible suicide reporting by the media
SELECTIVE – AT RISK GROUPS	**School age**	- School-based peer support and mental health literacy programs - Culture being taught in schools
	Young people	- Peer-to-peer mentoring, and education and leadership on suicide prevention - Programs to engage/divert, including sport - Connecting to culture/country/Elders - Providing hope for the future, education – preparing for employment
INDICATED – AT RISK INDIVIDUALS	**Clinical elements**	- Access to counsellors/mental health support - 24/7 availability - Awareness of critical risk periods and responsiveness at those times - Crisis response teams after a suicide/postvention - Continuing care/assertive outreach post Emergency-Department after a suicide attempt - Clear referral pathways - Time protocols - High quality and culturally appropriate treatments - Cultural competence of staff/mandatory training requirements

COMMON ELEMENTS	**Community leadership/ cultural framework**	Community empowerment, development, ownership – Community-specific responses Involvement of Elders Cultural framework
	Provider	Partnerships with community organisations and Aboriginal Community Controlled Health Organisations Employment of community members/peer workforce Indicators for evaluation Cross-agency collaboration Data collections Dissemination of learnings

The matrix below (Figure 1) summarises the research reviewed to date in relation to both the effectiveness of interventions on suicide and suicidal behaviour, and the current strength of evidence for these. This has been developed drawing on primary research, modelling and meta-analysis reports included in the literature review.

The literature reviewed through this process has primarily been developed in an international context, with few items reflecting specifically on Australian findings. Connecting this literature with findings from the final primary evaluation reports to explore the effectiveness of different interventions in an Australian perspective will be an important next step in this engagement.

The limited available literature also sometimes presents variable findings in relation to the effectiveness of these interventions for specific cohorts or in different locations. The summary provided in Figure 1 is intended to illustrate the general direction of findings only, with strength of evidence assessed in terms of the volume of available published peer-reviewed literature and the relative size of impacts reported in the literature identified in this review.

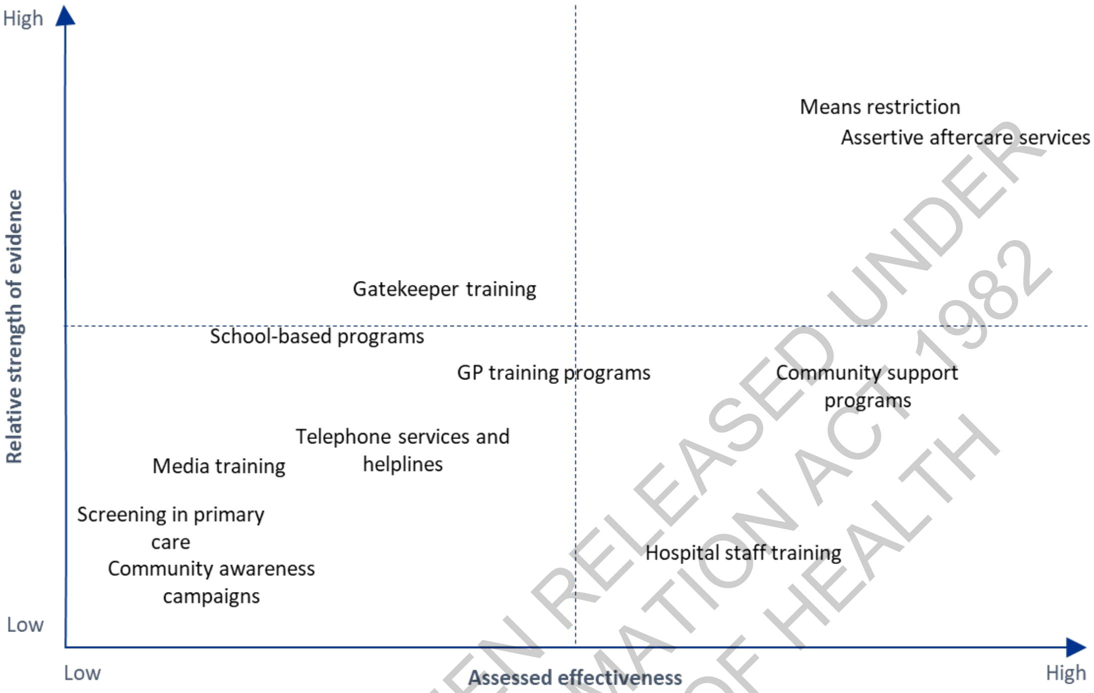


Figure 1 Relative estimated effectiveness and strength of evidence for interventions in identified literature

6 Implications of research

Overall, the identified literature strongly supported observations and implications presented in Progress Report 1. The similarities between themes presented in the literature and the experiences of PHNs involved in the three trials serve to highlight the sheer complexity of suicide prevention in any context. An exploration of implications not covered extensively in Progress Report 1 is presented below.

Research, evidence and knowledge-sharing

One of the strongest themes emerging from review of the identified literature was the lack of robust, translatable evidence supporting both individual interventions and systems-based approaches to suicide prevention. The need to tailor approaches according to a multitude of contextual factors has meant that approaches that successfully reduce suicide rates in certain contexts cannot be easily replicated in other locations or for other populations. As summarised by Atkinson et al.,

> *"The complexity of mental health service planning and suicide prevention at the regional level presents challenges (both analytically and politically) that demand sophisticated, transparent and interactive decision support tools that will support a more disciplined, strategic approach to the allocation of limited resources, will help manage expectations with regards to the size, nature and timing of intervention effects, and facilitate the navigation of effective partnerships to achieve aligned collective action across local stakeholder groups."* [122]

These challenges have multiple implications for suicide prevention in Australia. Firstly, considering the limited evidence base for effective suicide prevention practices, there is benefit in providing scope for innovative approaches which do not yet have a strong foundation in research. In designing interventions, there is value in incorporating academic, experiential/practice-based evidence and lived experience to support continual learning, innovation and engagement in the community. To achieve more inclusive and translatable research at a local level, organisations may benefit from having structures and processes in place which facilitate a range of perspectives and provide mechanisms for translating this information into action.

Secondly, there is a need to improve and embed evaluation capabilities in organisations involved in suicide prevention to cohesively build the evidence base in Australia. This includes increasing capabilities to plan, design, conduct and utilise evaluation findings in ongoing and future suicide prevention policy and practice decision making. While whole-of-program evaluations produce useful learnings to improve design, implementation and delivery, the wide range of partner organisations and implementing bodies at different levels of maturity means that the data captured at a more granular level is highly variable. This is particularly evident in the context of quantitative date. An emerging challenge throughout the course of this project has been identifying common outcomes measures across the three trials and accounting for the differences in quality of additional documentation supplied by trial sites. Building a more cohesive body of research that provides invaluable quantitative data may be facilitated by developing standardised resources for trial sites to build internal evaluation and research capacity and to allow for easier data translation. Furthermore, developing standard outcomes frameworks that can be provided to any future trial sites or other initiatives could have significant benefits by ensuring common outcomes and data collection methods are identified and applied.

In the absence of studies examining real-world outcomes of suicide prevention initiatives, there would also be benefit in Commonwealth grants programs prioritising innovative research methodologies, such as the systems simulation modelling conducted by Atkinson et al., to ensure contextual factors known to affect efficacy of interventions are accounted for when choosing which interventions will be implemented as part of a systems-based approach. The absence of strong evidence supporting outcomes of suicide prevention initiatives also underscores the importance of funding strong process evaluations in providing insights about the reasons why certain interventions do or don't achieve expected outcomes, and enable lessons learned to be shared throughout the field.

Finally, as the research and evidence base for suicide prevention will take time to develop in Australia, this challenge underscores the need to support knowledge sharing between organisations. As articulated in Progress Report 1, it is worth reflecting on the potential value in the Commonwealth playing a role in coordinated knowledge capture and transfer of detailed learnings from all these trials, in addition to the aggregated analysis commissioned from KPMG.

Priority populations as sources of knowledge/ the importance of lived experience in evidence

Many of the findings in the literature and through the trials' interim evaluation findings point to the need to incorporate lived experience and community representatives in the design, implementation and delivery of suicide prevention initiatives. The importance of, and challenges in, tailoring of approaches to different populations and contexts has been a consistent and dominant theme. However, in addition to the lack of robust evidence of outcomes for suicide prevention initiatives, the robustness assessment of articles included in this review found that research describing participation/involvement of community and stakeholders provides little detail about this process. This was highlighted by the voice and inclusion domain receiving the lowest rating on average in the robustness assessment across all of the research identified for this report . Members of KPMG's Expert Panel have identified that a contributing factor to this is the constraints faced by authors in publishing literature, which prioritises clinical expertise and demonstration of outcomes over the nature and quality of engagement of communities, organisations and people in interventions. Evaluation reports also provide limited information regarding where and how lived experience was incorporated and reflected in the design and implementation of interventions. Some articles in this review described the importance of engaging a wide range of program partners and the importance of generating engagement in systems approaches but presented limited discussion of how this would be achieved, and how lived experience of suicide factored into those decisions.

Given this is both a gap in the identified literature and interim trial evaluation reports, the ways and extent to which Australian trials include lived experience of suicide as a key resource to inform initiatives will be a focus in future reports.

The implications outlined above point to a challenging proposition for future suicide prevention activity and analysis. The need to include more robust and standardised quantitative evaluation data as well as incorporating qualitative inputs from people with lived experience will require targeted planning and nuanced implementation for any intervention. This balance and what it means in the context of suicide prevention policy will be explored further in future reports for this engagement.

7 Next steps

The change in timelines for the submission of final evaluation reports for both the PBSPT and LifeSpan trials have led to a change in KPMG's work program. This report is an adapted version of what was originally planned for this engagement as agreed with the project's sponsor. This report pulls together insights on the site-level interventions in greater detail than what was available at the time of writing the first Progress Report. This report also summarises the broader suicide prevention literature and how this translates to the evaluations of the three trials. The high-level implications outlined in *Implications of research* provides an introduction into what is planned for the following reports. The Insights Tool is designed to assist in understanding detailed information regarding activities at site level, state level and national level. This value of this tool will increase as information regarding outcomes becomes available.

KPMG will continue to liaise with the Department, the evaluation teams and PHNs as the engagement progresses. Further detail will be added to the Insights Tool as the details continue to be validated as more information becomes available. KPMG will continue to monitor developments in suicide prevention literature to ensure a comprehensive understanding is included in future reports.

The next report is the Rapid Review and Policy Implications Report that is due to be finalised by 10 December 2021. This report will provide a high-level summary of the final evaluation reports (where available) and the links between evaluation findings and the broader literature. This information will be analysed by all members of the KPMG team (including the Expert Advisory Panel) to inform policy implications and any gaps in the available evidence. As part of this process, we will consider best practice approaches and lessons learned from literature and trial evaluation reports. A findings validation workshop with the Department will also be conducted as part of the delivery of this report.

The Final report is due in March 2022 and will pull together the relevant information collected over the course of the engagement. This report will include a more detailed analysis of the final evaluation reports including a number of important activities such as a meta-analysis of data (where feasible), an exploration the gaps and any key issues to be addressed in future suicide prevention work.

Appendix A: Updated schedule of deliverables

KPMG will be undertaking multiple rounds of analysis for this project and preparing key reports. Table 3 below provides an overview of the initial deliverables plan and Table 4 outlines the revised plan for the deliverables with updated titles and timeframes. The revised plan is based on the expected availability of final evaluation reports.

Table 3 Initial plan for deliverables

Deliverable/Milestone	Finalisation date	Details
Project Plan and Research Framework	**Tuesday 17 November 2020**	The Project Plan forms a key governance document for the life of the engagement. The Research Framework provides a detailed outline of the inclusion and evaluation classification criteria, along with other information regarding the project approach.
Progress Report 1	**Friday 11 December 2020**	Includes a rapid stocktake analysis of findings from the early and interim evaluation reports across the three trials. Progress Report 1 will support the work of the National Suicide Prevention Adviser in making recommendations to government.
Progress Report 2	**Monday 5 July 2021***	Progress Report 2 includes detailed analytical findings which draw on both the full findings of the trial evaluations and broader recent literature on community and place-based suicide prevention interventions. Insights have a strong focus on trial outcomes and impacts. **The timing of Progress Report 2 is contingent on the availability of final evaluation reports from the Victorian and LifeSpan trials.*
Final Report and Research Summary Brief	**Thursday 16 December 2021**	Consolidates all findings from the literature review, research synthesis, gap analysis and policy implications review into a report addressing each of the project's key research questions. Includes a standalone Research Summary Brief suitable for public release, summarising the key synthesised findings for a general audience.

Table 4 Revised plan for deliverables

Deliverable/Milestone	Finalisation date	Details
Project Plan and Research Framework Completed	**Tuesday 17 November 2020**	The Project Plan forms a key governance document for the life of the engagement. The Research Framework provides a detailed outline of the inclusion and evaluation classification criteria, along with other information regarding the project approach.
Progress Report 1 Completed	**Friday 11 December 2020**	Includes a rapid stocktake analysis of findings from the early and interim evaluation reports across the three trials. Progress Report 1 will support the work of the National Suicide Prevention Adviser in making recommendations to government.
Progress Report 2* This report	**Monday 5 July 2021**	Progress Report 2 includes detailed information for each trial site provided in a user-friendly format. The site-level information expands on the details provided in Progress Report 1 and provides a comprehensive overview of site activity across Australia. Progress Report 1 provides a summary of the additional relevant research, assessed for robustness assessments, that informs the project's key research questions and suicide prevention policy.
Rapid Review and Policy Implications Report*	**Friday 10 December 2021** (Pending availability of final evaluation reports)	This report includes a rapid review of findings provided in the three trials evaluation final reports to identify key barriers to and enablers of suicide prevention in Australia. The review will be informed by our expert panel and outline the implications for suicide prevention policy. It is intended the report will include discussion of the potential implications for: • Future community and place-based suicide prevention interventions • Selection of locations, partners and commissioning bodies • Coordination with other suicide prevention interventions • Relative costs and benefits of different interventions
Final Report*	**Wednesday 2 March 2021** (Pending availability of final evaluation reports)	The Final Report consolidates all findings from the previous reports into an overarching report addressing each of the project's key research questions. This will include robustness assessments of the final trial evaluations and a more detailed synthesis and analysis of

		the evaluations than what was provided in the Rapid Review and Policy Implications Report. The intent is to include the following activities: • Undertaking meta-analysis of quantitative data from the original evaluations where feasible • Where possible, disaggregating findings presented at a whole of community or region level within individual evaluations/studies and re-aggregating these by populations of interest • Identifying the variations in both the intervention and the measurement approach • Engaging further with the original evaluation teams where necessary to check and clarify issues arising from their final reports • Identifying issues which warrant discussion and further clarification with the Department and explore these issues with you. If desired, this report can include a standalone Research Summary Brief suitable for public release, summarising the key synthesised findings for a general audience.

**Revised deliverable*

Appendix B: Expert Advisory Panel

The Expert Advisory Panel comprises KPMG and academic specialists with key skills that add genuine insight. The expert panel members are engaged when required throughout the project to contribute their relevant expertise.

Andrew Dempster: Andrew leads KPMGs Mental Health Advisory business conducting strategy, evaluation, review and improvement projects across Australia. He has experience consulting across the spectrum of health and human service sectors including: child and family services, health (acute and community), Aboriginal and Torres Strait Islander health, mental health, child protection, disability services, alcohol and other drug services, and justice.

Project role: Andrew provides subject matter expertise with regard to mental health, suicidality, health and social systems throughout the life of the project.

Chris Schilling: Dr Chris Schilling is an accomplished health economist with over 15 years of experience in economic modelling and research across academia, industry and consultancy. At KPMG, Chris leads a growing team of health economists providing economic evaluation and modelling to a range of government and industry clients. His work has influenced key public policy debates, particularly around mental health, suicide prevention, dementia and low-value care. Chris's strengths lie in his ability to design and develop detailed health economic models to answer key policy questions, and to communicate these findings in a clear, concise manner.

Project role: Chris provides technical expertise in health economics regarding meta-analysis of quantitative data from original Trial evaluations.

Lucio Naccarella: A/Prof Naccarella is a leading health care services researcher and evaluator, with interests in system change, health system literacy, health care design, care coordination, teamwork, professional development, primary care organisations and health workforce reforms, from a policy, research and practice perspective. He has published as first author in peer-reviewed journals and as part of project teams over 70 publications. Over his career he has won over 70 research and evaluation grants at a national, state, regional and local levels. A/Prof Naccarella has largely focused on four key areas:

- Building evaluation capability within public sector organisations
- Evaluating health workforce models of care and development
- Evaluating population health, health literacy and community based professional development initiatives;
- Researching health care facility design to optimise health care workforce.

Project role: A/Prof Naccarella provides health program evaluation expertise throughout the life of the project and has conducted the robustness assessment using the Bond Evidence Principles, to establish an agreed baseline for how evaluation findings should be weighted in the subsequent analysis.

Sarah Wayland: Dr Sarah Wayland is an early career researcher with a strong vision for her research and teaching focus. She has spent the last 21 years working and then researching the complexity of trauma and loss through a social work lens. In her current role, her primary research focus is building the evidence base surrounding lived experience inclusion in the fields of suicide prevention and mental health service delivery.

In the national suicide prevention space, Sarah's research has led to:

- Enhanced awareness of supportive interventions to better support carers of people who attempt suicide by ensuring research translation in academic, technical reports and website development embedded in each project;
- Implementation science and research evaluation honouring inclusion of lived experience voice in interpreting the complexity of knowledge, leading to awareness about how suicide attempting needs to be supported via workforce improvements.
- Inclusion in the Prime Minister's Suicide Prevention Taskforce due to a focus on evaluation of services, and to development of policies that aim to reduce the rate of deaths by suicide.

Project role: Dr Wayland provide expertise in lived experience research and inclusion and has conducted the robustness assessment using the Bond Evidence Principles, to establish an agreed baseline for how evaluation findings should be weighted in the subsequent analysis.

Greg Armstrong: Dr Greg Armstrong is a multidisciplinary mental health and suicide prevention researcher. He holds a prestigious Early Career Fellowship with the National Health and Medical Research Council (NHMRC) in Australia and is a Senior Research Fellow with the Melbourne School of Population and Global Health, University of Melbourne. While based at University of Melbourne, Gregory has undertaken public health research and consultancies in Australia and in low and middle-income countries (LMICs) over more than 10 years with specialisations in mental health, suicide prevention, substance misuse and the social determinants of health.

In the international mental health and suicide prevention space, Dr Armstrong has been involved in research and publications in Southeast Asia, India and Timor-Leste and has done considerable work with Aboriginal and Torres Strait Islander communities.

Project role: Dr Armstrong brings a wealth of knowledge and expertise in suicide prevention and will be specifically be involved by providing specialist technical advice on tailored approaches to meta-analysis as well as contributing the latest findings from suicide prevention evidence and best practice.

Appendix C: Literature Review

This literature review combines a structured approach to the selection and assessment of evidence with an open-ended review method which allows the analysis to be guided by the emerging findings of that evidence.

C.1 Methodology

Databases relevant to health and social sciences were systematically searched for systems/place-based suicide prevention approaches and models, and for specific models and approaches that are known to be relevant to Australia's Suicide Prevention Trials, e.g. European Alliance Against Depression. These databases were selected because they are publicly available through subscriptions held by the National Library of Australia and the various State Libraries. This ensures underlying research inputs are accessible to APS agencies, stakeholders and members of the community as necessary. Academic databases included:

- Cochrane Library
- EBSCO Academic Search Complete
- ERIC
- JSTOR
- PubMed.

Grey literature was also located through systematic searches of key Australian suicide prevention organisation websites, and through targeted Google searches. These organisations were selected because they are major contributors to the national conversation about suicide prevention. Online searches were conducted within:

- ATSISPEP
- Australian Institute for Suicide Research and Prevention
- Beyond Blue
- Black Dog Institute
- Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention
- Department of Health
- Headspace
- National Mental Health Commission
- Productivity Commission
- Roses in the Ocean
- Sax Institute
- Suicide Prevention Australia.

Finally, snowball searches were conducted using the reference lists of a sub-set of articles identified in initial database searches.

Selection criteria

Borrowing from the Cochrane Review methodology, research inputs were selected for this analysis based on the criteria displayed in Figure 2. These criteria have been designed to ensure all the primary trial evaluations will be in-scope, while also capturing broader available suicide prevention research addressing interventions and cohorts of interest.

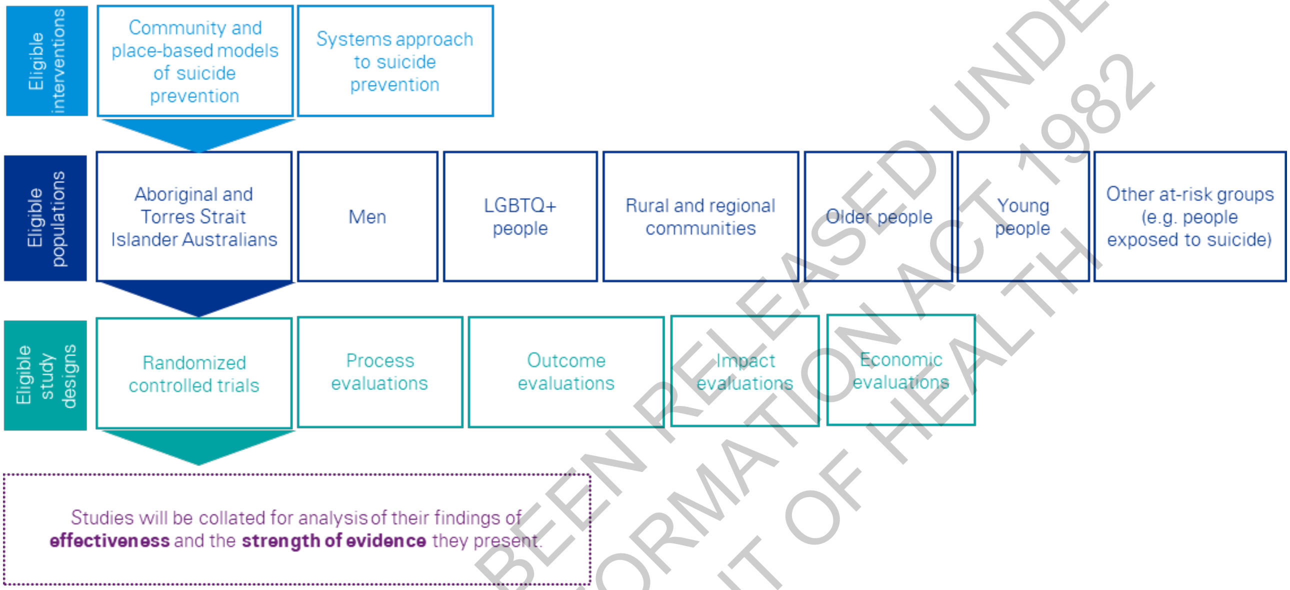


Figure 2 Literature inclusion criteria application process

This approach focuses selection on interventions which adopt a systems or multi-intervention approach, emphasising research which is readily comparable with the primary trial evaluations. Importantly, it still captures research which addresses multiple kinds of interventions within this systems approach, ensuring a diversity of research inputs.

Criteria were applied in the order shown in Figure 2, to all suicide prevention intervention studies identified through an initial search of the databases identified above. Where an eligible intervention was identified, the eligible population criteria were applied, so that interventions focused on other populations were excluded from the analysis. The eligible study design criteria were then applied, excluding any studies which do not meet these definitions, however due to the abundance of relevant literature that did not meet study design criteria, articles which did not meet study design criteria were also assessed as per the described realist review methodology according to their relevance to systems-based approaches to suicide prevention. A total of eight of the 20 articles included for robustness assessment did not meet study design exclusion criteria. Records retrieved through searches were tracked and filtered by inclusion criteria using Microsoft Excel software.

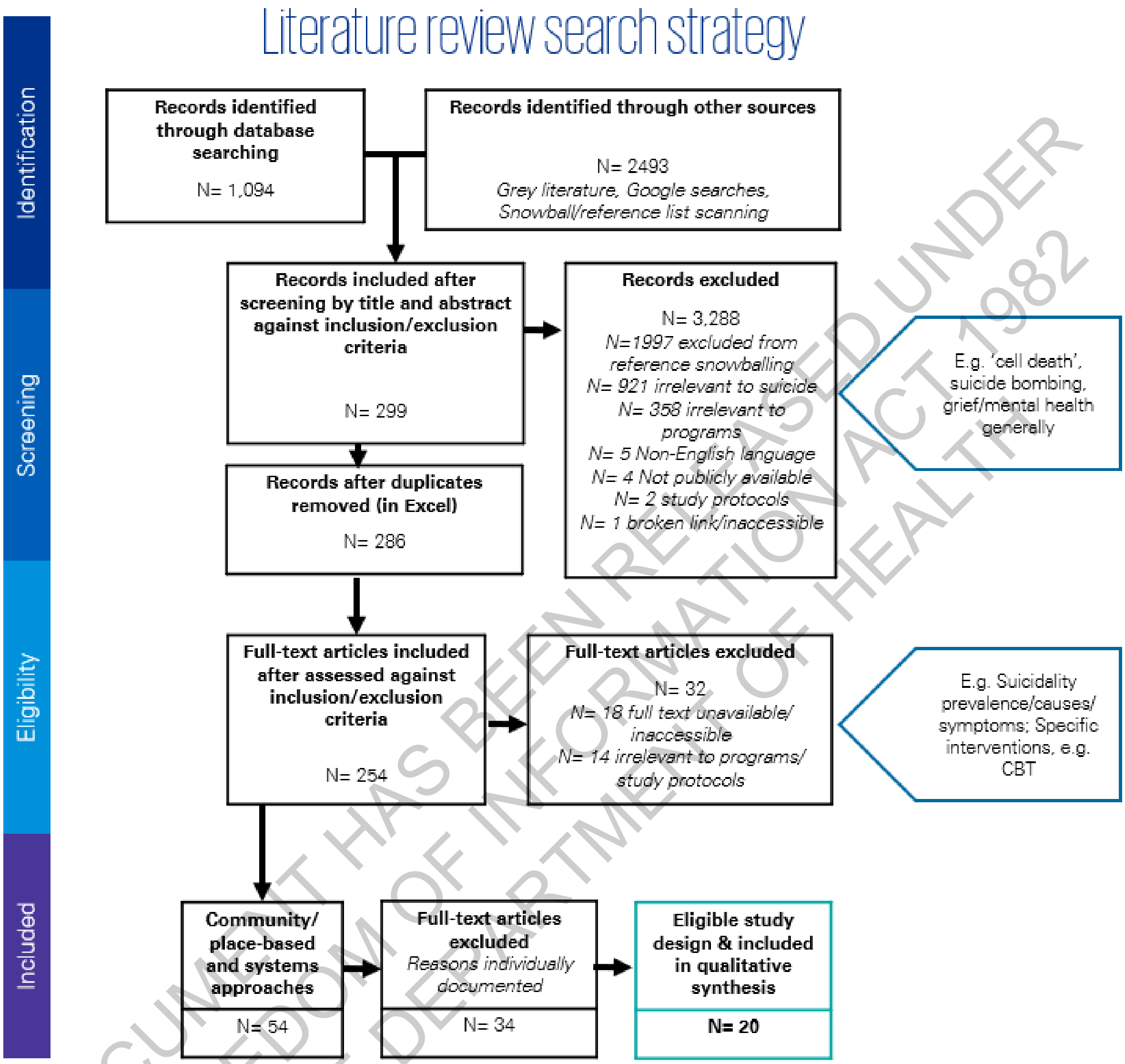


Figure 3 Literature review search strategy

C.2 Included articles

Table 5 provides the reference list for the 20 articles included in this review and supplied for robustness assessment.

Table 5 Literature supplied to Expert Panel for robustness assessment

Arensman, E., Coffey, C., Griffin, E., Van Audenhove, C., Scheerder, G., Gusmao, R., Costa, S., Larkin, C., Koburger, N., Maxwell, M., Harris, F., Postuvan, V., & Hegerl, U. (2016). Effectiveness of Depression-Suicidal Behaviour Gatekeeper Training among police officers in three European regions: Outcomes of the Optimising Suicide Prevention Programmes and Their Implementation in Europe (OSPI-Europe) study. The International journal of social psychiatry, 62(7), 651–660. https://doi.org/10.1177/0020764016668907

Atkinson, J. A., Skinner, A., Hackney, S., Mason, L., Heffernan, M., Currier, D., ... & Pirkis, J. (2020). Systems modelling and simulation to inform strategic decision making for suicide prevention in rural New South Wales (Australia). *Australian & New Zealand Journal of Psychiatry*, *54*(9), 892-901.

Collings, S., Jenkin, G., Stanley, J., McKenzie, S., & Hatcher, S. (2018). Preventing suicidal behaviours with a multilevel intervention: a cluster randomised controlled trial. BMC public health, 18(1), 140. https://doi.org/10.1186/s12889-018-5032-6

Coppens, E., Van Audenhove, C., Gusmão, R., Purebl, G., Székely, A., Maxwell, M., Koburger, N., Arensman, E., & Hegerl, U. (2018). Effectiveness of General Practitioner training to improve suicide awareness and knowledge and skills towards depression. Journal of affective disorders, 227, 17–23. https://doi.org/10.1016/j.jad.2017.09.039

Coppens, E., Van Audenhove, C., Iddi, S., Arensman, E., Gottlebe, K., Koburger, N., Coffey, C., Gusmão, R., Quintão, S., Costa, S., Székely, A., & Hegerl, U. (2014). Effectiveness of community facilitator training in improving knowledge, attitudes, and confidence in relation to depression and suicidal behavior: results of the OSPI-Europe intervention in four European countries. Journal of affective disorders, 165, 142–150. https://doi.org/10.1016/j.jad.2014.04.052

Dudgeon, P., Milroy, J., Calma, T., Luxford, Y., Ring, I., Walker, R., Cox, A., Georgatos, G. & Holland, C. (2016). Solutions that work: What the evidence and our people tell us. Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project Report. ATSISPEP: Crawley.

Harris, F. M., Maxwell, M., O'Connor, R. C., Coyne, J., Arensman, E., Székely, A., Gusmão, R., Coffey, C., Costa, S., Cserháti, Z., Koburger, N., van Audenhove, C., McDaid, D., Maloney, J., Värnik, P., & Hegerl, U. (2013). Developing social capital in implementing a complex intervention: a process evaluation of the early implementation of a suicide prevention intervention in four European countries. BMC public health, 13, 158. https://doi.org/10.1186/1471-2458-13-158

Harris, F. M., Maxwell, M., O'Connor, R., Coyne, J. C., Arensman, E., Coffey, C., Koburger, N., Gusmão, R., Costa, S., Székely, A., Cserhati, Z., McDaid, D., van Audenhove, C., & Hegerl, U. (2016). Exploring synergistic interactions and catalysts in complex interventions: longitudinal, mixed methods case studies of an optimised multi-level suicide prevention intervention in four european countries (Ospi-Europe). BMC public health, 16, 268. https://doi.org/10.1186/s12889-016-2942-z

Hegerl, U., & Wittenburg, L. (2009). Focus on mental health care reforms in Europe: the European alliance against depression: a multilevel approach to the prevention of suicidal behavior. Psychiatric Services, 60(5), 596-599.

Hegerl, U., Althaus, D., Schmidtke, A., & Niklewski, G. (2006). The alliance against depression: 2-year evaluation of a community-based intervention to reduce suicidality. Psychological medicine, 36(9), 1225.

Hegerl, U., Rummel-Kluge, C., Värnik, A., Arensman, E., & Koburger, N. (2013). Alliances against depression–A community based approach to target depression and to prevent suicidal behaviour. Neuroscience & Biobehavioral Reviews, 37(10), 2404-2409.

Krysinska, K., Batterham, P. J., Tye, M., Shand, F., Calear, A. L., Cockayne, N., & Christensen, H. (2016). Best strategies for reducing the suicide rate in Australia. *Australian & New Zealand Journal of Psychiatry*, *50*(2), 115-118.

Pirkis, J. (2016). The population-level effectiveness of suicide prevention strategies that might be used in a systems-based approach.

Sakashita, T., & Oyama, H. (2016). Overview of community-based studies of depression screening interventions among the elderly population in Japan. *Aging & Mental Health*, *20*(2), 231-239.

Smith, L., Purton, T., Auckland, S., Lees, D., & Mond, J. (2020). Local evaluation of the Tasmanian component of the National Suicide Prevention Trial—Preliminary learnings. *Australian journal of rural health*, *28*(2), 218-223.
Székely, A., Thege, B. K., Mergl, R., Birkás, E., Rózsa, S., Purebl, G., & Hegerl, U. (2013). How to decrease suicide rates in both genders? An effectiveness study of a community-based intervention (EAAD). PloS one, 8(9), e75081.
Turner, K., Sveticic, J., Almeida-Crasto, A., Gaee-Atefi, T., Green, V., Grice, D., ... & Patist, C. (2020). Implementing a systems approach to suicide prevention in a mental health service using the Zero Suicide Framework. Australian & New Zealand Journal of Psychiatry, 0004867420971698.
York, J. A., Lamis, D. A., Pope, C. A., & Egede, L. E. (2013). Veteran-specific suicide prevention. *Psychiatric quarterly*, *84*(2), 219-238.
Zalsman, G., Hawton, K., Wasserman, D., van Heeringen, K., Arensman, E., Sarchiapone, M., ... & Zohar, J. (2016). Suicide prevention strategies revisited: 10-year systematic review. The Lancet Psychiatry, 3(7), 646-659.
Zbukvic, I. C., Mok, K., McGillivray, L., Chen, N. A., Shand, F. L., & Torok, M. H. (2020). Understanding the process of multilevel suicide prevention research trials. Evaluation and program planning, 82, 101850.

C.3 Synthesis

All included articles were compiled in a database using Microsoft Excel software for thematic categorisation. For each article included, the database captured details relating to themes and findings:

- At the overall intervention coordination level
- In relation to specific intervention elements
- In relation to regions/types of region
- In relation to specific target populations
- In terms of barriers to and enablers of effectiveness
- In relation to the costs and benefits of the intervention.

This categorisation process informed synthesis of findings against the broader research questions.

Appendix D: Robustness assessment

This project aims to support informed decision-making by government on future suicide prevention policymaking and investment.

Project findings will be reached through synthesising and analysing primary inputs from:

- Evaluation of the National Suicide Prevention Trial
- Evaluation of the LifeSpan Trials
- Evaluation of the Victorian Place-Based Suicide Prevention Trials
- Relevant selected literature on systems-based models of suicide prevention.

Due to the reliance on these inputs, it is important to understand how robust each of these inputs are. This allows the project team form judgements about how much weight to put on individual findings within the broader analysis. As the final evaluation reports for two of the three trials are yet to be supplied at the time of writing, this report solely incorporates the robustness assessment of the identified literature relating to systems-based models of suicide prevention (as described in Appendix A).

In developing aggregated findings and conclusions from this research, the analysis places greater emphasis on findings from inputs which have been assessed as highly robust. Findings from inputs which have been assessed as less robust are still included, but with appropriate caveats about the partial or preliminary nature of this evidence.

D.1 Methodology

The robustness assessments have been undertaken by two members of this project's Expert Panel:

- Dr Lucio Naccarella – University of Melbourne; Lucio brings expertise in the formal evaluation of health, mental health and social sector programs.
- Dr Sarah Wayland – University of New England; Sarah brings expertise in understanding lived experience perspectives and incorporating these into academic and policy research.

Figure 4 outlines the methodological process undertaken by Dr Naccarella and Dr Wayland to assess the identified literature.

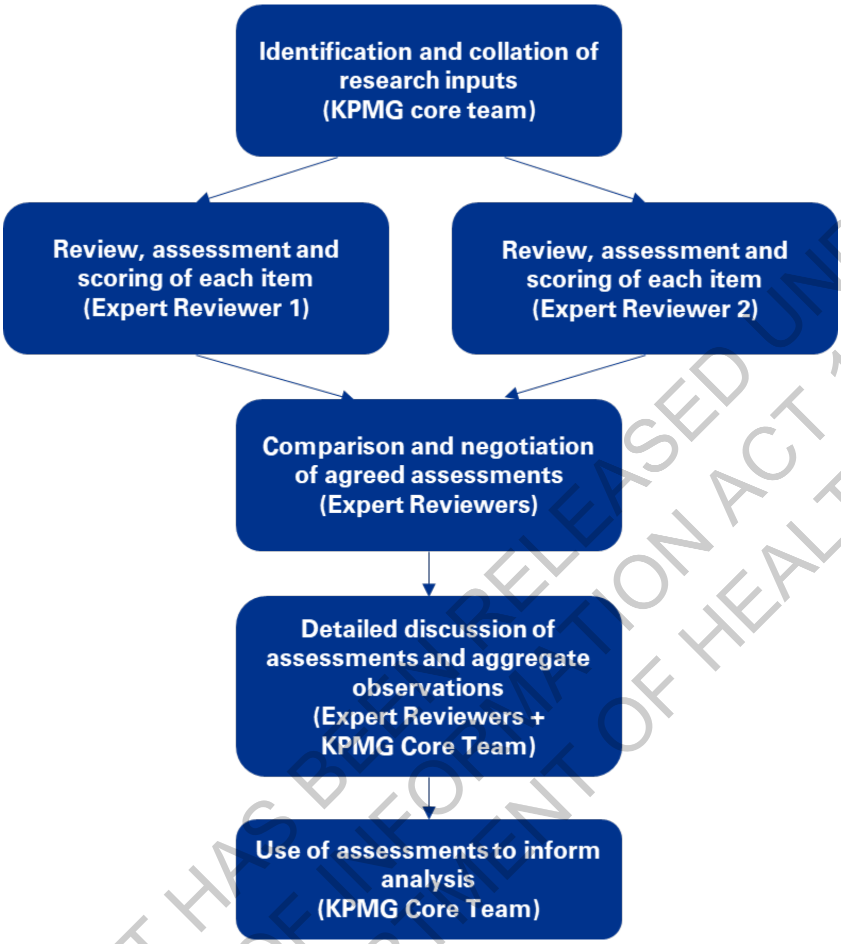


Figure 4 Robustness assessment process

Scoring: Bond Evidence Principles

The Bond Evidence Principles were used as the underpinning methodology for the robustness assessment of identified literature. These principles allow for the assessment of quality of evidence in a structured way.[123] This methodology assesses the robustness of research in relation to the following domains:

- **Voice and inclusion** of beneficiaries' views of the effects of the intervention, and who has been affected and how
- **Appropriateness** of methods to the nature of the intervention and purpose of the assessment
- **Triangulation** of findings across a mix of methods, data sources and perspectives
- **Contribution** of variables and factors which cause the observed change
- **Transparency** about data sources, methods, results and strengths and limitations of the evidence.

Each of the five principles has four questions and each question can be answered on a scale of 1 to 4. To aid with the scoring and to ensure consistency, scales have been developed for each question. Table 6 shows an example of the scoring scale.

Table 6 Bond Evidence Principle scoring scale

Score:	**1**	**2**	**3**	**4**
Question: Are the perspectives of beneficiaries included in the evidence?	No beneficiary perspectives included	Beneficiary perspectives presented, but not integrated into the analysis	Beneficiary perspectives presented and integrated into the analysis	Beneficiary perspectives presented and integrated into the analysis, and beneficiaries have validated the findings

Scores for each of the questions are then combined and an overall score out of 16 is provided for each article against each the principles. Depending on the score, the principle is then assigned a colour, as shown in Table 7.

Table 7 Overall scoring scale: Bond Evidence Principles

An overall score for the principle of **4 – 6**	Evidence is **weak** in this area
An overall score for the principle of **7 – 10**	Evidence meets a **minimum standard** in this area
An overall score for the principle of **11 - 13**	Evidence meets a **good standard** in this area
An overall score for the principle of **14 – 16**	Evidence meets **gold standard** in this area

D.2 Assessment outcomes

The Expert Reviewers provided individual assessments and scores on each research input. Aggregating these highlights some useful observations about the literature on the systems-based approach to suicide prevention, which will inform the approach to the primary evaluation reports from the three Australian trials. Table 8 provides an aggregate overview of the distribution of scores against each Bond domain.

Table 8 Literature robustness assessment results

Domain	Lower bound	Average	Upper bound
Voice and inclusion	25	**56**	100
Appropriateness	38	**77**	94
Triangulation	31	**63**	88
Contribution	31	**67**	100
Transparency	38	**62**	94

Table 9 provides the reference list for the twenty articles included in this review and a breakdown of their respective robustness assessment scores according to domain.

Table 9 Literature supplied for robustness assessment and respective scores

Article	Score				
	Voice & inclusion	Appropriateness	Triangulation	Contribution	Transparency
Arensman, et al. (2016)	🟢	🟩	🟢	🟢	🟢
Atkinson, et al. (2020)	🟩	🟩	🟩	🟢	🟩
Collings, S., et al. (2018)	🟨	🟩	🟢	🟩	🟢
Coppens, E., et al. (2018).	🟨	🟩	🟢	🟢	🟢
Coppens, E., et al. (2014).	🟢	🟩	🟢	🟢	🟢
Dudgeon, P., et al. (2016).	🟢	🟩	🟩	🟢	🟢
Harris, F. M., et al. (2013).	🟩	🟩	🟢	🟢	🟢
Harris, F. M., et al. (2016).	🟨	🟩	🟢	🟢	🟢
Hegerl, U., & Wittenburg, L. (2009).	🟨	🟨	🟨	🟢	🟨
Hegerl, U., et al. (2009).	🟨	🟨	🟢	🟢	🟢
Hegerl, U., et al. (2013).	🟨	🟨	🟨	🟢	🟨
Krysinska, K., et al. (2016).	🟨	🟩	🟢	🟢	🟨
Pirkis, J. (2016).	🟧	🟢	🟨	🟨	🟢
Sakashita, T., & Oyama, H. (2016).	🟨	🟩	🟢	🟩	🟨
Smith, L., et al. (2020).	🟨	🟩	🟩	🟨	🟢
Székely, A., et al. (2013).	🟨	🟢	🟢	🟩	🟢

Turner, K., et al. (2020).	🟩	■	🟩	■	🟩
York, J. A., et al. (2013).	🟩	■	🟩	🟩	🟩
Zalsman, G., et al. (2016).	🟩	■	🟩	🟩	🟩
Zbukvic, I. C., et al. (2020).	🟩	🟩	🟩	🟨	🟩

Appendix E: Implementation Matrix

To assist with clustering similar sites for this analysis and discussion, KPMG has mapped specifically what was implemented at each site across the National, Victorian Place-Based and LifeSpan trials in an Implementation Matrix. The level of detail is dependent on availability of information supplied in the interim evaluation reports, any additional information supplied to KPMG by PHNs directly through document requests and/or validation of information compiled in the Implementation Matrix. This matrix is the basis on which the Insights Tool has been developed to enable user readability, described further in Appendix F.

E.1 Methodology

Documentation available to KPMG was used to develop an overview of all activities at each trial site, which was then provided to PHN contacts for validation and amendment. Table 12 lists the additional documentation supplied to KPMG from PHNs involved in all three trials, used to develop the Implementation Matrix, while Table 10 indicates which PHNs validated information compiled in the Implementation Matrix.

Table 10 Trial site PHNs which responded / did not respond to request to validate information for the Implementation Matrix

Trial site PHN	Responded to request to validate information (Y/N)
National Suicide Prevention Trial	
Brisbane North PHN	**Y**
Central Queensland, Wide Bay, Sunshine Coast PHN	**Y**
Country South Australia PHN	**Y**
Northern Territory PHN	**Y**
Country Western Australia PHN	N
Mid-West Western Australia PHN	N
North Coast PHN	N/A[124]
North Western Melbourne PHN	**Y**
Perth South PHN	N
Tasmania PHN	**Y**
Northern Queensland PHN	**Y**
Western NSW PHN	N
Victorian Place-Based Suicide Prevention Trial	

North Western Melbourne - Macedon Ranges	**Y**
Eastern Melbourne - Maroondah, Whittlesea	**Y**
South Eastern Melbourne - Dandenong, Mornington Peninsula, Frankston	**Y**
Murray - Benalla, Mildura	N
Western Victoria - Ballarat, Great South Coast	N
Gippsland - Bass Coast, Latrobe Valley	**Y**
LifeSpan Trial	
Newcastle	N/A*
Illawarra Shoalhaven	N/A*
Central Coast	N/A*
Murrimbidgee	N/A*

**Please refer to Table 12 for further details.*

E.2 Design of the Implementation Matrix

Programs, projects and interventions that were designed and implemented across trial sites have been categorised for input into the Implementation Matrix according to the definitions provided in Table 11.

Table 11 Definitions of intervention types in the context of this project

Intervention type	Description
Aftercare services	Aftercare commonly refers to medical, emotional and other support provided to someone after they have made a suicide attempt.
AOD supports	Supports and services addressing primarily Alcohol and Other Drug use as a risk factor for suicide.
Arts/culture/wellbeing initiatives	Projects, programs and other initiatives that incorporate artistic, creative, or recreational means.
Care coordination	Initiatives which refine or develop medical and psychological support provided to individuals, e.g. establishing new referral pathways.
Community awareness/media campaigns	Promotional activities distributed to audiences for the purposes of increasing their awareness or understanding of suicidality and/or suicide prevention.
Community capacity building	Building the skills of the broader community to contribute to or participate in suicide prevention initiatives.

Community grants/infrastructure	The provision of funding, materials or facilities to communities for the purposes of suicide prevention.
First responder coordination	Organisation and/or management of first responder workforces (e.g. paramedics, fire fighters, police).
Gatekeeper training	Teaching people to "recognise and respond to people at potential risk of suicide, to support those who are bereaved by suicide or those who have lived experience." [125]
GP capacity building and engagement	Initiatives that improve the skills, knowledge or practices of GPs in relation to suicide.
Improved clinical infrastructure/services	Initiatives focused on enhancing existing infrastructure and/or services in medical settings.
Indigenous-specific programs	Initiatives which are highly targeted to Indigenous (Aboriginal and Torres Strait Islander) peoples/ communities and/or contain a heavy focus on Indigenous culture.
Information/ Resource Development	Production of materials and/or tools relevant to suicide prevention.
Means restriction	Limiting availability and/or accessibility to items or activities that can be used to carry out suicide.
Media training	Increasing the capabilities of media organisations and professionals to report on and refer to suicide in a responsible way.
Non-school based youth activities	Initiatives targeted toward young people (children and adolescents) that are implemented in settings outside of the school environment.
Online programs	Suicide prevention activities which are conducted remotely via the internet.
Other	Initiatives that primarily do not fit the descriptions of other interventions described in this table.
Peer support initiatives	Peer support refers to people with lived experience of suicide providing care and/or support to other people with lived experience of suicide.
Postvention	Medical, emotional and other support provided to individuals and communities after someone has died by suicide.
Problem gambling supports	Interventions primarily addressing gambling addiction as a risk factor for suicide.
QPR/ASSIST/ safeTALK/ Mental Health First Aid training	Specific types of gatekeeper training programs (see above).
Research/data collection	Gathering data or information and producing research, usually to facilitate development of tailored suicide prevention initiatives.

School-based programs	Initiatives targeted toward young people (children and adolescents) that are implemented within the school environment.
Screening and assessment tools	Tools such as checklists and frameworks used to identify or determine the severity of risks for suicide in individuals.
Strategic working group	Broadly used to refer to central coordinating bodies (including advisory groups and steering committees) which have oversight of trial activities.
Workplace initiatives (non-clinical)	Interventions primarily designed for and delivered in workplace settings outside of health/ medical sectors.

E.3 Documentation informing the Implementation Matrix

Table 12 Additional documentation supplied by PHN contacts for input in Implementation Matrix

		National Suicide Prevention Trial
Site	**Date received**	**Document/s received**
Country SA	20/05/2021	CSAPHN_AAC Evaluation-Report_V4
		CSAPHN_NSPT Research Report
North Coast	9/03/2021	Bellingen Suicide Prev Plan
		Lismore Suicide Prev Plan
		Kempsey Suicide Prev Plan
		Tweed Byron Suicide Prev Plan
		Don't let suicide kill you
		Our health clarence_Wellbeing plan
Tasmania	16/03/2021	NSPT Infographic
		NSPT Tas Evaluation Final Report
		Email correspondence
	21/05/2021	Suicide Prevention Trial Evaluation Final Report_

		Place-Based Suicide Prevention Trial
Site	**Date received**	**Document/s received**
Gippsland PHN	16/03/2021	Email response - GPHN
		Summary of Suicide Prevention Activity
North Western Melbourne PHN	15/03/2021	Annual report - Macedon Ranges 19-20
		Annual report - Melton 19-20
		Annual report - state funded site Melton Brimbank
		Email response - NWMPHN

		Annual report - Macedon Ranges 18-19 Annual report - Melton 18-19 Macedon Ranges - Activity plan 2020 - 2021 MB PBT 2020-2021 Annual Plan - FINAL NWMPHN Annual report 2017-18 Macedon Ranges PBSPT AWP DHHS 2019-20 MeltonBrimbank PBSPT AWP DHHS 2019-20
	26/05/2021	DHHS - Evaluation Framework - FINAL Exec summary
Murray PHN	22/03/2021	2020-02-24 PHN Report Annual Activity Plan Mildura_2020-2021_Mildura July 2020_coded CAMS trial licence evaluation_summary and next steps 2020_1.1 DHHS - Progress reporting template - December 2020 - Mildura LE Live4Life Evaluation Report FINAL SP0243_ConnectBenalla timeline_A1_V3 Survey on participation interests_50918
Eastern PHN	23/03/2021	CrossroadstoCommunityWellbeing_ActionPlan2020_FINAL EMPHN_Suicide_Prevention_Poster group interview response KPMG trial evaluation interview PlaceBased_Suicide_Prevention_Reports_Phase2_Collective_Impact_Workshops_Whittlesea_Final (1) Site Summary - Whittlesea 2019 SOTW_2020_Program_Evaluation_SUMMARY_FINAL SOTW_Whittlesea_outcomes_2020 SOTWIN_Whittlesea_2018_Outcome_Report SOTWIN_Whittlesea_2019_Evaluation_Final Summary_Report_Whittlesea_Suicide_Prevention_Phase_1_workshops_FINAL Whittlesea_Annual_report_2017_18_final Whittlesea_Annual_report_2018_19 Final

		Whittlesea_annual_report-state_funded_site-2019-20_FINAL
	25/05/2021	metrics EMPHN PBSPT

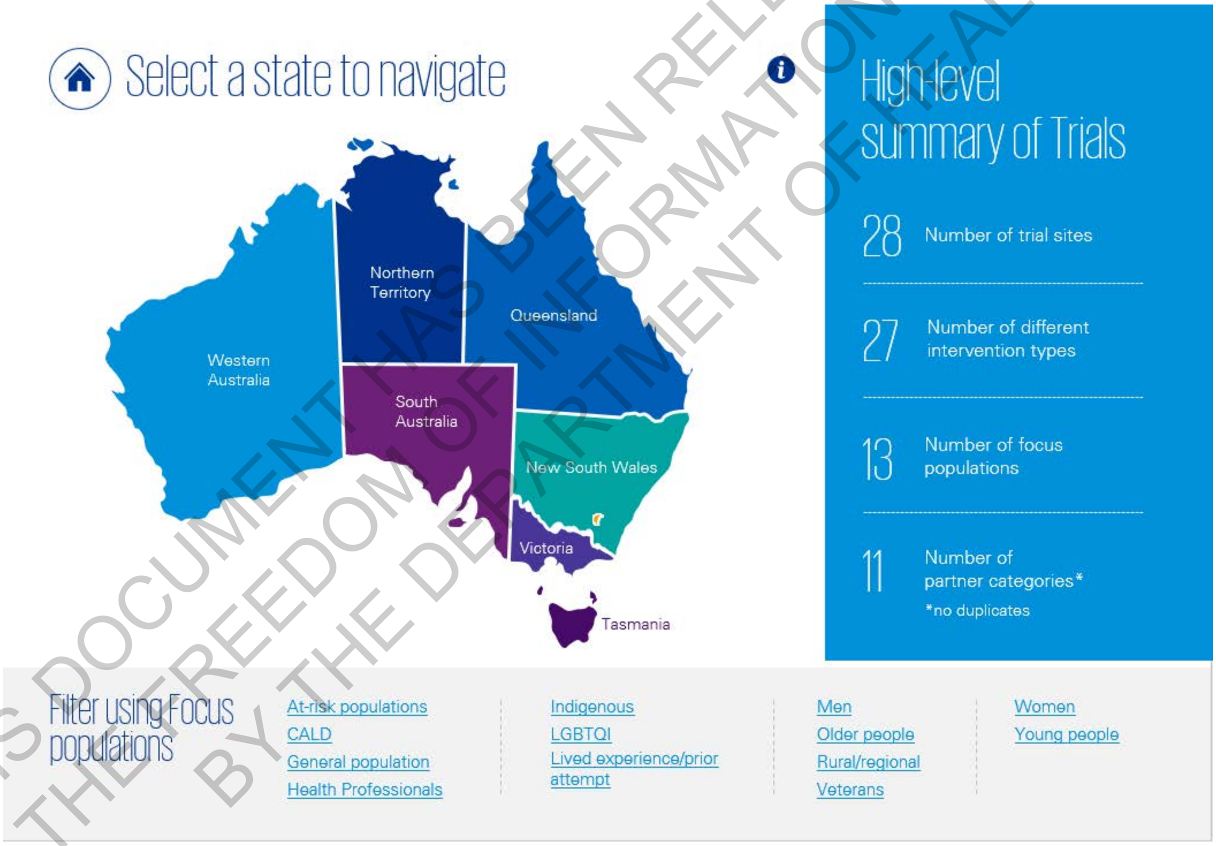
		LifeSpan Suicide Prevention Trials
Site	**Date received**	**Document/s received**
		No additional documentation received from LifeSpan trial sites. Due to considerable delays in the implementation, delivery and evaluation of the LifeSpan trial, these sites were unable to provide or validate information. Some local trial site documentation had been provided for Progress Report 1 and is included in the Implementation Matrix. KPMG will seek to collect and validate information from LifeSpan sites for inclusion in future reports.

Appendix F: Activity Insights Tool

F.1 Implementation Matrix to Insights Tool

The information contained in the Implementation Matrix was used to develop the Activity Insights Tool in Microsoft PowerPoint. The Insights Tool uses links within the PowerPoint document to allow the user to select the information they would like to see. Information can be viewed at the individual site level or by focus populations.

The Home page of the Insights Tool is displayed below for reference. The Insights Tool itself is a separate document. A glossary and how to use the tool section are provided within the Insights Tool.



Select a state to navigate

High-level summary of Trials

28 Number of trial sites

27 Number of different intervention types

13 Number of focus populations

11 Number of partner categories*
*no duplicates

Filter using Focus populations

At-risk populations
CALD
General population
Health Professionals

Indigenous
LGBTQI
Lived experience/prior attempt

Men
Older people
Rural/regional
Veterans

Women
Young people

Figure 5 Home page of Insights Tool

Appendix G: References

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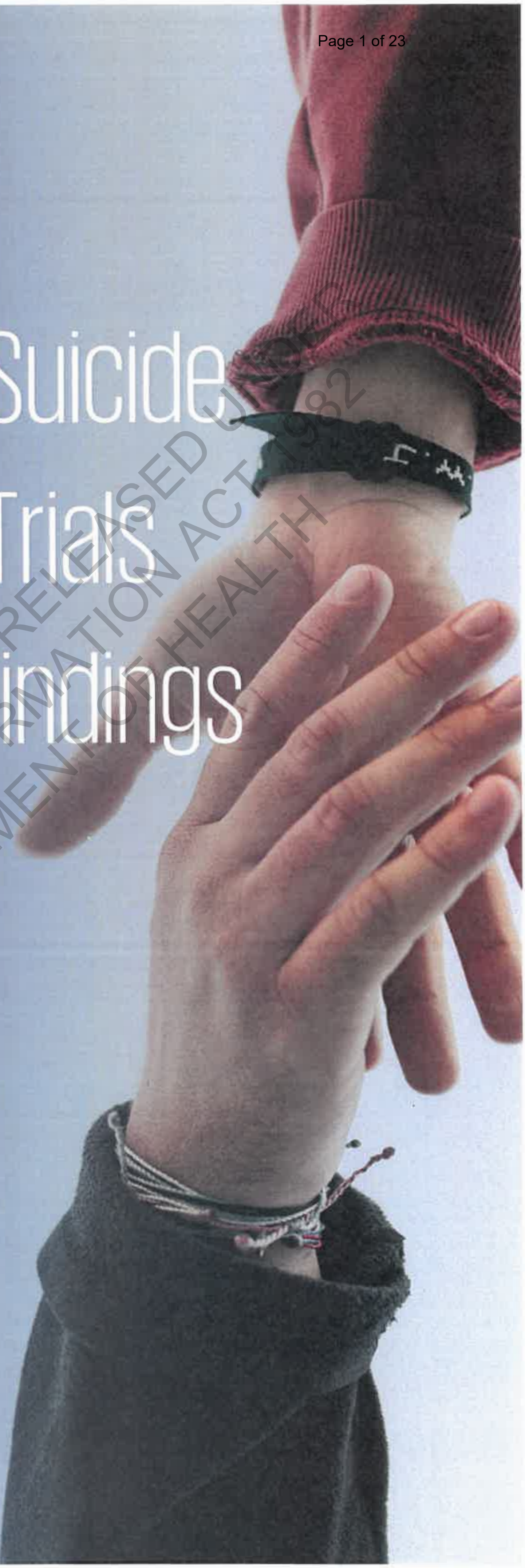
Contact us

Trixie Makay
Partner
+61 2 6248 1224
tmakay@kpmg.com.au

kpmg.com.au

Analysis of Suicide Prevention Trials Evaluation Findings



Policy implications report

Department of Health

November 2021

Disclaimer

Inherent Limitations

This report has been prepared as outlined with the Department of Health in the Services and subcontractors section of the contract dated 13 October 2020. The services provided in connection with this engagement comprise an advisory engagement, which is not subject to assurance or other standards issued by the Australian Auditing and Assurance Standards Board and, consequently no opinions or conclusions intended to convey assurance have been expressed.

No warranty of completeness, accuracy or reliability is given in relation to the statements and representations made by, and the information and documentation provided by, primary evaluation teams and Primary Health Networks consulted as part of the process.

KPMG have indicated within this report the sources of the information provided. We have not sought to independently verify those sources unless otherwise noted within the report.

KPMG is under no obligation in any circumstance to update this report, in either oral or written form, for events occurring after the report has been issued in final form.

The findings in this report have been formed on the above basis.

Third Party Reliance

This report is solely for the purpose set out in the Final Project Plan dated 17 November 2020 and for the Department of Health's information and is not to be used for any other purpose or distributed to any other party without KPMG's prior written consent.

This report has been prepared at the request of the Department of Health in accordance with the terms of the contract dated 13 October 2020. Other than our responsibility to the Department of Health, neither KPMG nor any member or employee of KPMG undertakes responsibility arising in any way from reliance placed by a third party on this report. Any reliance placed is that party's sole responsibility.

This report supersedes our previous report dated 15 December 2021. The sole purpose of this report is to address an incorrect factual reference on page 16 from '$27 million' to '$12 million'. No findings were added or removed and the findings and the rest of the report remain unchanged.'

Contents

Introduction and context

This report provides a summary of the policy implications arising from shared learnings across suicide prevention trials being undertaken by the Commonwealth Government, Victorian Government and the Black Dog Institute, as well as a review of published suicide prevention literature.

The Australian Government has identified suicide prevention as a national priority, setting an ambitious zero suicide target in 2019.[1] The suicide prevention trials provide an important opportunity to build the evidence base on what works in supporting Australians at risk of suicide. In addition to the separate evaluations being conducted across the three trials, the Commonwealth Department of Health (the Department) has commissioned a combined analysis of findings from all three projects, to strengthen the coordination of this evidence and amplify its findings.

Noting there is a broad suite of work underway in the sector, many of these implications align strongly with recently announced initiatives arising from the findings of the National Suicide Prevention Advisor to the Prime Minister, Christine Morgan. This report is therefore both a positive endorsement of work underway to address shortcomings in suicide prevention services, programs and policy, and a confirmation of the challenges faced by the sector in implementing interventions and measuring change.

Systems approach

The national trials have been undertaken in different parts of Australia, using diverse models and with various target cohorts. However, each of these trials have adopted a regional systems-based approach to suicide prevention which involves a mix of interventions being delivered through diverse local and community partnerships with the collective aim to strengthen community resilience to suicide (details of the approach and interventions within each trial are provided in Appendix B: Trial details). As an example of this approach, trials may complement suicide prevention training for General Practitioners (GPs) and other healthcare workers with improved clinical infrastructure to support patient pathways, with gatekeeper training for key community members to guide people at risk of suicide into appropriate services, and with community awareness campaigns to increase the general population's ability to recognise risk factors for suicide.

While these approaches are in line with a contemporary understanding of suicidality and its risk and protective factors, findings gathered to date by KPMG and the Suicide Prevention Expert Panel established for this project (see Progress Reports 1 and 2) indicate the complexities and challenges inherent in a systems approach. Some of the consistent challenges in a systems approach to suicide prevention relate to:

- Adapting to emerging trends and incorporating dynamic changes across the system
- Implementing emergent co-design and co-delivery opportunities
- Enabling localised, embedded approaches through partnerships, and
- A lack of consistency about which systems should be engaged in the trials and what frameworks of codesign and collaboration should be utilised.

The trials are designed to include a wide range of interventions (collectively, trial sites are working with partner organisations from 11 different categories, implementing 27 different intervention types, with 13 focus populations). However, the priority for the trials has been successful implementation, rather than testing or trialling the impact on outcomes of the high volume and diversity of work underway. Measuring the success of trial implementation is complex with several consistent themes identified and explored in Progress Reports 1 and 2. Significant challenges in capturing meaningful outcomes data from the trials have also been identified, leading to limitations in measuring the overall

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impact of trials. This challenge is also described in broader published research, highlighting the need for effective approaches when evaluating system-based approaches. With the current trials analysed in this work, evidence is still unclear as to whether all these intervention components are equally important or whether combinations of them synergise to create more powerful impact.

Based on work to date to bring together trial findings, policy implications from two themes are presented in this report; those focused on measurement and evaluation; and implications for implementation.

Key enablers of effective measurement and evaluation

The evaluation of the trials to date have highlighted the need to, and importance of, establishing robust measurements of progress in systems approaches to suicide prevention. It is notoriously difficult to evaluate whether interventions reduce suicide rates due to factors including the complexity and multifactorial nature of each situation, the small number of deaths by suicide, the lack of people seeking help for suicidality and attempts, and challenges with accurate classification of deaths. Systems based approaches also suffer from a lack of robust evidence of their effectiveness compared with more traditional standalone programs, due to the attribution challenges associated with any existing suicide prevention efforts that may also be in place.[2] The multiple interactions amongst and between components of systems-based approaches adopted, and confounding factors from other policy levers that impact suicide risk or protective factors also present attribution challenges. Findings from the three trial site evaluations and the broader review of the literature highlights these challenges in measuring and evaluating systems approaches to suicide prevention. Evidence from these sources also indicates the importance of two key enabling factors which may counteract these challenges: strong leadership and governance structures, and alignment of outcomes and data sources.

To assist the linking of suicide prevention efforts through evaluation, commissioning bodies need to be clear about the intentions of any trials or pilot initiatives. Whether the intent is to understand implementation processes or outcomes, targeted evaluation frameworks are required to drive rigour in data collection and analysis. For future trials, it may also be worth identifying intended outcomes other than reductions in suicide deaths and attempts. For example, community capacity building or quality of life indicators for people with suicidality may be highly valuable outcomes associated with suicide prevention trials. The National Suicide Prevention Trial program logic includes short- and medium-term impacts and outcomes such as an aware and trained community and improved individual and community resilience. Identifying long term measures as part of the design phase of future trials would allow for ongoing visibility of the impact on these outcomes.

Frameworks to guide evaluation of complex interventions may also go beyond assessing whether an intervention achieves its intended outcomes. Robust frameworks may ask broader questions about how an intervention works and how it contributes to systems change. Such a framework can support decision making, enabling prioritisation of information according to its usefulness.[3] Establishing an overarching evaluation framework for future trials would also help to address the gap in published process evaluations associated with multilevel suicide prevention research trials seen globally.[4]

Leadership and governance

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[2] Collings, S., Jenkin, G., Stanley, J., McKenzie, S., & Hatcher, S. (2018). Preventing suicidal behaviours with a multilevel intervention: a cluster randomised controlled trial. BMC public health, 18(1), 1-13.

[3] Skivington, K., Matthews, L., Simpson, S. A., Craig, P., Baird, J., Blazeby, J. M., ... & Moore, L. (2021). A new framework for developing and evaluating complex interventions: update of Medical Research Council guidance. bmj, 374.

[4] Zbukvic, I. C., Mok, K., McGillivray, L., Chen, N. A., Shand, F. L., & Torok, M. H. (2020). Understanding the process of multilevel suicide prevention research trials. Evaluation and program planning, 82, 101850.

Highly complex social and economic issues generally necessitate an overarching framework for national, state and territory and local strategies, legislation, policies, and actions that target the issue. Strategies articulate goals and objectives, allowing all actors relevant to the strategy to align efforts to increase the likelihood of achieving overarching goals. Strategies also allow for focussed reporting, accountability, and funding to facilitate achievement of identified goals.

Table 1 provides an overview of national plans, strategies, and key policy initiatives that are currently in effect and relevant to suicide prevention in Australia. States and territories also have a range of current plans, strategies, and policy initiatives specific to their jurisdictions, not presented here. As described in Vision 2030 for Mental Health and Suicide Prevention, several long term national mental health plans and strategies exist at the system level and are complemented by more targeted strategies and implementation mechanisms. Most of the initiatives provided in Table 1 are led by the Commonwealth government, and all operate at the federal level.

Table 1 Current plans, strategies, and policy initiatives relevant to suicide prevention at the national level

Health system building block	National Plans, Strategies, frameworks, and key initiatives
Overarching mental health/ suicide prevention	— Australia's Long Term National Health Plan: to build the world's best health system — The Fifth National Mental Health and Suicide Prevention Plan 2017 (2021 TBC) — National suicide prevention strategy for Australia's health system: 2020–2023 — National Suicide Prevention Strategy (includes -Living is for Everyone (LIFE) framework, -NSPS Action Framework, -National Suicide Prevention Program) — National Aboriginal and Torres Strait Islander suicide prevention strategy — National Mental Health and Wellbeing Pandemic Response Plan — Vision 2030 for Mental Health and Suicide Prevention — National Children's Mental Health and Wellbeing Strategy 2021 — National LGBTI Mental Health and Suicide Prevention Strategy (produced by National LGBTI Health Alliance) — Mentally Healthy Workplaces Alliance — National Disaster Mental Health and Wellbeing Framework (in development) — National Workplace Initiative (in development) — National Stigma and Discrimination Reduction Strategy (in development)
Workforce	— National Mental Health Workforce Strategy 2011 and National Youth Mental Health Workforce Strategy 2016 – 2020 — National Alcohol and Other Drug Workforce Development Strategy 2015 - 2018 — National Peer Workforce Development Guidelines (in development) — Commonwealth Aboriginal and Torres Strait Islander Workforce Strategy 2020 - 2024 — Aboriginal and Torres Strait Islander Health Workforce Strategic Framework 2016 - 2026 — National Strategic Framework for Rural and Remote Health 2011 — Every Doctor, Every Setting: A National Framework
Financing	— Federal budget response to the Productivity Commission and Christine Morgan advice: National Mental Health and Suicide Prevention Plan funding across five pillars — The LIFEWAYS Project: Leading research into suicide prevention
Information systems	— National Suicide and Self-Harm Monitoring System - Turning Point to develop the National Ambulance Surveillance System (NASS) for overdose and suicidal behaviour - Mental Health Information Strategy Standing Committee (ED suicide and self-harm related presentations) - Multi-Agency Data Integration Project

	— Suicide Prevention Intelligence System (Black Dog; LifeSpan) — National Mental Health Research Strategy — Minimum data set of National Suicide Prevention Leadership and Support Program (now LIFEWAYS Project)
Leadership & governance	— Australian Mental Health Leaders Fellowship — National Suicide Prevention Office
Access to essential treatments	— Suicide Prevention Quality Improvement Program (Suicide Prevention Australia) — ALIVE research centre (in development)
Service delivery	— Safe in Care, Safe at Work (Reducing Restrictive Practices)

Observations regarding key national strategies and plans

The Fifth National Mental Health and Suicide Prevention Plan outlines progress indicators, measures, and data sources in detail, with an independent evaluation to be completed in mid-2022 according to the Implementation Plan.[5] The Implementation Plan also describes the role of the National Digital Health Agency in developing a National Digital Mental Health Framework. It also stipulates that the Mental Health Information Strategy Standing Committee (MHISSC) will develop data sources. It is unclear which agency is earmarked as data custodian, although many of the data sources provided in the Fifth Plan are held by either the Australian Bureau of Statistics (ABS) or the Australian Institute of Health and Welfare (AIHW).

Not all data sources described in the Fifth Plan are publicly available including the National Hospital Morbidity Database and the Mental Health Establishments National Minimum Data Set and several others. Other core data sets such as the Victorian and Queensland suicide registers are also not publicly available, barring reports generated by the AIHW. Furthermore, while most strategies and plans provide relevant intended outcomes and indicators, they do not provide detailed monitoring and evaluation approaches or plans. Overall, while a strong body of work is underway across suicide prevention in Australia, there is a clear need to establish commonalities and specify shared outcomes, and associated datasets, to ensure alignment and support meaningful measurement of impact and implementation.

The existence of such a broad suite of initiatives and strategic direction demonstrates the high priority status of suicide prevention. It also leads to a crowded landscape and can raise questions regarding how actors in all jurisdictions and at all levels of government 'keep track' of efforts in the space. There is a need to make sure that these strategies, plans, indicators, and their associated data sources remain well integrated and that the work underway across relevant strategic agendas is leveraged.

Considering the breadth of current suicide prevention activity, there is a role for a central body such as the Department to connect all strategic activity by establishing long term measurement points, shared key definitions, and disseminating overarching learnings throughout the sector to drive continuous improvement. This oversight and strategic coordination would feasibly lead to savings as gaps and duplications of investment become evident. It would also drive better coverage of interventions across systems and better datasets to establish what works, ultimately preventing more deaths from suicide.

In practice, this leadership could take the form of a set of agreed outcomes and indicators at the national level that informs the monitoring and evaluation of all future suicide prevention trials and programs. This will enable future meta-analyses and enhanced evaluation opportunities. This is directly aligned with the responsibilities of the proposed National Suicide Prevention Office in developing a national outcomes framework, announced in May 2021.[6] A National Suicide Prevention Office will help to ensure that a national outcomes framework is "applied nationally and down to a program and service level," and will set priorities for research and knowledge-sharing across all

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[5] Department of Health. (2017). The Fifth National Mental Health and Suicide Prevention Plan Implementation Plan. Retrieved from https://www.mentalhealthcommission.gov.au/getmedia/7641fccf-4338-47a1-83af-f94c73d0aac2/Fifth-National-Mental-Health-and-Suicide-Prevention-Plan_Implementation-Plan

[6] National Mental Health Commission. (2021). About the National Suicide Prevention Office. Retrieved from https://www.mentalhealthcommission.gov.au/national-suicide-prevention-office/about-the-national-suicide-prevention-office

jurisdictions. The Office will also develop a National Suicide Prevention Workforce Strategy.[7] This oversight and coordination of shared outcomes and indicators will increase accountability across all areas of government.[8]

Another function of this Office could be to establish shared definitions of core concepts and approaches, such as codesign or collaboration. Despite all three trials utilising codesign strategies, there is no overarching framework in use which defines collaboration, codesign or coproduction methods. This lack of shared definition is a barrier to measurement of their effectiveness across trials. The complexity and criticality of suicide prevention activity across the nation requires effective coordination and strong leadership to optimise outcomes. The current strategic landscape demonstrates an array of plans, initiatives and activities that do not necessarily align. Establishing a central body that can connect and oversee the strategic activity in suicide prevention will support the translation of findings and the opportunity for national insights.

Key points: Leadership and governance

1. **Multiple long term national mental health plans and strategies exist at the system level, complemented by targeted strategies and implementation mechanisms**
2. **The 'crowded' landscape requires these strategies, plans and their associated data sources to be well integrated, with work underway across relevant strategic agendas to enhance coordination.**
3. **Shared outcomes and indicators for suicide prevention at the national level would increase opportunities for analysis and evaluation. This directly supports the announcement of the National Suicide Prevention Office and its role in developing a national outcomes framework.**

Alignment of outcomes, indicators, and data sources

There is extensive work underway in Australia by key data custodians to improve the quality and coverage of data relating to suicide deaths, attempts, risk and protective factors. Several of these initiatives are outlined in Table 1 above and described in further detail below. *Appendix C: Current data sources- suicide & mental health* provides further detail regarding current data sources relevant to suicide.

The ultimate aim is to ensure the impacts of interventions are able to be measured in terms of suicide attempts and deaths. There is no shortage of relevant data being collected at the national level but there remains a need to link these data sets with local level data from interventions such as the suicide prevention trials. This would allow for more effective use of data to observe longitudinal trends at both the local and national levels. The recent establishment of the National Suicide and Self-harm Monitoring system, a joint venture between the AIHW and ABS, is an example of this in action, bringing the ability to conduct specialised project analyses on suicide amongst priority populations.[9] Ensuring that any new suicide prevention projects also promote coordination and allow for strategic data collection will be imperative to measure longitudinal outcomes. The National Suicide Prevention Leadership and Support Program minimum data set (MDS), compiled and managed by Australian Healthcare Associates under the National Suicide Prevention Plan is another relevant initiative.[10] This MDS ties in with other data collection projects, including the Primary Mental Health Care MDS reported by organisations undertaking the suicide prevention services funded by the Australian

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[7] National Mental Health Commission. (2021).

[8] Suicide Prevention Australia. (2021). National Suicide Prevention Office gets green light. Retrieved from https://www.suicidepreventionaust.org/national-suicide-prevention-office-gets-the-green-light/

[9] National Mental Health Commission. (2021). Data collection and analysis provides important insights to reinforce a national response towards zero suicide. Retrieved from https://www.mentalhealthcommission.gov.au/News/2021/September/national-response-towards-zero-suicide

[10] Australian Healthcare Associates. (n.d.). National Suicide Prevention Leadership and Support Program - Minimum Data Set collection and reporting. Retrieved from https://www.ahaconsulting.com.au/projects/nsplsp/

Government.[11] Continuing to build on the data points already collected longitudinally will contribute to a rich source of information to measure future initiatives. As described above, this would be supported by the National Suicide Prevention Office developing evaluation frameworks which specify common indicators and data sources.

The suicide prevention trials are collecting data against a range of short, medium, and long-term outcomes measures. These vary considerably between the three trials as shown in Table 2. Associated data sources and collection approaches also vary between trials, with most outcomes being measured via qualitative measures (especially the NSPT and PBSPT). The LifeSpan Trial utilises several major public, quantitative datasets to measure impact as well as qualitative data. The variation in outcome measures between the trials and the associated data collection approaches limits the opportunities for collective findings. The primary data collection being conducted by trial sites and evaluation teams would benefit from alignment with datasets available at the national level and through consistent outcomes measures.

Table 2 Evaluation questions of the suicide prevention trials

Trial	**Evaluation questions/ outcomes evaluated**
NSPT	• How did sites plan and develop suicide prevention strategies? • What strategies were found to be effective in facilitating local planning? • What barriers were encountered? • What are the policy implications? • What strategies did sites use to develop and sustain a system-based approach to suicide prevention? • What strategies were found to be effective in facilitating a system-based approach? • What strategies were used to enhance, target and deliver services and activities [for people who had made a suicide attempt or were at risk for suicide, focus populations, general population, focus populations]? • What strategies were found to be effective in preventing suicide deaths and suicidal behaviour [among Aftercare service users, general population, focus populations]? • What challenges were encountered?
LifeSpan	• Suicide attempts and deaths, geospatial clusters • Economic benefit of suicide prevention • Emergency and follow up aftercare for people: ED experiences • GP capacity building & support: effectiveness of training programs • Community awareness & gatekeeper training: community suicide literacy, effectiveness of training programs • School based interventions: efficacy of YAM program • Media guidelines: quality of media reporting on suicide • Lessons are learned about the implementation of a complex model • Barriers and enablers to implementing the evidence-based CAMS model in Australian health services

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[11] Australian Healthcare Associates. (n.d.).

PBSPT	• How well are the place-based suicide prevention trials progressing? • What factors are influencing progress (e.g., key strengths & challenges)? • Are the intended system and individual-level outcomes being achieved? • What are the key contributors to any changes in these outcomes? • Are the intended community-level outcomes being achieved? *(These comprise summative evaluation 2 due in 2024/25)* • Does the place-based approach provide good value for money? *(These questions comprise summative evaluation 2 due in 2024/25)*

To enhance future suicide prevention data that supports the establishment of a long-term monitoring and evaluation system, data linkage needs to be considered. This is supported by the recommendation within the National Mental Health and Suicide Prevention Plan to establish a National Evaluation Strategy as well as the new National Suicide Prevention Office.

The intended National Evaluation Strategy also highlights the benefits of a central coordinating body that oversees linkage of existing and future datasets and the translation of research into practice. Having this coordination in place would allow for a meta-evaluation across multiple trials, as was the intent with the current trials. The Suicide and Self-Harm Monitoring Project is working to establish the infrastructure required to achieve linkage, access to and translation of key suicide-related datasets. The project consists of a public facing monitoring site to be supplemented by a State and Territory Information Portal, which data custodians and other vetted users will have access to, aiding policy evaluation, service planning and other sector activities, such as identifying emerging areas or priority population groups.[12] As part of this project, the AIHW are leading several data integration projects, including linking data from the Medicare Benefits Schedule, Pharmaceutical Benefits Scheme, National Death Index, and specialist Victorian mental health services records to provide in-depth insights to the Royal Commission into Victoria's Mental Health System.[13] Future trials of systems approaches to suicide prevention should be considered as potential partners or contributors to these linked datasets, which can be used to show trends in impacts of these approaches over time.

Key points: Alignment of outcomes, indicators, and data sources

4 **There is extensive work underway in Australia by key data custodians to improve the quality and coverage of data relating to suicide deaths, attempts, risk and protective factors.**

5 **The three suicide prevention trials are measuring different short, medium, and long-term outcomes, utilising varying data sources and collection methods, limiting the ability to aggregate and compare findings.**

6 **Intended outcomes of suicide prevention interventions must be thoughtfully identified and clearly defined. This may include process outcomes or other indicators that fall outside of suicide deaths and attempts at the individual, community and/or system level.**

7 **There remains a need to link national data sets with local level data from future interventions to enhance opportunities for data to demonstrate longitudinal trends at both the local and national levels.**

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[12] Flego, A., Dempster, G., Cutler, T., Robinson, J., & Pirkis, J. (2021). Evaluation of the National Suicide and Self-harm Monitoring Project and System: Interim Report. Retrieved from https://www.aihw.gov.au/getmedia/86365084-83a5-4097-823e-7e9e5f8f0029/Interim-Report_Evaluation_NSSHMS_UoM_May-21.pdf.aspx

[13] Flego, et al. (2021).

8 This would be supported by the development of a centralised evaluation framework with common indicators and associated datasets that individual initiatives can leverage, rather than develop individually.

In summary, there is a vast body of work either currently underway or funded to occur in the near future that will strengthen the measurement of suicide prevention initiatives. In exploring the evaluations of the three suicide prevention trials, key learnings directly support the need for progress in leadership and governance structures to align outcomes measures and data sources. Key initiatives underway are expected to directly address some of the challenges observed through the analysis of trial evaluations.

Key enablers of successful trial implementation

Throughout the course of this project, two dominant and interacting factors emerged as affecting implementation of the trials: workforce and funding. A range of issues relating to these factors are evidenced in the trial sites and explored further in Progress Reports 1 and 2. These findings have also been supported by published and grey literature, despite significant differences in structures, locations, models, target cohorts, capabilities, partnerships, and other factors. The consistent issues related to workforce include the need for workers to be attracted, retained, and developed, and possess the necessary skillset to form strong working partnerships. Having adequate time and being adaptable and flexible were also crucial for workers to support successful implementation. Inadequate or short-term resourcing was identified as a major barrier to the implementation of trial initiatives. This interplay between workforce and funding is outlined below.

Sitting over the top of these key enablers is the need for a clearly articulated implementation strategy encompassing all trials. This has been identified as a significant gap in the current trials, despite the emphasis on gathering information on how interventions are implemented in real-world settings. The absence of an overarching strategy can give rise to tensions on the ground between bottom-up and top-down approaches (including doubts over interventions that are supposedly evidence-based). It can also lead to inefficient processes such as conducting community consultation over every part of the intervention rather than using consultation strategically. The field of implementation science provides evidence on the determinants of successful implementation and provides direction on implementation strategies that may inform future initiatives.[14] [15] As well as providing the guardrails to support implementation, an overarching strategy might also include other key success factors such as approaches to increase uptake and impact of intervention components and a communication strategy. The importance of an implementation strategy is highlighted as the component that connects the key enablers, such as those discussed below.

Workforce capability

A workforce which is adequately skilled and resourced is necessary to execute a coordinated strategy for suicide prevention. The suicide prevention workforce (or, more commonly and often conflated, mental health workforce) is a key driver of implementation in suicide prevention approaches. The extensive amount of suicide prevention activity has placed this workforce under immense pressure that is characterised by several significant challenges that coincide with implementing systems-based approaches. Noting that the 'suicide prevention workforce' is a subset or aligned cadre of the broader mental health workforce, there are many similarities between these challenges and those affecting the suicide prevention trial workforce as covered in Progress Reports 1 and 2.

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[14] Smith, J. D., Li, D. H., & Rafferty, M. R. (2020). The implementation research logic model: a method for planning, executing, reporting, and synthesizing implementation projects. Implementation Science, 15(1), 1-12.

[15] Smith, J. D., Fu, E., Rado, J., Rosenthal, L. J., Carroll, A. J., Atlas, J. A., ... & Csernansky, J. (2021). Collaborative care for depression management in primary care: A randomized roll-out trial using a type 2 hybrid effectiveness-implementation design. Contemporary clinical trials communications, 23, 100823.

Outlined in an extensive literature review which underpins the forthcoming National Mental Health Workforce Strategy,[16] these core challenges include:

- Defining the mental health workforce, due to diversity of skillsets
- Adapting to the needs of a diverse and changing population and the investment this requires
- Shortages, in terms of mix and distribution of skills and turnover
- Challenges being intensified in rural and remote service provision
- The need to be responsive and flexible to changing circumstances, e.g., industry and technology changes, major events
- Limited access to evaluation of mental health workforce strategies.

Previous reports have highlighted the importance of skills in building strong and effective relationships with a diversity of partners, particularly for coordinator roles, in allowing for successful implementation of a systems-based approach. This is due to the necessity of bringing a suite of players together to deliver and facilitate interventions in different areas of a system. This can include some non-traditional suicide prevention roles such as those played by sporting clubs. Furthermore, for people to collaborate meaningfully, they must feel valued and included in their communities, which further underscores the need for strong relationship building capability. This 'soft' skillset, which sits alongside the importance of suicide prevention-specific knowledge and skills, emerged strongly as a key enabler throughout the trials. Developing these skills within the suicide prevention or mental health workforce should be included as a key enabler for the success of any future systems approaches in the forthcoming National Suicide Prevention Workforce Strategy.

Actions that can be taken to support the development of these skills in suicide prevention workforces are similar to those required to support an effective mental health workforce. This includes the value of having:

- *"Co-design processes embedded from project inception and delivered in a genuine and meaningful way by service providers who are adequately supported, trained, and resourced to engage in these processes.*
- *Respectful, mutually beneficial, and sustainable partnerships and collaborations across all areas of the mental health workforce.*
- *Appropriate and responsive education, training, professional development, and mentorship throughout all career stages."*[17]

Through the trials, several core mechanisms were identified as beneficial for workforce capability building. These include establishing communities of practice or learning systems across the suicide prevention workforce, investing in ongoing professional development, and prioritising the innovative use of project collateral, such as data dashboards. The community of practice facilitated by Black Dog Institute amongst site representatives implementing the LifeSpan framework was recognised as highly valued in sharing learnings as well as in providing a forum to facilitate peer support. When considering the key enablers of improved suicide prevention activities as identified by the trials, the KPMG Suicide Prevention Expert Panel has highlighted professional development as a critical gap. The panel identified that the educational curriculums for workforces required to play a part in suicide prevention do not deliver explicit suicide prevention training. Furthermore, key stakeholders across

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[16] Institute for Social Science Research. (2020). Final Report: National Mental Health Workforce Strategy – A literature review of existing national and jurisdictional workforce strategies relevant to the mental health workforce and recent findings of mental health reviews and inquiries. Retrieved from https://www.health.gov.au/sites/default/files/documents/2021/08/national-mental-health-workforce-strategy-a-literature-review_0.pdf

[17] Institute for Social Science Research. (2020).

PHNs reported the value of dashboards in helping to strengthen engagement and to support a sense of momentum for core implementation partners.

The need to support the health and wellbeing of the suicide prevention workforce has been identified both through these trials and in the broader discourse surrounding COVID-19. Having adequate supports in place such as peer-to-peer connections for trial workers, paid or unpaid, contributes to resilience and sustainability of committing to implementing a complex intervention in an emotionally taxing subject matter.

Future suicide prevention initiatives require the integration of core mechanisms that help develop necessary skillsets and support the workforce to deliver complex initiatives. To establish a more sustainable workforce, long-term strategies for increasing inclusion of suicide prevention-specific skillsets, including skills relevant to partnership building, should be included in higher education curriculums and professional development opportunities. Alongside this, paid and unpaid contributors to suicide prevention initiatives should be provided with adequate social-emotional supports to ensure the sustainability of their commitment on an individual level.

Key points: Workforce capability

9 The workforce is a critical driver of implementation in suicide prevention approaches but faces several significant challenges.

10 Findings from the trials highlight the importance of workers in coordination roles and the need to be skilled in building effective and sustainable relationships and partnerships between partners across all components of a 'system'.

11 In addition to curriculum inclusion in formal education and professional development, specific mechanisms to build capacity and maintain engagement of partners and workers, and adequate social-emotional supports should be built into future suicide prevention initiatives.

Financial sustainability

Findings from the current trials also indicate that when establishing funding for systems-based approaches, there must be recognition of existing workforce retention issues and the time required for implementing systems-based models. This encompasses the need for adequate codesign with communities, forming and establishing partnerships between a broad range of actors within the system, and allowing for necessary adaptation and flexibility in how different project partners work together.

As described above, the skillsets required to effectively implement systems-based approaches are largely interpersonal and relationship based, which are harder to find and establish. This makes the attraction and retention of the people with this type of skillset vital for the success of these initiatives. The broader health and mental health workforces are already facing significant and well-known shortages and distribution issues around the country, placing skilled workers in very high demand. As these workers are required to establish long-term relationships between implementing partners, short-term tenures create enormous inefficiency in the need to re-establish those relationships.

Findings to date show that funding pilots or short-term trials is ineffective in supporting a workforce working within an approach that takes a very long time to develop. A key recommendation for future suicide prevention initiatives is that workers, and communities, be given sufficient time and associated funding to enact the essential components of systems-based approaches. This includes establishing relationships, participating in meaningful codesign, and obtaining the high level of engagement required. Consultation with PHNs involved in Victoria's Place-Based Suicide Prevention Trial revealed the importance of support mechanisms such as communities of practice, guidance from established entities such as Black Dog Institute, and the professional development opportunities these bring. These structures form part of the necessary resources for implementation and must be accounted for in future project funding. Determining the proportion of funding required to enable this work may fall within the remit of the funder, or of central or specialist bodies such as the proposed National Suicide Prevention Office.

Key points: Financial sustainability

12 Future funding for suicide prevention initiatives needs to recognise the existing workforce retention issues, as well as the time required to effectively implement systems-based models.

13 Developing long-term relationships between partners is pivotal for success of implementing systems-based approaches; providing workers with longer contracts reduces the potential inefficiency in re-establish those relationships.

14 Sufficient time and associated funding to enact the essential components of systems approaches is required for future suicide preventions initiatives.

In summary, there are significant challenges facing the suicide prevention workforce, which interplay with the additional requirements of them in implementing systems-based approaches. Building workforce capability requires sustained investment in mechanisms such as knowledge-sharing forums as well as professional development opportunities, which also serve to increase engagement of workers and partners. These requirements must be reflected in the level and/or longevity of funding in future suicide prevention initiatives.

Conclusion

While there is considerable investment in systems-based approaches to suicide prevention, the need for an implementation strategy coupled with challenges in monitoring and evaluation have meant that their collective impact on suicide attempts and deaths remains unclear. There is an overarching need for a centrally developed evaluation framework that includes strong process evaluation focus to enhance the generation of learnings through future suicide prevention efforts.

The three suicide prevention trials demonstrate that effective measurement and evaluation of future systems approaches require strong, central leadership, such as from the Department or the proposed National Suicide Prevention Office. The integration of strategic directives and the establishment of shared intended outcomes and indicators at the national level would add significant value to future initiatives. The alignment of datasets through linkage and translation, such as in the National Suicide and Self-Harm Monitoring Project, would also facilitate enhanced longitudinal monitoring. Having these mechanisms in place would facilitate better understanding of the collective impact of suicide prevention programs over time. Enhanced understanding would inform more effective funding and design decision-making for future implementation.

As described earlier, the complexity in implementing systems approaches drives key challenges for workforce capability and funding. Capacity building of workforces, particularly in partnership and relationship building, through mechanisms for professional development would drive a more sustainable suicide prevention workforce in the future with the required capabilities. The funding of future suicide prevention activity should also allow for the core enablers of systems-based approaches that take significant time and resource investment, such as best-practice codesign and relationship building, through an implementation strategy with a clear evaluation framework.

If these enablers of effective measurement and implementation are achieved, complex, systems-based approaches to suicide prevention will be strengthened and their impacts will become increasingly evident.

Appendix A: Key points

The key points presented throughout this report are provided below.

Leadership and governance

1. Multiple long term national mental health plans and strategies exist at the system level, complemented by targeted strategies and implementation mechanisms
2. The 'crowded' landscape requires these strategies, plans and their associated data sources to be well integrated, with work underway across relevant strategic agendas to enhance coordination.
3. Shared outcomes and indicators for suicide prevention at the national level would increase opportunities for analysis and evaluation. This directly supports the announcement of the National Suicide Prevention Office and its role in developing a national outcomes framework.

Alignment of outcomes, indicators, and data sources

4. There is extensive work underway in Australia by key data custodians to improve the quality and coverage of data relating to suicide deaths, attempts, risk and protective factors.
5. The three suicide prevention trials are measuring different short, medium, and long-term outcomes, utilising varying data sources and collection methods, limiting the ability to aggregate and compare findings.
6. Intended outcomes of suicide prevention interventions must be thoughtfully identified and clearly defined. This may include process outcomes or other indicators that fall outside of suicide deaths and attempts at the individual, community and/or system level.
7. There remains a need to link national data sets with local level data from future interventions to enhance opportunities for data to demonstrate longitudinal trends at both the local and national levels.
8. This would be supported by the development of a centralised evaluation framework with common indicators and associated datasets that individual initiatives can leverage, rather than develop individually.

Workforce capability

9. The workforce is a critical driver of implementation in suicide prevention approaches but faces several significant challenges.
10. Findings from the trials highlight the importance of workers in coordination roles and the need to be skilled in building effective and sustainable relationships and partnerships between partners across all components of a 'system'.
11. In addition to curriculum inclusion in formal education and professional development, specific mechanisms to build capacity and maintain engagement of partners and workers, and adequate social-emotional supports should be built into future suicide prevention initiatives.

Financial sustainability

12. Future funding for suicide prevention initiatives needs to recognise the existing workforce retention issues, as well as the time required to effectively implement systems-based models.
13. Developing long-term relationships between partners is pivotal for success of implementing systems-based approaches; providing workers with longer contracts reduces the potential inefficiency in re-establish those relationships.
14. Sufficient time and associated funding to enact the essential components of systems approaches is required for future suicide preventions initiatives.

Appendix B: Trial details

The following section summarises the background and context to these trials.

The National Suicide Prevention Trial

The National Suicide Prevention Trial (NSPT) was initially funded for four years from 2016, with a one-year extension announced in 2018. The Trial represents a major investment by the Australian Government to expand the evidence base on suicide prevention, with $49 million in funding provided across 12 sites nationally.

The Trial has been designed to provide evidence on how the regional systems-based approach to suicide prevention might best be undertaken within the Australian context, and identify new learnings in relation to effective suicide prevention interventions for at-risk populations.[18] Its program logic states that the NSPT's primary intended impacts are: decreased suicidality of individuals using services delivered through the trial; strengthened awareness and capacity within communities to respond to the needs of people at risk of suicide; and improved integration of services and systems.[19]

The NSPT is being delivered in 12 regions across Australia, which are overseen by 11 PHNs. The specific trial sites within PHN catchments were selected based on an assessment of community need, with considerations including current suicide rates and availability of existing suicide prevention services or supports.

In addition to addressing of whole-of-population suicide prevention, six at-risk groups were identified as priority populations for the NSPT:

- people who have attempted suicide or are considered at-risk of suicide
- Aboriginal and Torres Strait Islander peoples
- Lesbian, gay, bisexual, trans, intersex, queer (LGBTIQ+) people
- young adult and middle-aged men
- young people
- Australian Defence Force Veterans.

While most sites targeted more than one priority population, activities in individual sites did not generally address all of these groups.

Sites within the NSPT have been able to select their preferred systems-based model. The Black Dog institute was commissioned to assist PHNs to undertake scoping and community planning. Eight sites adopted the LifeSpan model which has been developed by the Black Dog Institute,[20] and two adopted the Alliance Against Depression (AAD) model which is widely used in Europe and has been adopted in some parts of Australia.[21] A further two sites which have a specific focus on Aboriginal and Torres

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[18] (No author). (2017). *National Suicide Prevention Trial Evaluation Framework: Guide for the conduct of the evaluation.* p12. Supplied to KPMG.

[19] Currier, D. et al. (2020). *National Suicide Prevention Trial Interim Evaluation Report: planning and implementation.* University of Melbourne. Supplied to KPMG.

[20] Black Dog Institute. (2020). *LifeSpan: Integrated Suicide Prevention.* Retrieved from https://www.blackdoginstitute.org.au/education-services/lifespan-integrated-suicide-prevention/" \l ":~:text=Lifespan%20is%20a%20comprehensive%20systems,multiple%20sectors%2C%20communities%2C%20organisations

[21] WA Primary Health Alliance. (n.d.). *The Alliance Against Depression: An integrated, community-based approach to tackling depression and suicide.* Retrieved from https://www.wapha.org.au/wp-content/uploads/2019/06/AAD-Easy-Guide-Brochure.pdf

Strait Islander communities adopted an approach guided by the principles set out through the Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (ATSISPEP).[22]

Across the 12 Trial locations, PHNs have commissioned and overseen the implementation of a wide range of evidence-based and novel initiatives. These included delivering new services for individuals such as aftercare services for those attempting suicide, supporting community capacity building activities, and initiatives aimed at increasing integration and coordination among existing suicide prevention services and providers.

Place-based Suicide Prevention Trials

The Place-Based Suicide Prevention Trials (PBSPT) are a key initiative within the *Victorian Suicide Prevention Framework 2016-2025*. The Victorian Budget 2016-17 provided $27 million over four years to support two flagship initiatives: place-based suicide prevention trials and assertive outreach trials, with $12 million allocated to the place based trials. PBSPT focus outcomes are to:

- reduce rates of suicide
- reduce suicide attempts
- improve individual and community resilience and wellbeing
- improve systems to prevent suicide in an ongoing way.[23]

This program defines an improved system for preventing suicide as one which has locally tailored partnerships; is inclusive, effective, and adaptive; is coordinated and evidence informed; has capable leadership and stakeholders, and a supportive community.[24]

The Department of Health (DH) provides financial and practical support to Trial sites, encouraging PHNs to develop tailored approaches to suicide prevention aligned with existing networks, investments and activities. To support joint capacity building and coordination across the sites, DH has developed a Community of Practice which brings together all Trial coordinators and DH representatives for collaborative knowledge-sharing.

The specific combination and extent of activities delivered through the trials is locally tailored to each site. However, program documentation indicates activities have been selected and designed from within three broad categories:

- Collective backbone – activities targeting all potential stakeholder groups, aimed towards strengthening the local suicide prevention system through training, resources and other initiatives which make the system more connected and cohesive.
- Capacity building – training, media and other resources tailored to community needs and priorities across a variety of themes, aimed towards building community and stakeholder capacity to understand suicide and effectively implement evidence-informed prevention strategies.
- Resilience promotion – programs and resources targeting priority groups, people with lived experience, young people and schools, and the broader community, aimed towards improving individual and community resilience and protective factors.[25]

LifeSpan Suicide Prevention Trials

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[22] ATSISPEP. (2016). *Solutions that work: what the evidence and our people tell us. Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project Report*. Crawley: University of Western Australia. Retrieved from https://www.atsispep.sis.uwa.edu.au/__data/assets/pdf_file/0006/2947299/ATSISPEP-Report-Final-Web.pdf

[23] Newell, S., Shawyer, F., Redman, A., Johnson, B. & Kennedy, H. (2019). *Place-Based Suicide Prevention Trials: Establishment Phase Evaluation Report*. p.15. Sydney: Sax Institute.

[24] Newell, S. et al., (2019). p.15.

[25] Newell, S. et al., (2019). p.14.

LifeSpan is an integrated framework for suicide prevention combining nine evidence-based strategies. It incorporates activities and interventions delivered through health, education and frontline services, business and the community.[26] Initiatives within each component of the framework are intended to be implemented simultaneously in a localised area, to strengthen and expand available supports and better connect people with these. Components of the model also address whole-of-population level interventions such as means restriction and media reporting, providing an integrated and multi-layered response to suicide.

The LifeSpan trials are being delivered in four locations across NSW between 2017 and 2021. A further trial site has been established in the ACT through a partnership with ACT Health but is proceeding on a different timeframe from the original core trials. The Black Dog Institute received funding from the Paul Ramsay Foundation to deliver the LifeSpan trials in the initial four locations, evaluate the outcomes and disseminate the findings to strengthen the Australian evidence base on effective suicide prevention interventions.

The LifeSpan trials are explicitly seeking to test whether implementation of the model leads to a reduction in the rate of episodes of intentional self-harm within trial sites, compared with the five-year period before trial implementation.[27] A secondary focus outcome is change in the rate of suicide deaths within trial sites, although it is recognised that demonstrating progress on this metric may take longer than the designated trial period. [28]

To maximise capacity for rigorous analysis of trial impacts, the LifeSpan trials have been implemented using a stepped wedge design which involved a new site commencing operation every six months. This is intended to support clearer identification of any differences in outcomes and impacts over the trial period across the trial sites. The four NSW LifeSpan trial sites are based in a mix of state-based Local Health Districts and Commonwealth PHNs in both metropolitan and regional/rural locations

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[26] Black Dog Institute. (2020). *LifeSpan Trials.* Retrieved from https://www.blackdoginstitute.org.au/research-centres/lifespan-trials/

[27] Black Dog Institute. (2020).

[28] Black Dog Institute. (2020).

Appendix C: Current data sources- suicide & mental health

Source	Suicide-relevant data fields	Frequency and Scope	Other Information
ABS: National Health Survey Presents key findings for health statistics including long-term health conditions; mental wellbeing; and health risk factors https://www.abs.gov.au/statistics/health/health-conditions-and-risks/national-health-survey-first-results/latest-release	Prevalence: — Feeling hopeless — Mental illnesses- diagnosed and feelings of depression, anxiety. — Core socio demographic and lifestyle risk and protective factors	1989-90, 1995, 2001, 2004-05, 2007-08, 2011-12, 2014-15, 2017-18, 2021 (survey currently underway) *Most Recent*: 2017-18 - The NHS was conducted from a sample of approximately 21,300 people in 16,400 private dwellings across Australia. Urban and rural areas in all states and territories were included, while Very Remote areas of Australia and discrete Aboriginal and Torres Strait Islander communities were excluded. Non-private dwellings such as hotels, motels, hospitals, nursing homes and short-stay caravan parks were excluded from the survey.	In 2014-15 and 2017-18, a module specifically dedicated to mental and behavioural conditions was included in the NHS to collect information on cognitive, organic and behavioural conditions. In previous NHS cycles, mental and behavioural conditions were collected in a module that included a wide range of long-term health conditions. The number of persons who reported having a mental and behavioural condition in 2014-15 increased from the 2011-12 NHS, potentially due to the greater prominence of mental and behavioural conditions in the new module. Data on mental and behavioural conditions for 2014-15 and 2017-18 are therefore not comparable with data in previous National Health Surveys.
ABS: National Survey of Mental Health and Wellbeing https://www.abs.gov.au/statistics/health/mental-health/national-survey-mental-health-and-wellbeing-summary-results/latest-release	Prevalence — Suicidal behaviour (ideation, plans, attempts) — Multiple mental disorder types — Level of social and emotional support for people with mental disorder	1997 2007 Due to be updated from 2020–21 as part of the Intergenerational Health and Mental Health Study – The National Study of Mental Health and Wellbeing *Most recent: 2007* - The scope of the survey is people aged 16-85 years, who were usual	— Collected information on three major groups of mental disorders: Anxiety disorders; Affective disorders; and Substance Use disorders. — An emphasis on persons with a 12-month mental disorder, that is, persons with a lifetime mental disorder who experienced symptoms in the 12 months prior to the survey interview. — Also collected information on the use of health services and medication for mental health problems, physical conditions,

Source	Suicide-relevant data fields	Frequency and Scope	Other Information
	— Perceived need for help (for people who did access mental health services and who did not) — Core socio demographic and lifestyle risk and protective factors	residents of private dwellings in Australia, excluding very remote areas. There were 8,841 fully responding households (60% response rate)	functioning and disability, social networks and caregiving, and a range of demographic and socio-economic characteristics.
Department of Health: The National Survey of People Living with Psychotic Illness Aim of survey was to provide updated information on the lives of people with psychotic illness who receive public specialised mental health services. Department of Health | Executive summary and key findings	Prevalence — Suicide ideation and attempts — Core socio demographic and lifestyle risk and protective factors	1997-98 (first National Study of Psychotic Illness) 2010 *Most recent:* 2010 - Public specialised mental health services and NGOs providing mental health services in seven catchment sites, participated in the survey. Together these sites cover 10% of the Australian population. The sample for the survey was drawn from people receiving these services over the period from April 2009 to March 2010. The survey methodology was based on a two-phase design: 1. All people seen by these services in the catchment sites over the period of the survey were screened, with 7,955 assessed as having psychosis and eligible for interview.	The 2010 survey had four key aims to: 1. Estimate the prevalence of psychosis and age when symptoms were first experienced 2. Describe the profile of people with psychotic illness, including their personal, social and living circumstances, and mental and physical health 3. Determine the use of health and other services and 4. Assess the impact of psychotic illnesses on the lives of people with these disorders and identify factors related to better outcomes. The main focus of the 2010 survey was on consumers of public specialised mental health services administered by state/ territory governments. It also included a sample of people who were only in contact with non-government organisations. It did not cover people with psychotic illness who were being treated only in the private sector or by their general practitioner.

Source	Suicide-relevant data fields	Frequency and Scope	Other Information
		2. A random sample (1,825) of these people was interviewed over the period from April 2010 to March 2011.	
The Australian Child and Adolescent Survey of Mental Health and Wellbeing (also referred to as the 'Young Minds Matter' survey) Funded by the Australian Government Department of Health and conducted by the Telethon Kids Institute at The University of Western Australia in partnership with Roy Morgan Research. Survey results | Young Minds Matter (telethonkids.org.au)	— Adolescent reported self-harm and suicidal behaviours (ideation, plans, attempts) — Prevalence of a range of mental disorders in the student population — Severity of impact on functioning — Psychological distress — Behavioural problems — Service use — Core socio-demographic and lifestyle risk and protective factors	The survey was conducted in 2013-14 with over 6,000 families participating from across Australia, with children and adolescents aged 4-17 years. Comparisons made to 1998 National Survey of Mental Health and Wellbeing – assume no other survey completed	The Diagnostic Interview Schedule for Children Version IV (DISC-IV) was used to determine whether children had mental disorders in the previous 12 months, including: — Anxiety disorders (Social phobia, Separation anxiety disorder, Generalised anxiety disorder, and Obsessive-compulsive disorder) — Major depressive disorder — Attention-Deficit/Hyperactivity Disorder (ADHD) — Conduct disorder. The survey also assessed oppositional problem behaviours Key questions that were addressed in the analysis included associations between mental health problems and academic achievement, connectedness or engagement.
Black Dog Institute: Suicide Prevention Intelligence System Suicide Prevention Intelligence System - Black Dog Institute	Suicide deaths and attempts by location	The System is currently being deployed as part of Black Dog Institute's LifeSpan trials.	In collaboration with the Australian National University and SAS, Black Dog has developed the Suicide Prevention Intelligence System to gain insights and help local communities develop more targeted and evidence-based suicide prevention initiatives.

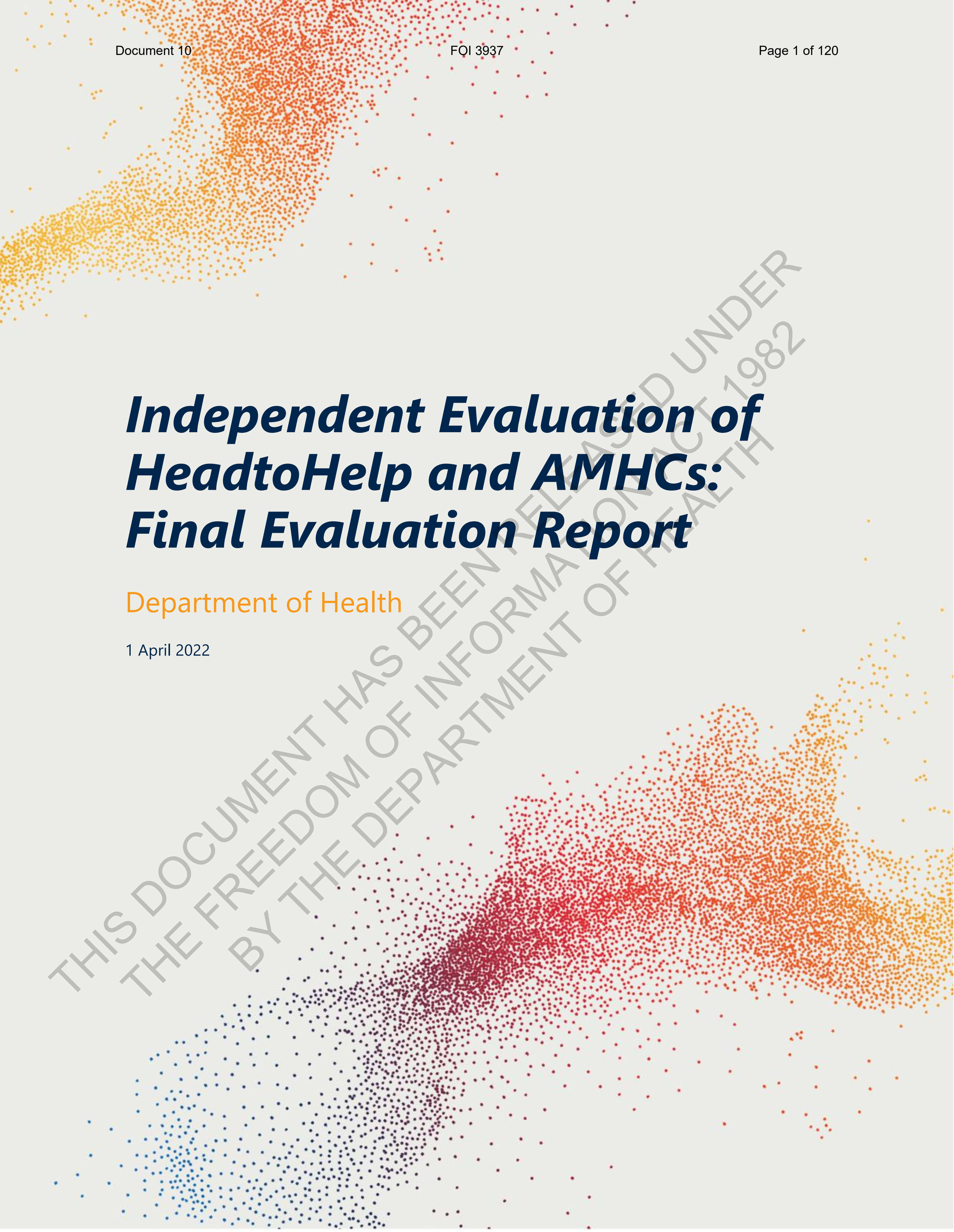
Source	Suicide-relevant data fields	Frequency and Scope	Other Information
ABS: Suicide mortality rate (Causes of Death) Suicide mortality rate - Datasets - data.gov.au	— National suicide mortality rate — Intentional self-harm (suicide) (by method)	Updated annually. The Suicide mortality rate is calculated and reported under the Sustainable Development Goals. Underlying dataset, Causes of Death data, provides detailed data regarding suicide deaths and methods by State.	
AIHW: Serving and ex-serving Australian Defence Force members who have served since 1985: suicide monitoring 2001 to 2019 Serving and ex-serving Australian Defence Force members who have served since 1985: suicide monitoring 2001 to 2019, About - Australian Institute of Health and Welfare (aihw.gov.au)	— Demographic details — Suicide counts	Include the population of ADF members who served in the ADF between 1985 and 2019.	Draws data from a number of sources, including: — National Mortality Database — National Death Index — Department of Defence Payroll personnel system data — Defence Suicide Database
Turning Point: National Ambulance Surveillance System (NASS) Suicide and mental health (turningpoint.org.au)	— Suicidal ideation, suicide attempt and non-suicidal injury	Utilises coded ambulance call-out data. This is a current research project and frequency of updating is unknown.	Project funded by the AIHW.

KPMG

Contact us

Trixie Makay
Partner
+61 2 6248 1224
tmakay@kpmg.com.au

kpmg.com.au



Independent Evaluation of HeadtoHelp and AMHCs: Final Evaluation Report

Department of Health

1 April 2022

nous

Disclaimer:

*Nous Group (**Nous**) has prepared this report for the benefit of The Australian Department of Health (the **Client**).*

The report should not be used or relied upon for any purpose other than as an expression of the conclusions and recommendations of Nous to the Participant as to the matters within the scope of the report. Nous and its officers and employees expressly disclaim any liability to any person other than the Participant who relies or purports to rely on the report for any other purpose.

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Contents

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

Acronym or abbreviation	Definition
NGO	Non-government organisation
NQPHN	Northern Queensland Primary Health Network
NTPHN	Northern Territory Primary Health Network
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.

BACKGROUND AND CONTEXT

The COVID-19 pandemic and related restrictions have **HEAVILY IMPACTED** **MENTAL HEALTH** and **WELLBEING**.[1]

The prolonged Victorian lockdown in response to the COVID-19 pandemic brought **substantial hardship** and a significant increase in demand for **MENTAL HEALTH SERVICES.**

In August 2020, the Australian Government responded by announcing funding of **$26.9 MIL** for **15 *HEADTOHELP*** hubs in Victoria to operate until September 2021.

Prior to the COVID-19 pandemic (in the May 2019 budget), the Australian Government announced it would invest **$114.5 MIL** **OVER FIVE YEARS** to trial **eight AMHCs** – one in each state and territory.

Further funding has now been announced for an additional **EIGHT** **Head to Health AMHCs** and 24 satellites.

DURING THE COURSE OF THIS EVALUATION, the federal government announced a **FURTHER INVESTMENT** of **$17.7 MIL** in additional mental health measures to support people in lockdown. In Victoria, the federal government has extended the current *HeadtoHelp* clinics to 30 June 2022. In New South Wales the network is being replicated with ten pop-up Head to Health clinics established, with a particular focus on west and south-west Sydney and three throughout the rest of the state. A pop-up clinic has also been established in ACT.

While there are **several similarities between the *HeadtoHelp* and AMHC models** it is envisioned that AMHCs, with a relatively larger funding allocation, will have greater in-house capacity to deliver services that are limited in the current delivery of ***HeadtoHelp***.

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.

HEADTOHELP FINDINGS

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.

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.

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?

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.

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[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.’

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.

AMHC FINDINGS

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

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.

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

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

Need for *HeadtoHelp* and AMHCs is evidenced by an increase in the demand for mental health services over the last ten years and in response to the COVID-19 pandemic, particularly in Victoria. There is insufficient supply of services that cater to low and medium intensity needs, and the complex and fragmented nature of the service system means consumers are unable to access the service/s they require. This results in consumers not receiving the care they require and/or presenting to Eds and specialised services.

there is a clear ‘front door’ to the mental health service system with an intake process that is welcoming and person-centred, but also clinical and standardised, followed by early and warm connection to appropriate services that meet whole-of-person needs, including provision of free clinical and psychosocial services for people with mild to moderate needs or those in acute mental health crisis…

…consumers will be able to better navigate to and through their local mental health service system, access and receive appropriate support in a timely manner, and develop greater capacity and feel empowered to manage their feelings of distress…

…clear care pathways will exist across service settings, to provide appropriate services for whole-of-person needs, resulting in improved alignment of service availability and mental health needs for low- and medium-intensity supports.

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

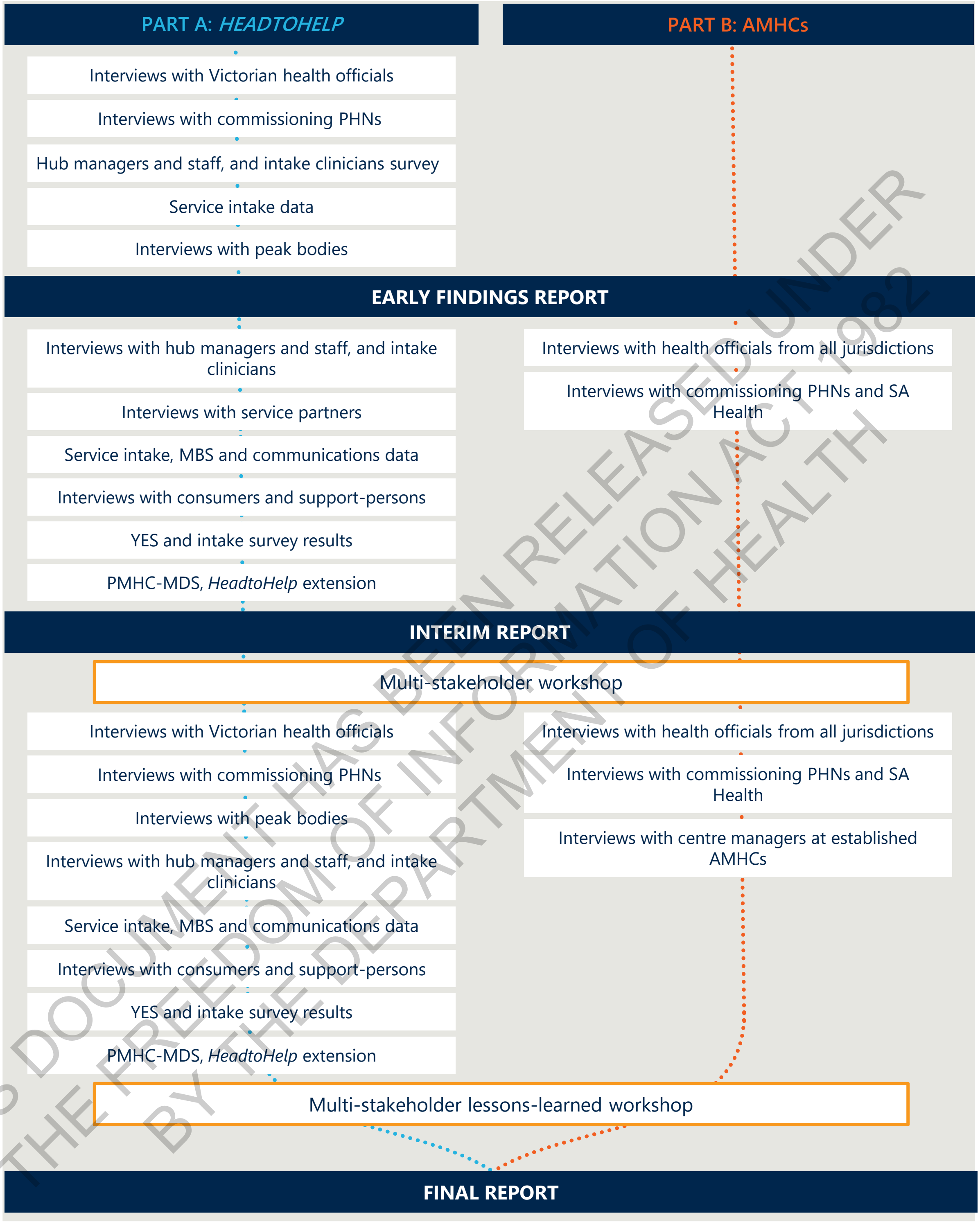

Table 2 | Overview of data sources

	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* extension	Understand participant demographics, presenting need and 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.

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.

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

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.

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

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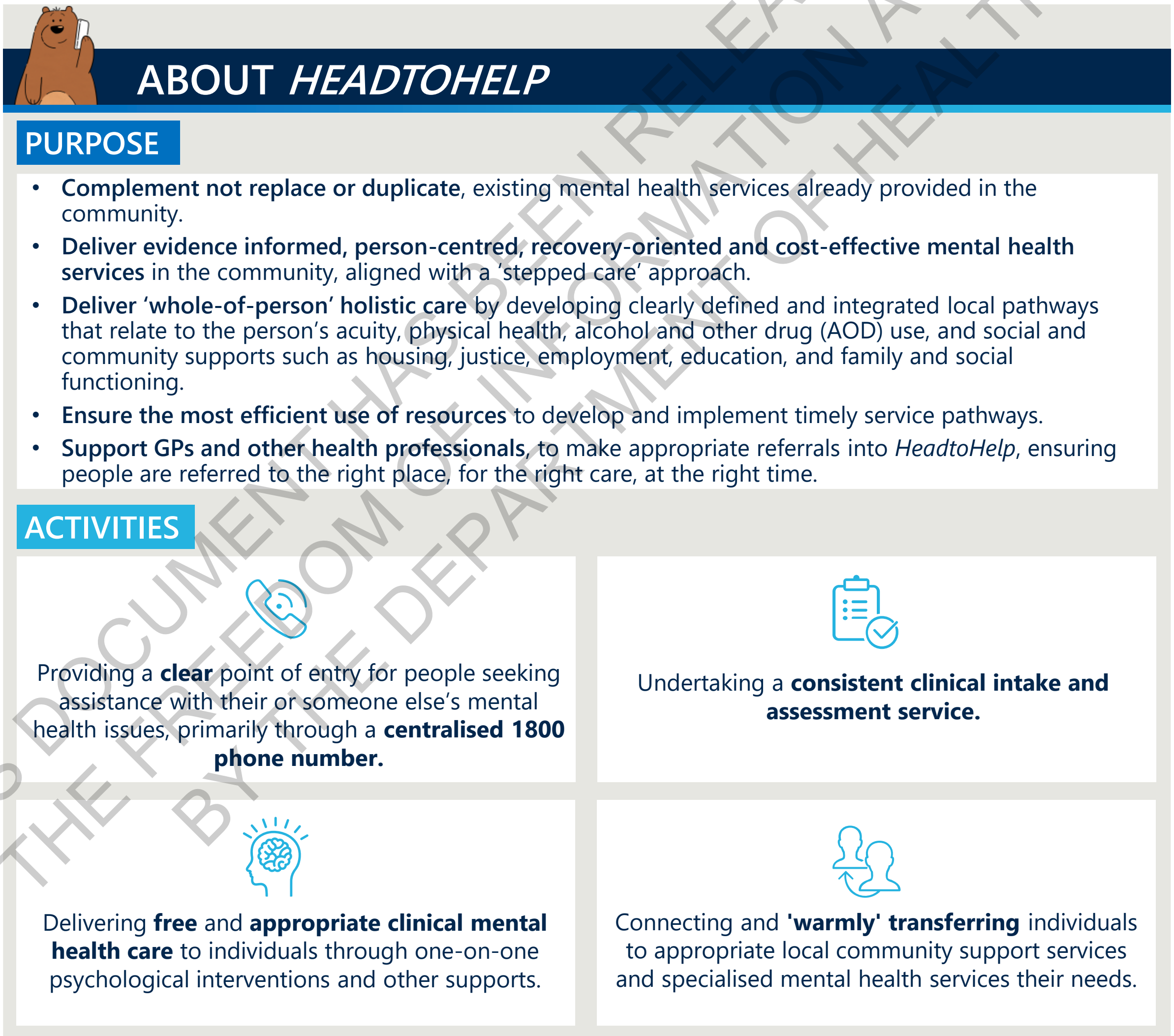
[2] IAR DST-level of care was not considered because participants in GPHN did not have their IAR DST-level of care data in the PMHC-MDS.

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*



ABOUT *HEADTOHELP*

PURPOSE

- **Complement not replace or duplicate**, existing mental health services already provided in the community.
- **Deliver evidence informed, person-centred, recovery-oriented and cost-effective mental health services** in the community, aligned with a 'stepped care' approach.
- **Deliver 'whole-of-person' holistic care** by developing clearly defined and integrated local pathways that relate to the person's acuity, physical health, alcohol and other drug (AOD) use, and social and community supports such as housing, justice, employment, education, and family and social functioning.
- **Ensure the most efficient use of resources** to develop and implement timely service pathways.
- **Support GPs and other health professionals**, to make appropriate referrals into *HeadtoHelp*, ensuring people are referred to the right place, for the right care, at the right time.

ACTIVITIES

Providing a **clear** point of entry for people seeking assistance with their or someone else's mental health issues, primarily through a **centralised 1800 phone number.**

Undertaking a **consistent clinical intake and assessment service.**

Delivering **free** and **appropriate clinical mental health care** to individuals through one-on-one psychological interventions and other supports.

Connecting and **'warmly' transferring** individuals to appropriate local community support services and specialised mental health services their needs.

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[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.

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.

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[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?

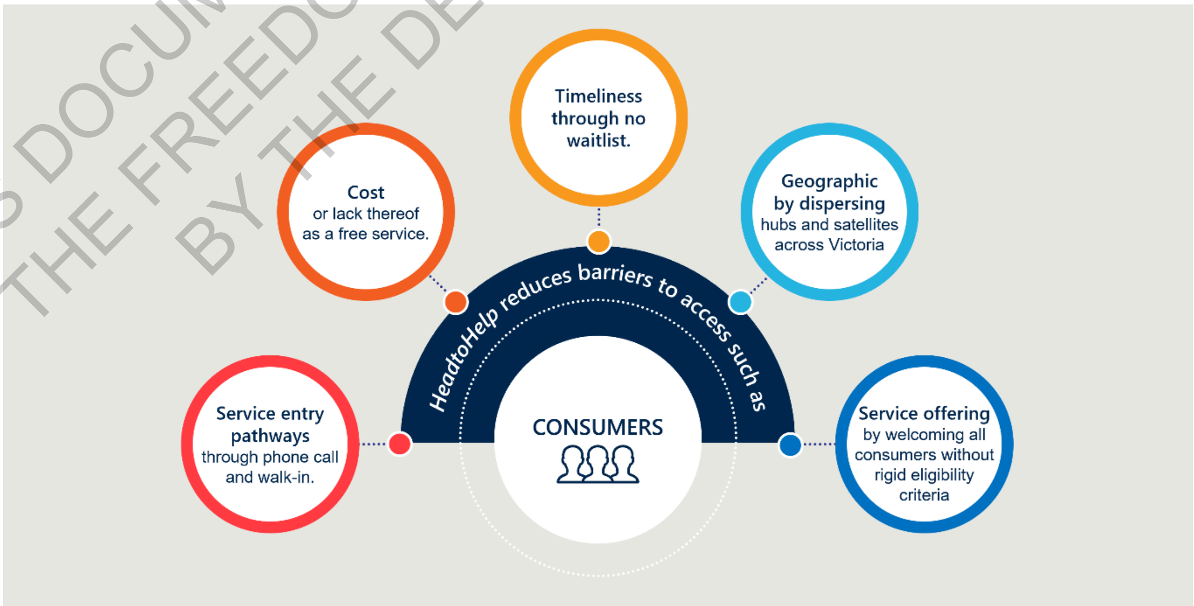
Key findings: *HeadtoHelp* was appropriately designed to increase access to and support navigation of mental health services during a time of heightened need. Specific design features, such as mechanisms to remove barriers to access, use of the IAR-DST and role of multi-disciplinary teams were key to 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*

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[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.

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[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.

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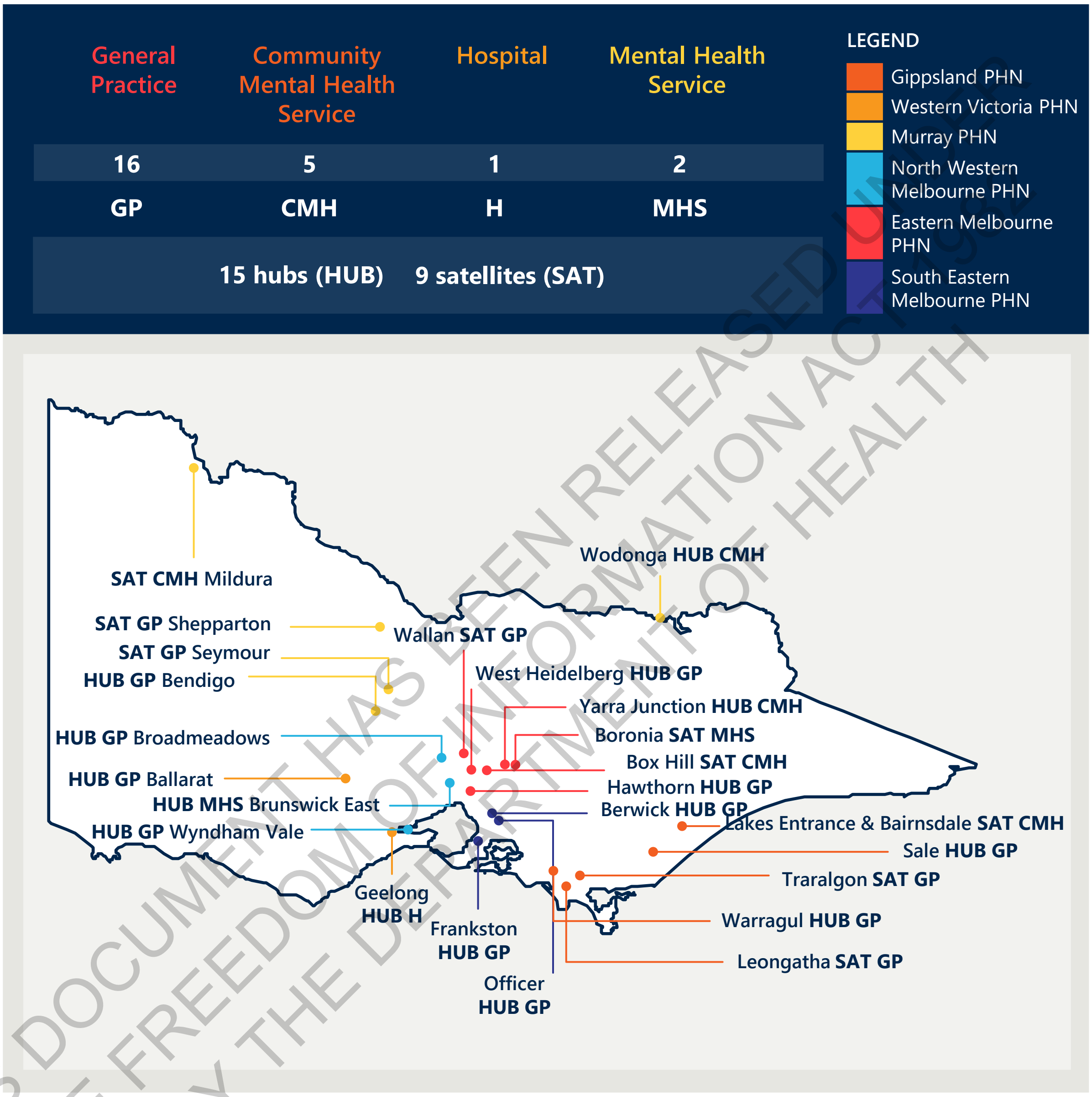
[14] Royal Commission into Victoria's Mental Health System. Final Report. February 2021. Page 43.; Productivity Commission. Mental Health Inquiry Report Volume 1. June 2020. Page 74.

[15] Premier of Victoria. Giving Victorians Mental Health Support Close to Home. March 2021.

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.

Figure 7 | Map of *HeadtoHelp* hubs and satellites



General Practice	Community Mental Health Service	Hospital	Mental Health Service
16	5	1	2
GP	CMH	H	MHS

15 hubs (HUB) 9 satellites (SAT)

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.

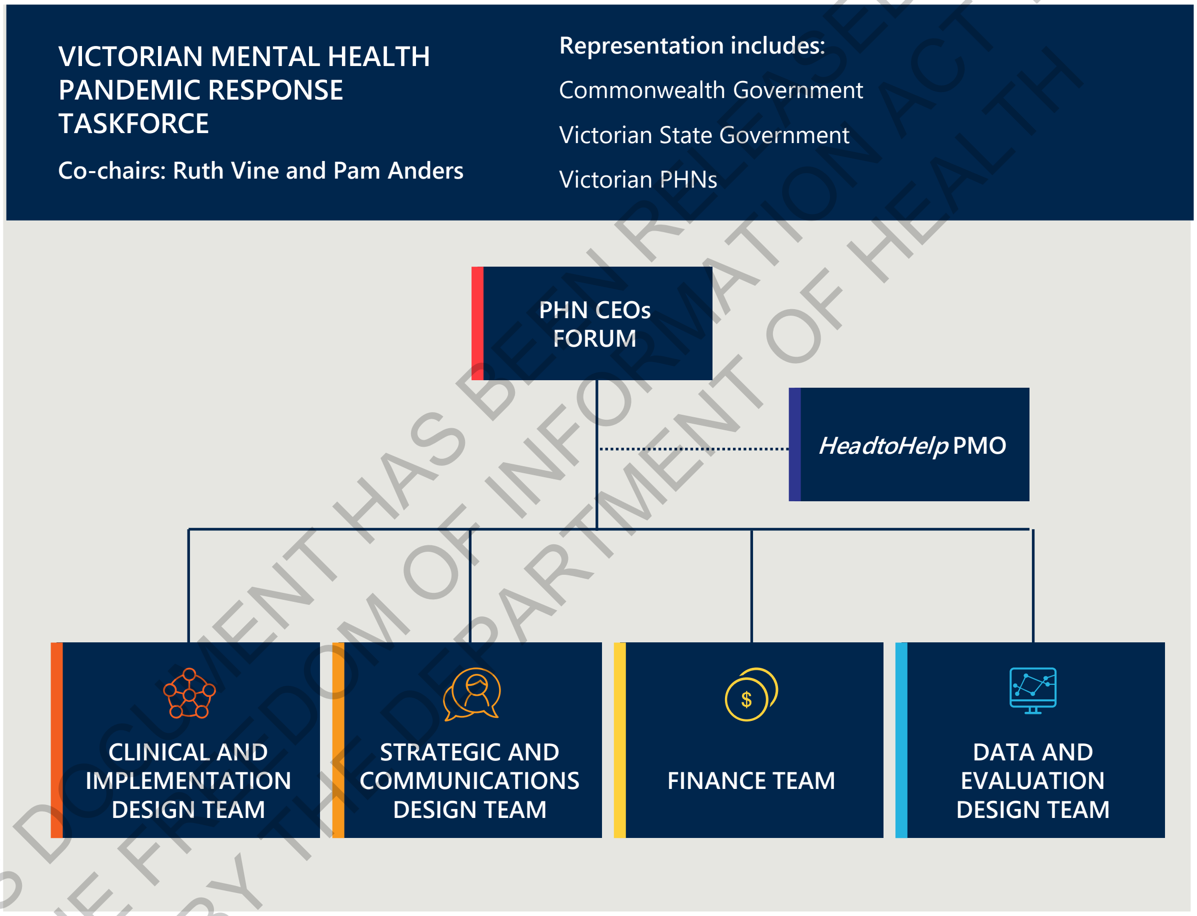
3.2.2 Governance and collaboration

***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. 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

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

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.

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

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

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

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[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.

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.

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[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.

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

4.1.1 Volume of service use

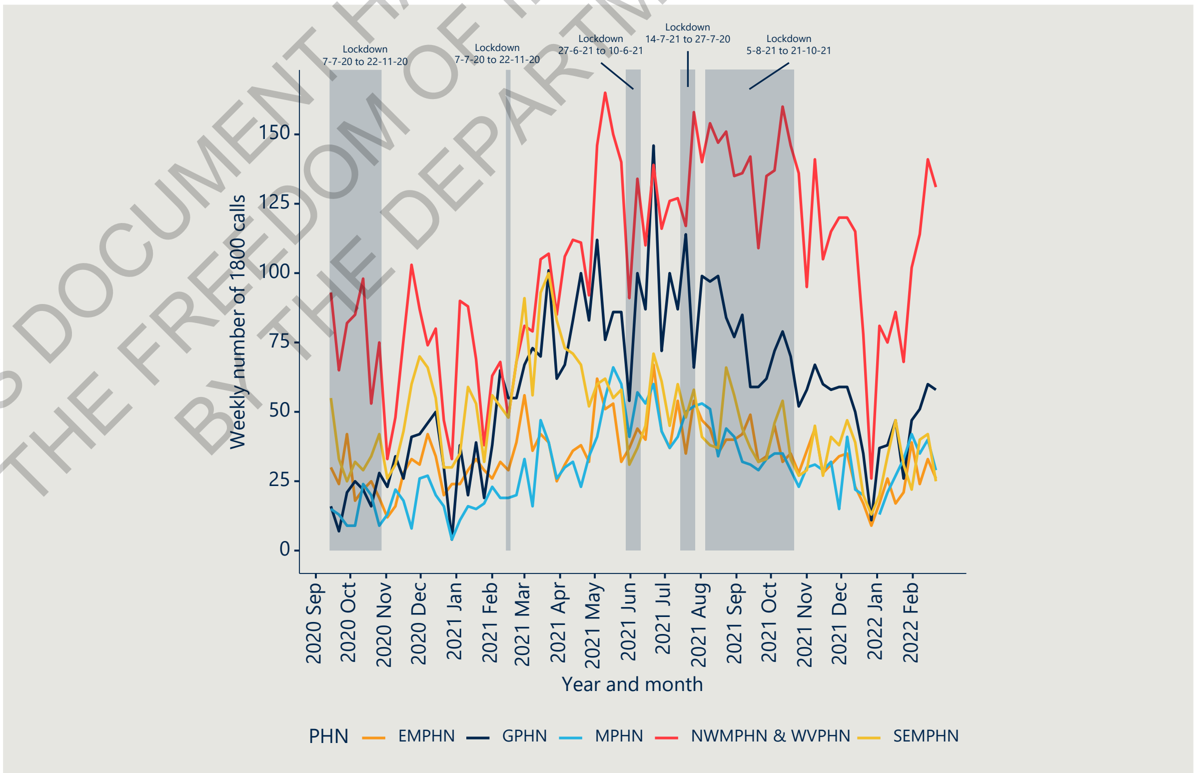
Since program inception, over 20,600 people have called the 1800 number

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

Aft



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

Source: Intake data, September 14 2020 to February 28 2022.
[1] 276 No IARs are included and are currently under investigation.

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 returning for additional episodes of care

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[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.

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

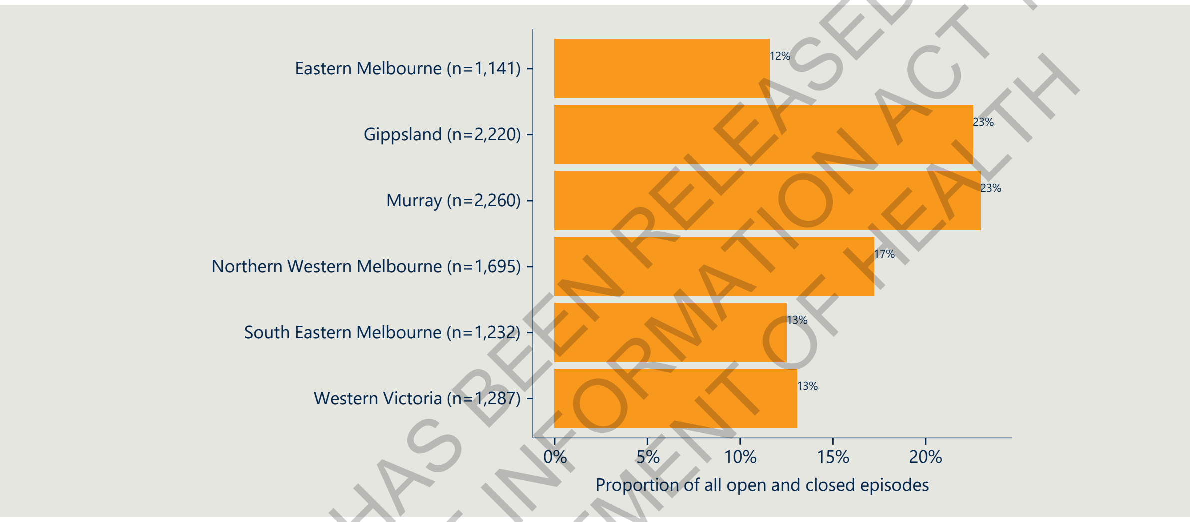
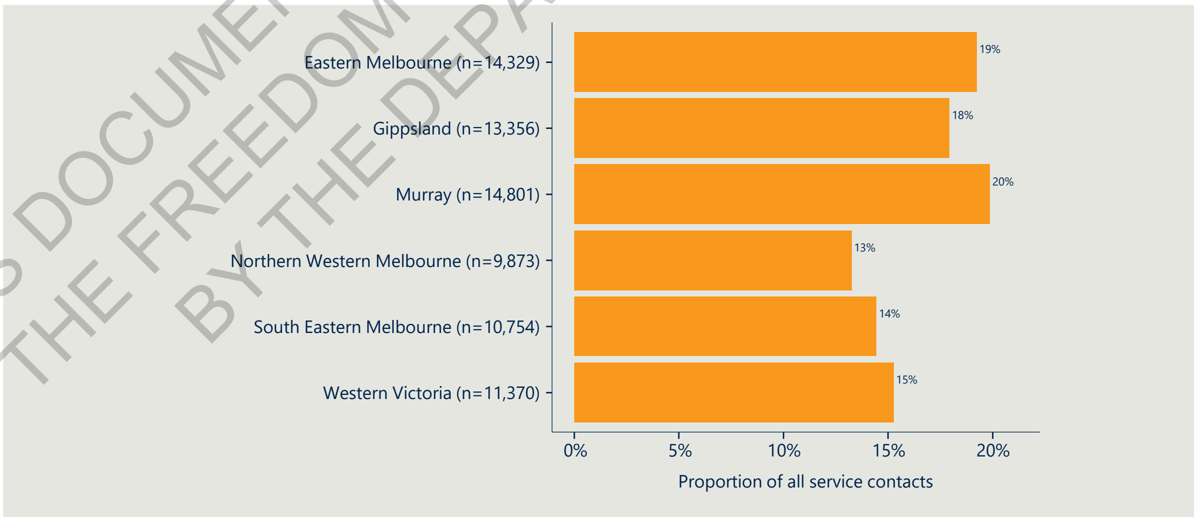


Figure 13 | Service contacts by PHN for open and closed episodes



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

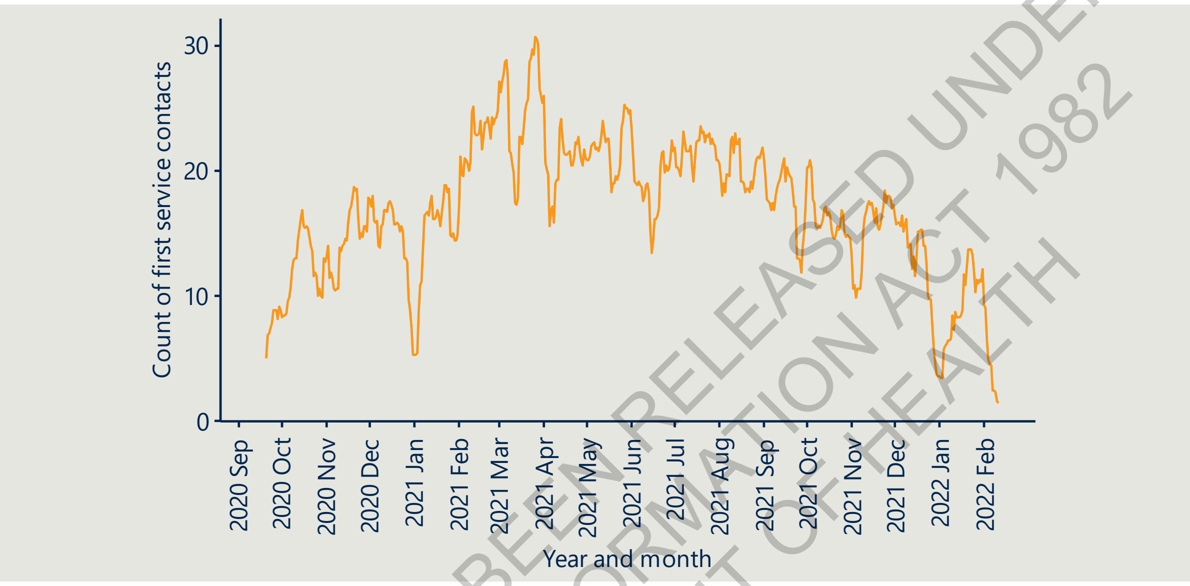
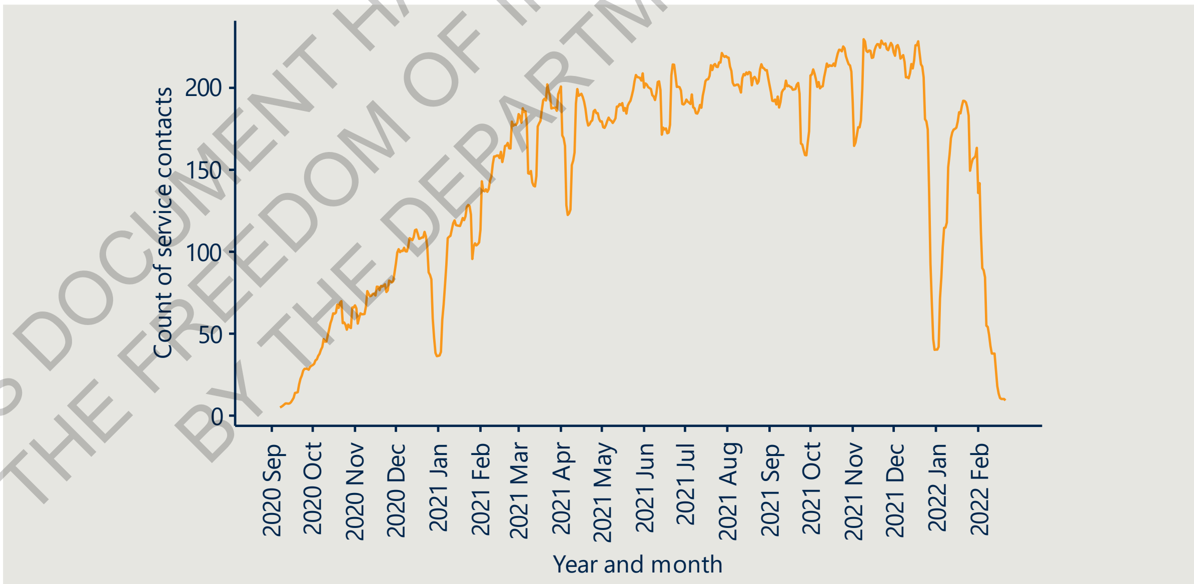


Figure 15 | Service contacts by date for closed and open episodes



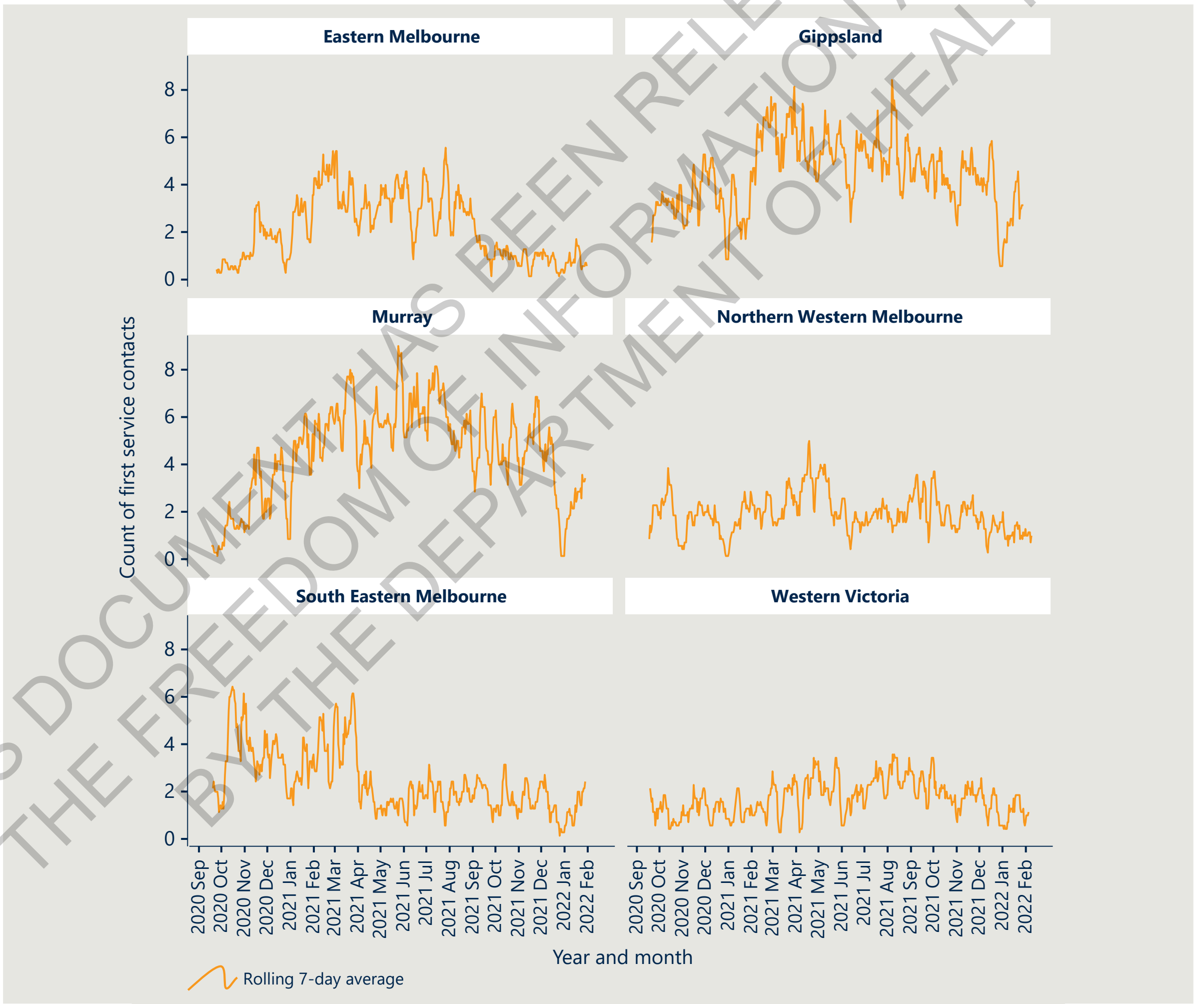
In contrast, when comparing the number of first service contacts with the total number of service contacts (Figure 15), there is no observed peak in the total number of service contacts. In fact, service contacts continue to increase slightly from April 2021 before peaking around November and December 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.

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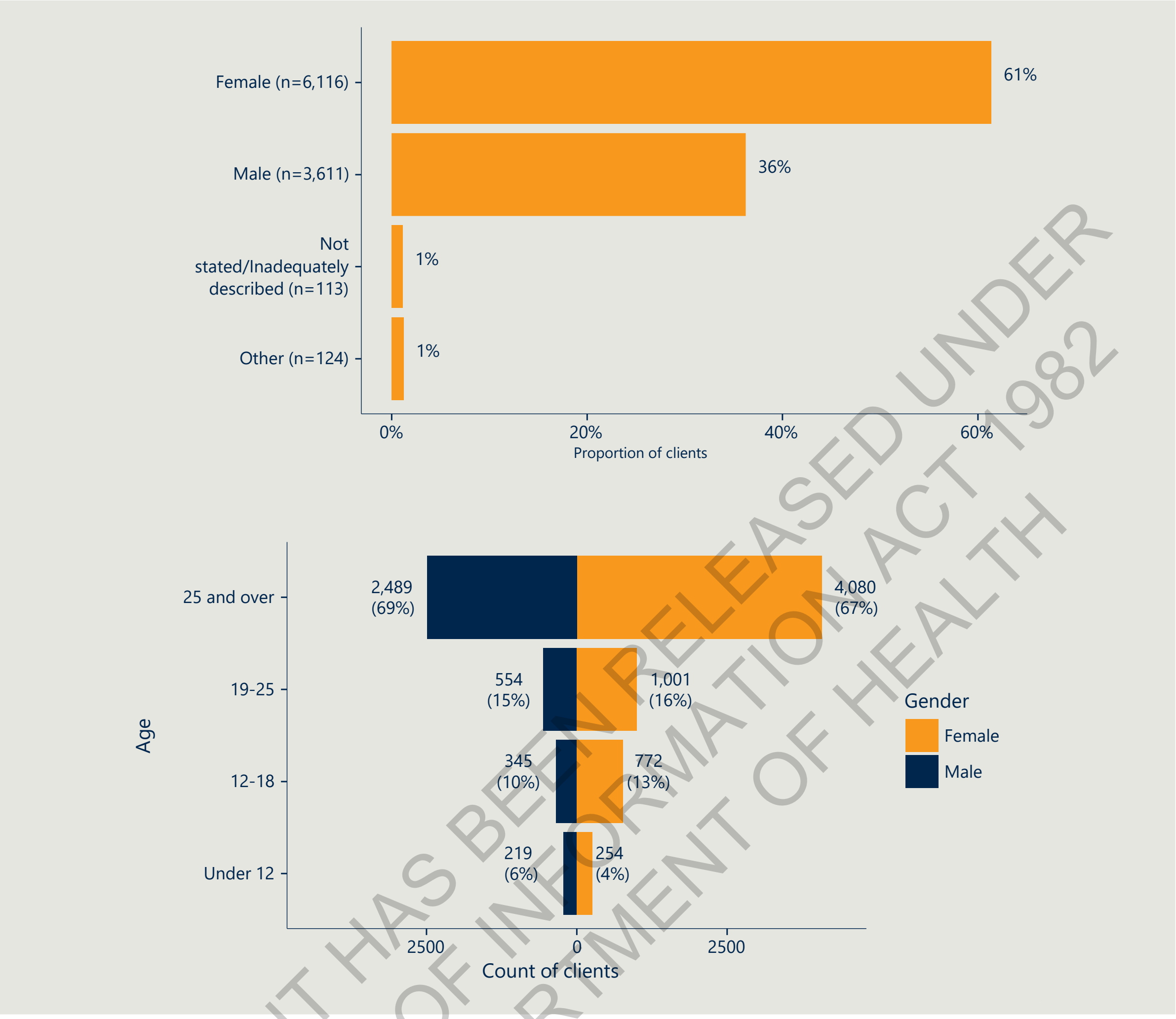
[24] World Health Organization. Mental health and substance use. https://www.who.int/teams/mental-health-and-substance-use/gender-and-women-s-mental-health

[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

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[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.

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]

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.

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[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.

[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.

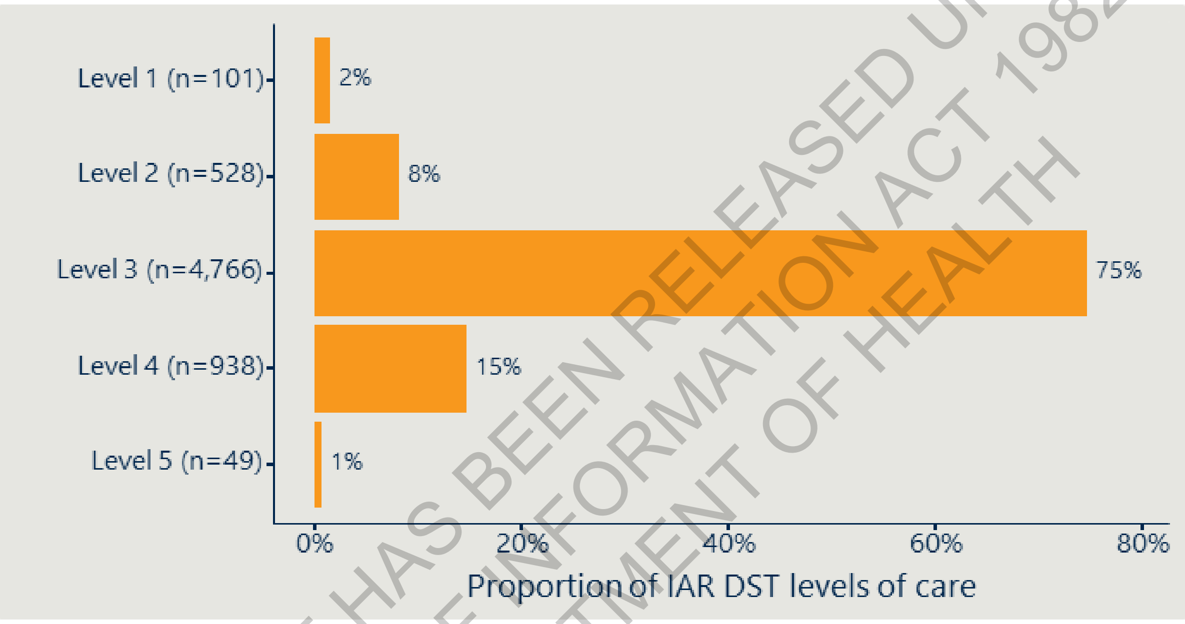
[31] Australian Institute of Health and Welfare. Indigenous health and wellbeing. https://www.aihw.gov.au/reports/australias-health/indigenous-health-and-wellbeing

[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.

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).

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

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[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

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 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.

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[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

[37] National Institute for Health and Care Excellence. Common mental health problems: identification and pathways to care. May 2011.

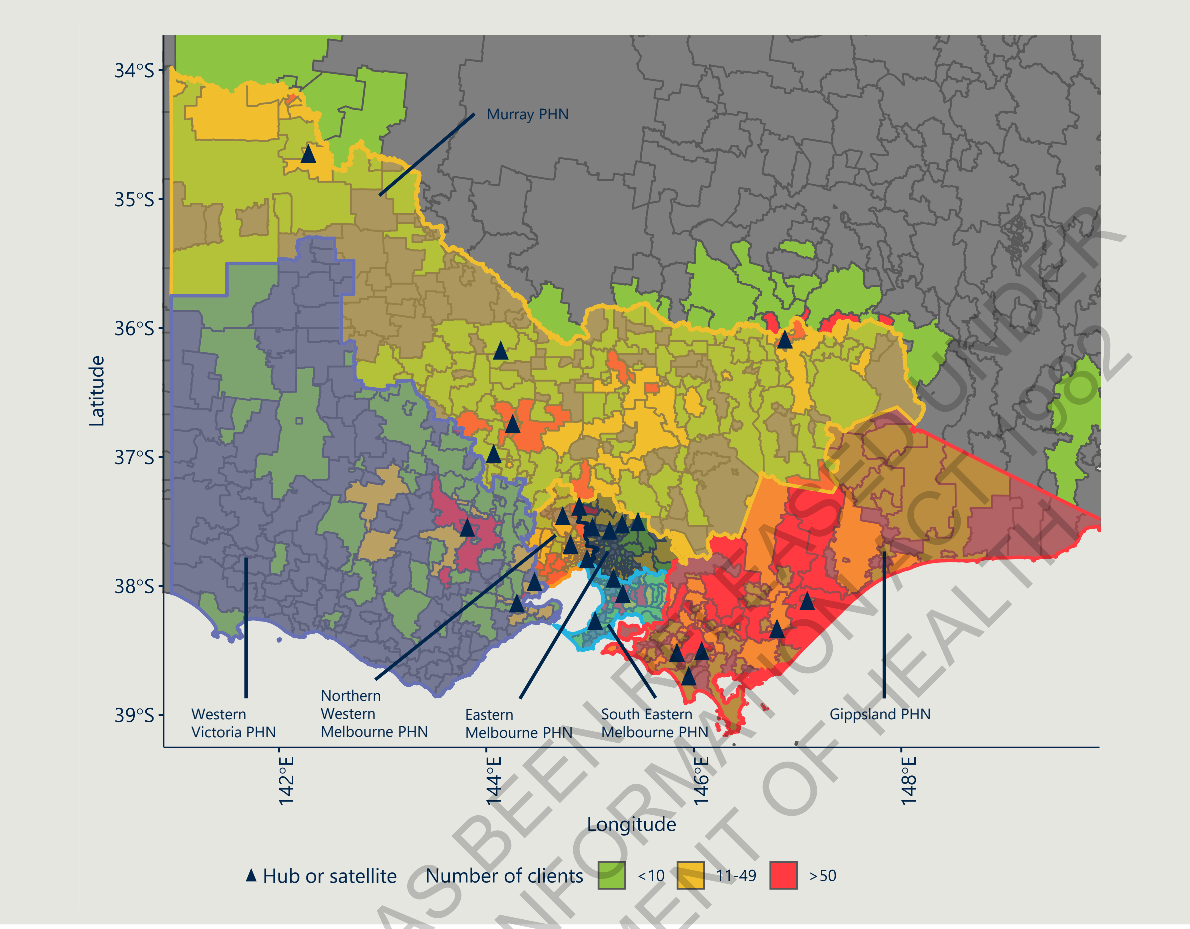
[38] It should be noted that an average of 42 per cent of participant's prescription history in each of the medication subgroups antidepressants, antipsychotics, anxiolytics, hypnotics and psychostimulants as prescribed in the PMHC-MDS was not known.

[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.

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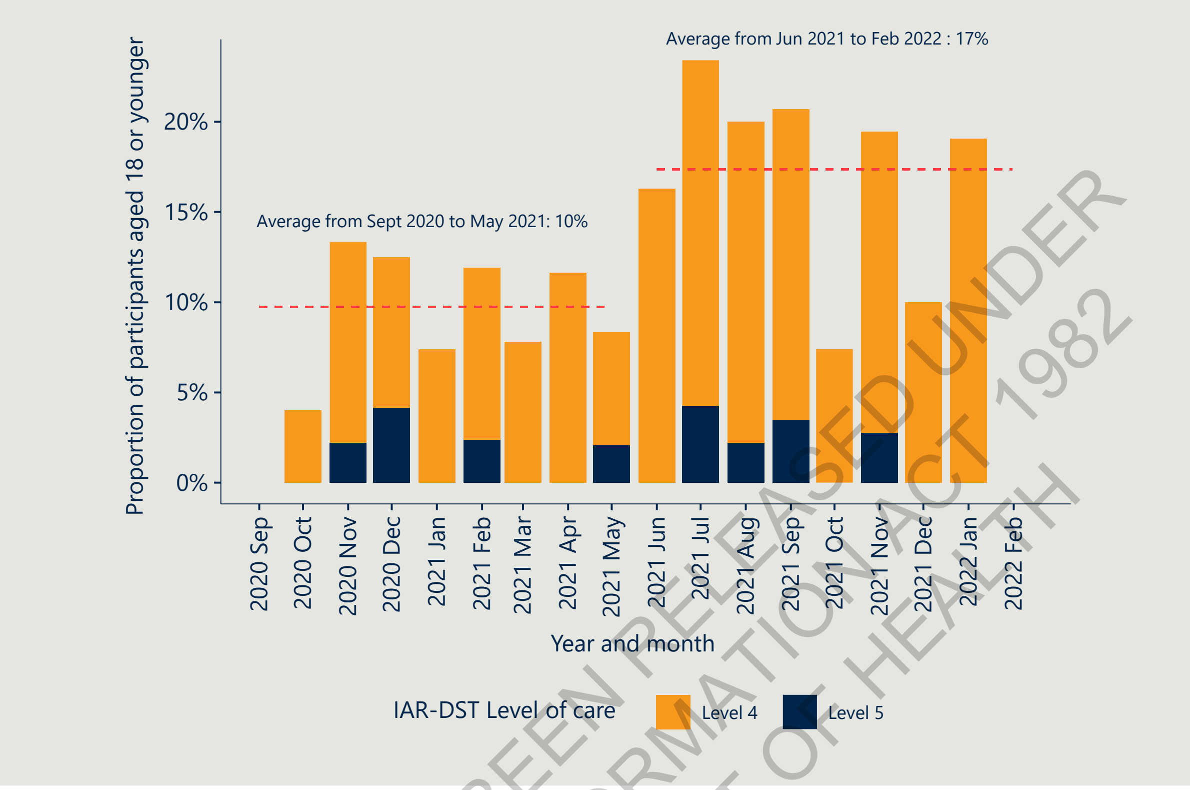
[42] By way of comparison, 23 per cent of the Australian population is aged 18 and under (ABS, Population by age and sex – national, as at 30 June 2021). While on face value, this would appear that younger people are under-represented, given the existence of specialist child and youth services, in particular 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.

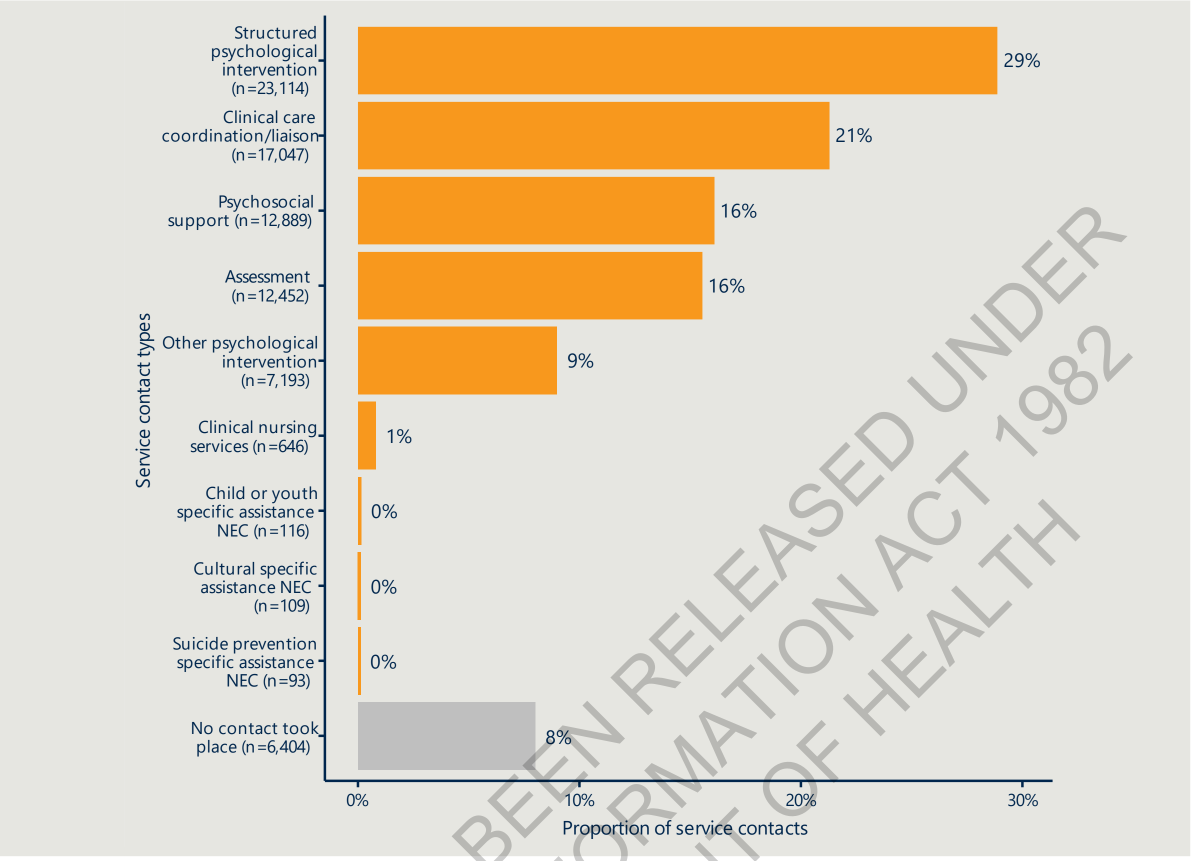
Eleven per cent of people reported that COVID-19 did not play a part in why they contacted *HeadtoHelp* for mental health assistance.

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.

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

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.

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[44,45,46]. 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.

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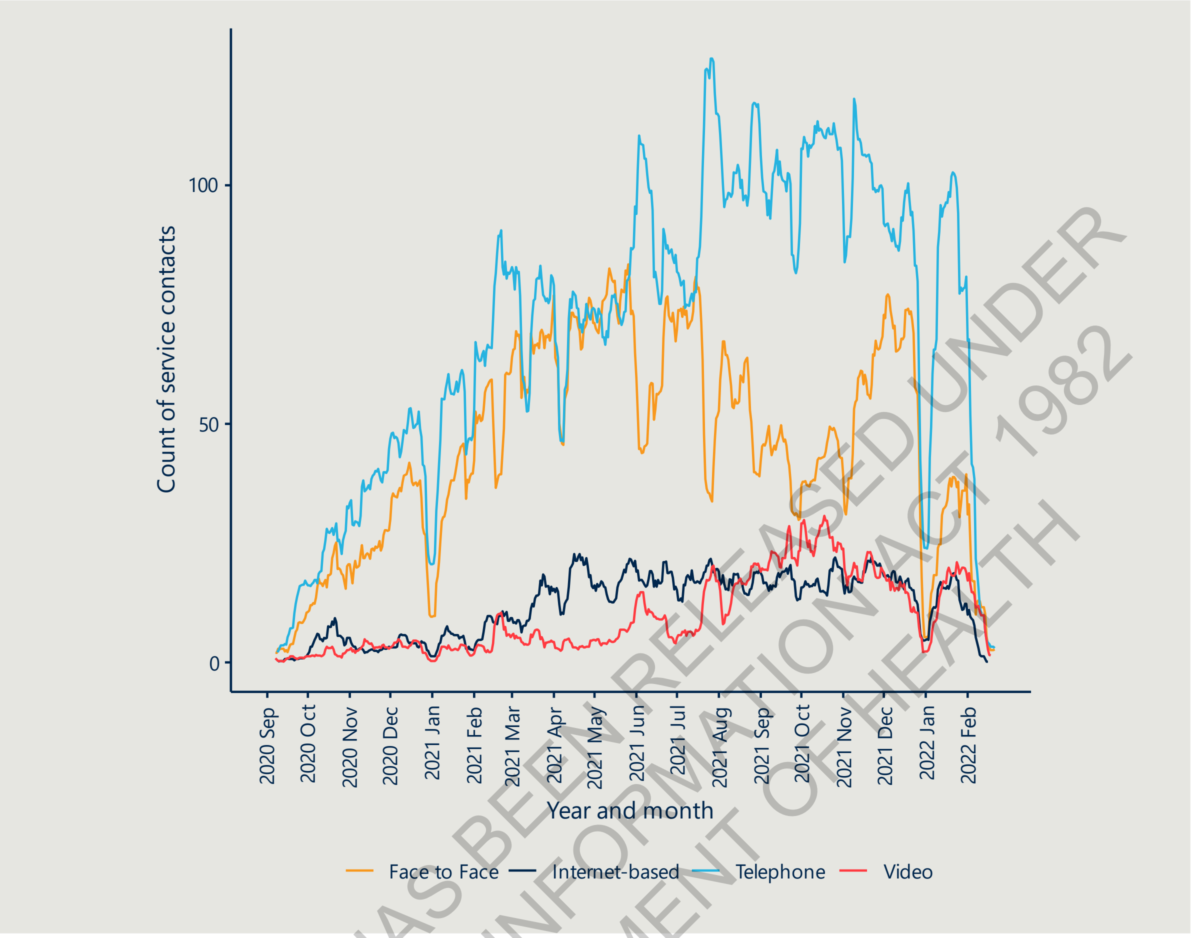
[44] Amos A. J. et al. Remote mental health clients prefer face-to-face consultations to telehealth during and after the Covid-19 pandemic. September 2021.

[45] Predmore Z. S. et al. Assessment of Patient Preferences for Telehealth in Pos-Covid-19 Pandemic Health Care. December 2021.

[46] headspace. Young people's experience of telehealth during Covid-19. July 2020.

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[47] 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.

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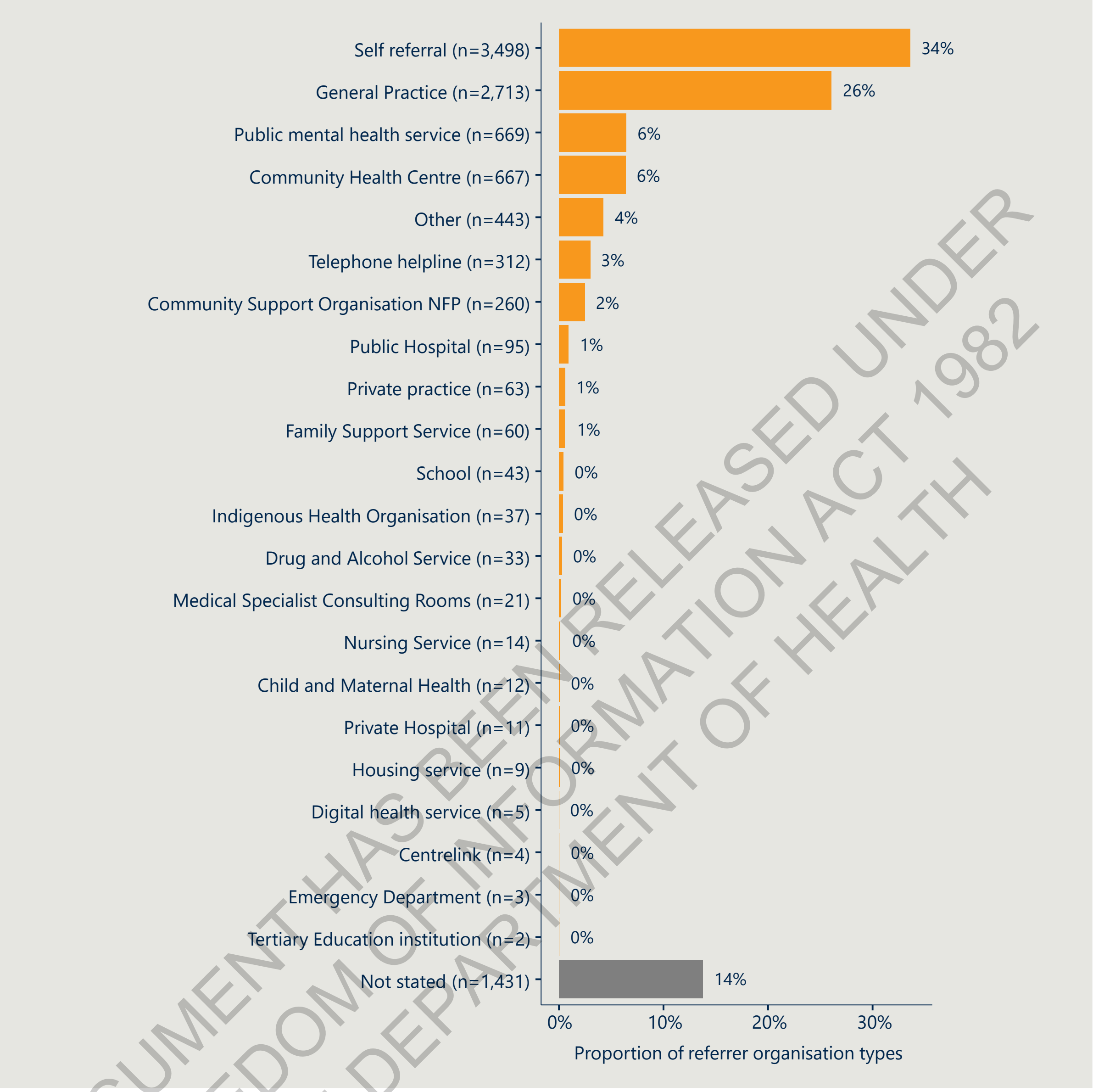
[47] Note that the total number of identified referral pathways (n=4,131) does not equal to the distinct number of participants (n=5,013). See Appendix E for more details on how these were derived.

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[48] have higher proportions of 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).[49]
- 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 [50] to comprehensive assessment[51] 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.

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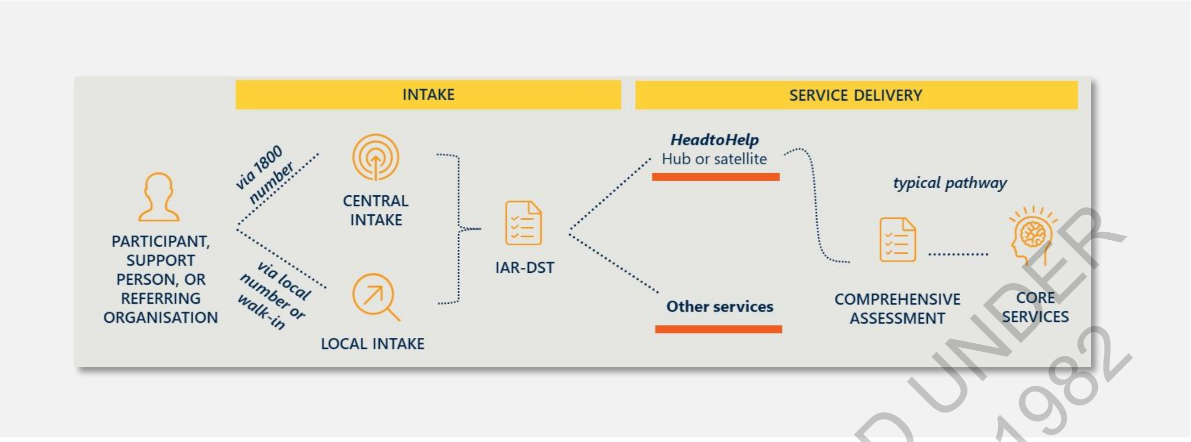
[48] Unless otherwise specified, this includes referrer organisations classed as 'community health centre' and 'community support organisation not for profit.'

[49] 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.

[50] Intake referral is when a participant has completed intake and, typically, also completed the IAR and has been referred to *HeadtoHelp* services.

[51] 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.[52]

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.

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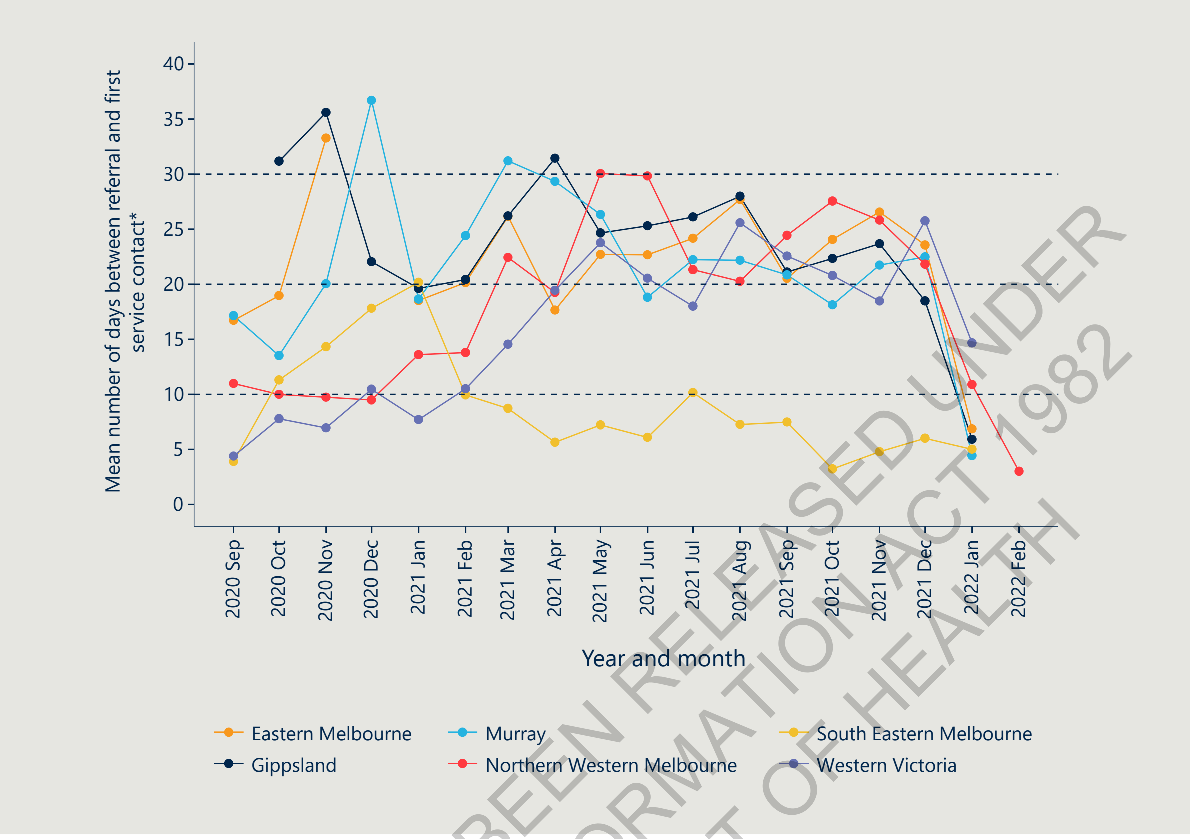
[52] Cook, H. Psychologists stretched to limit as virus drives spike in referrals. Published 28 October 2020.

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[53] 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).

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

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

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

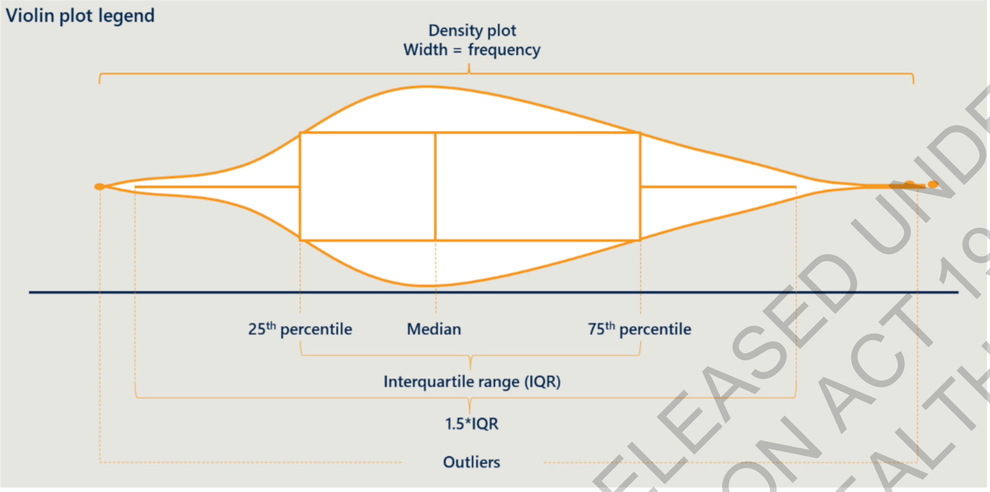
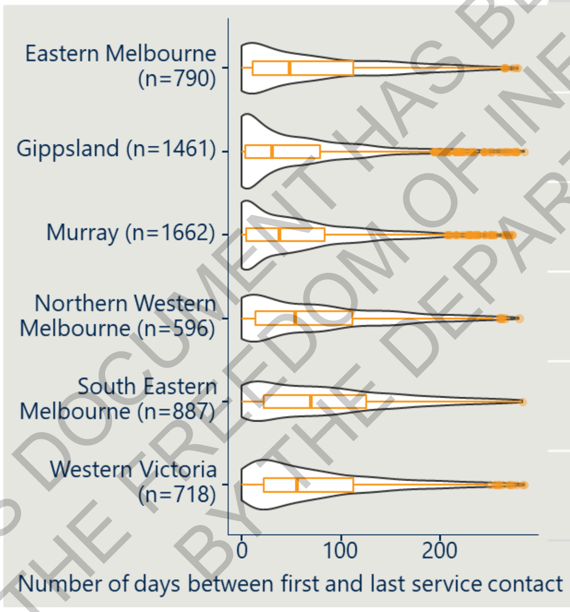
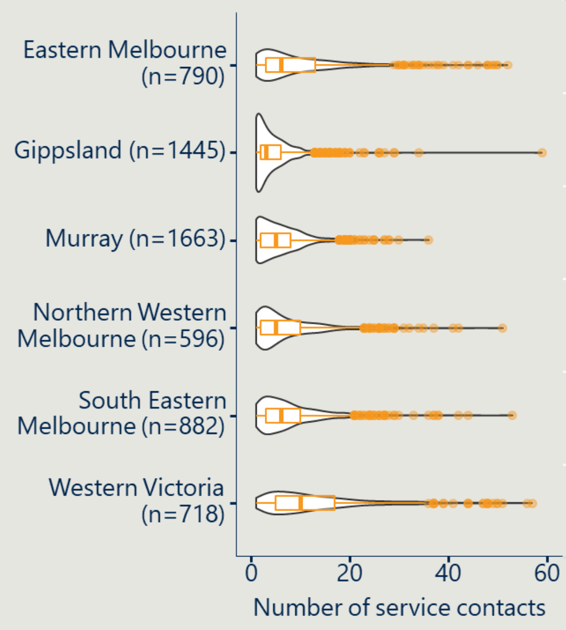


Figure 28 | Length of episodes by PHN for closed episodes of care



	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[54]



	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[55], 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 reporting just

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[54] 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.

[55] A total of 19 people reported being referred to other services, of which eight were given warm referrals.

over five per cent[56]. 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 provided in all aspects of treatment, well-funded and well-staffed services will have greater propensity to provide options.

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[56] 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.

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 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*

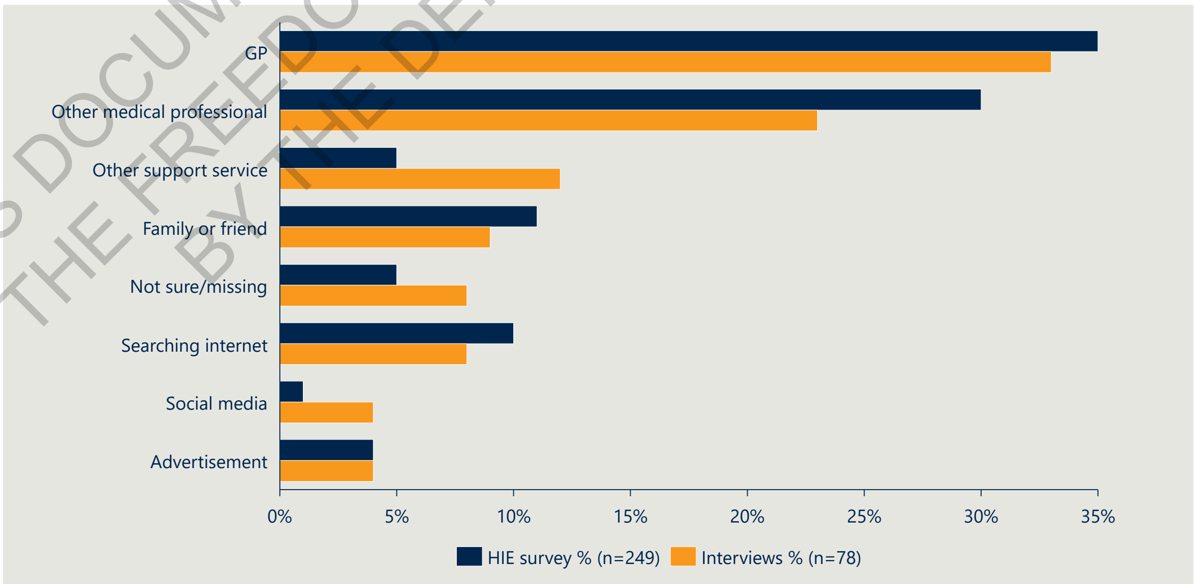
> "I was just sort of surprised to learn that that kind of service existed and that I wasn't at all aware of it… If I had of known… we could have perhaps done it, you know, before we got to as bad a position that we were in." – *Support person*

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.

> "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*

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 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[57]. 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

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

- 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.

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[58] 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

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:

> "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*

- **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.
- **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

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

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 service. • Some participants appreciate speaking with someone 'neutral' or unknown to them to tell their story. • Supports a 'system-wide' approach.	*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 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.[59, 60] 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.[61] 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[62,63]. However, the mean post-episode score of 12 is still a high level of psychological distress – albeit at the bottom end of this range.[64]

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[59] 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.

[60] In this case, the analysis is based on participants with both pre- and post-episode K10 scores (n=1,411).

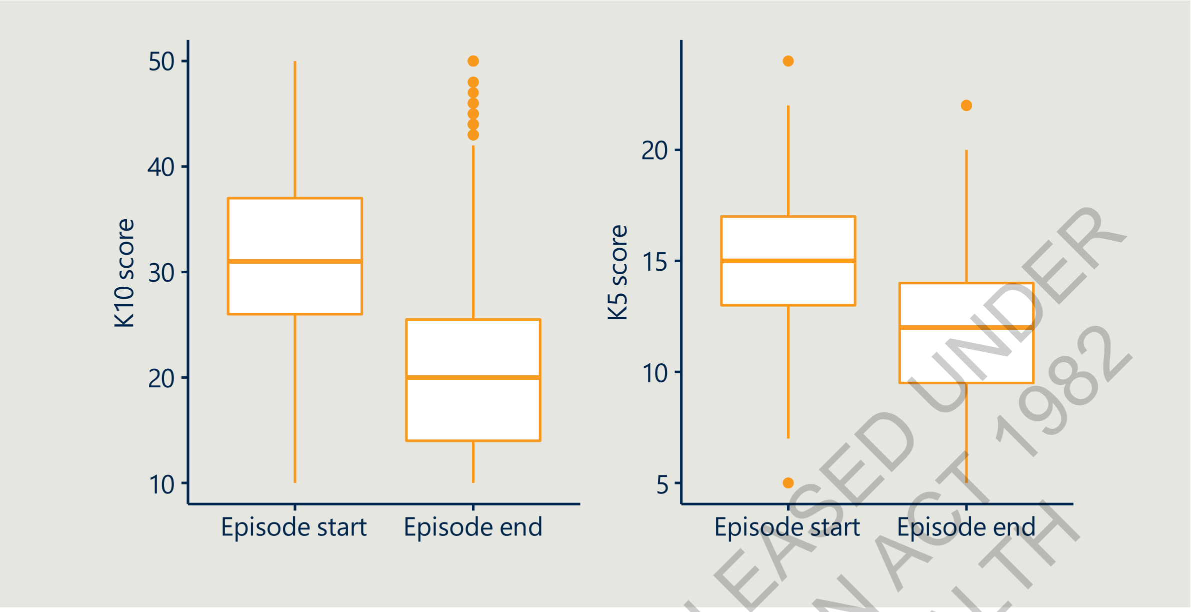
[61] Australian Government Department of Health. Primary Mental Health Care Minimum Data Set – Scoring the Kessler-5. September 2018.

[62] 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.

[63] The analysis is based on participants with both pre- and post-K5 scores (n=183).

[64] 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[65]. A multiple linear regression was used[66]. Service and demographic factors included in the regression model include:

Service[67]

- 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.

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[65] The regression analysis is based on 1,113 participants.

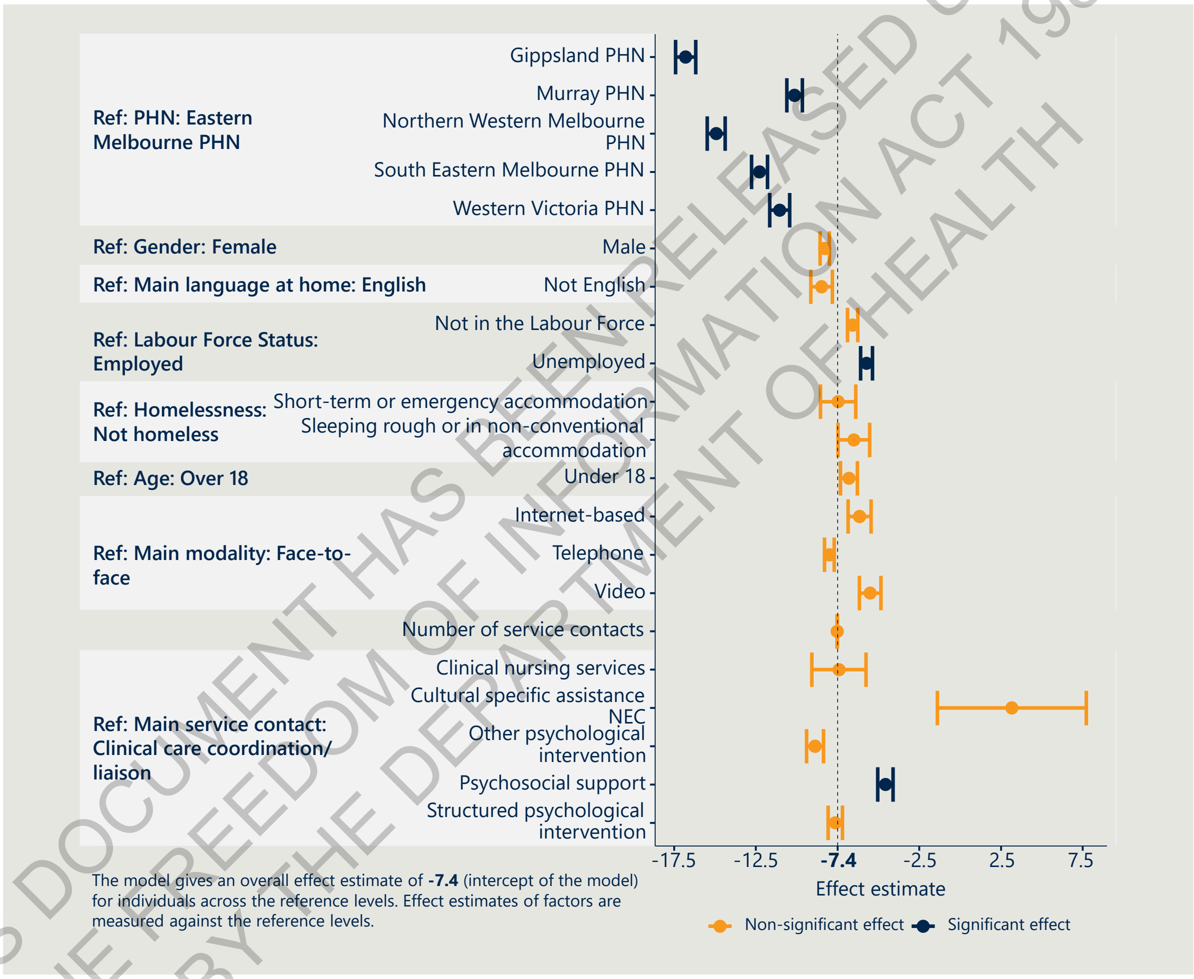
[66] Appropriate tests were used to ensure that key assumptions in the regression were met such as low or no collinearity across the factors and constant variance of residuals.

[67] 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.

The regression model (with demographic and service factors) explains about 11 per cent of the variability in the data.[68] This figure is meaningful to this evaluation as it indicates that demographic 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[69].

Figure 32 | Effect size of factors correlated with change in K10 scores from pre- to post-service[70]



The model gives an overall effect estimate of **-7.4** (intercept of the model) for individuals across the reference levels. Effect estimates of factors are measured against the reference levels.

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[68] 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.

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

[70] 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.

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 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).[71] 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.

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[71] 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

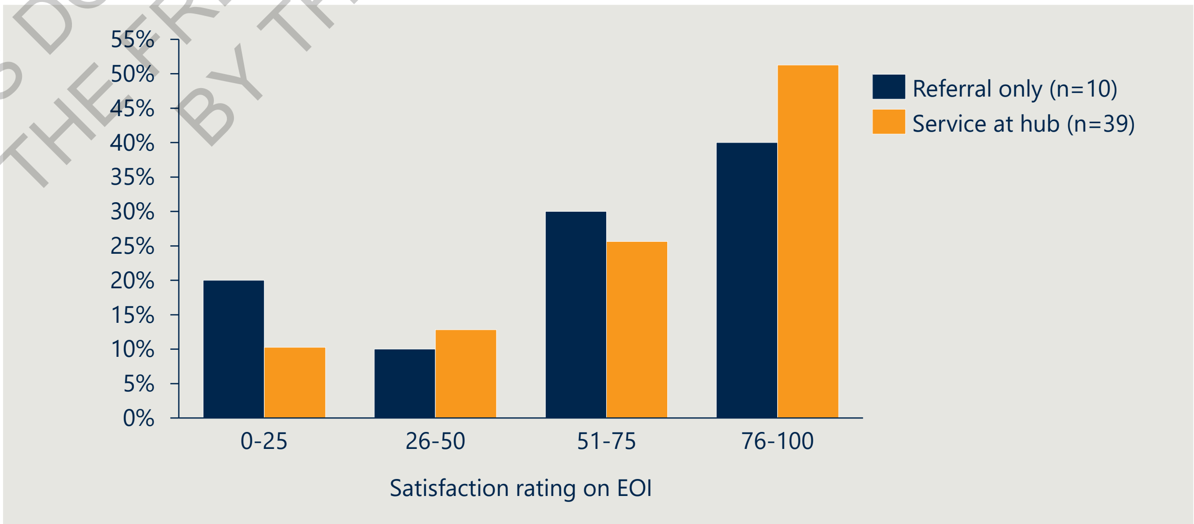
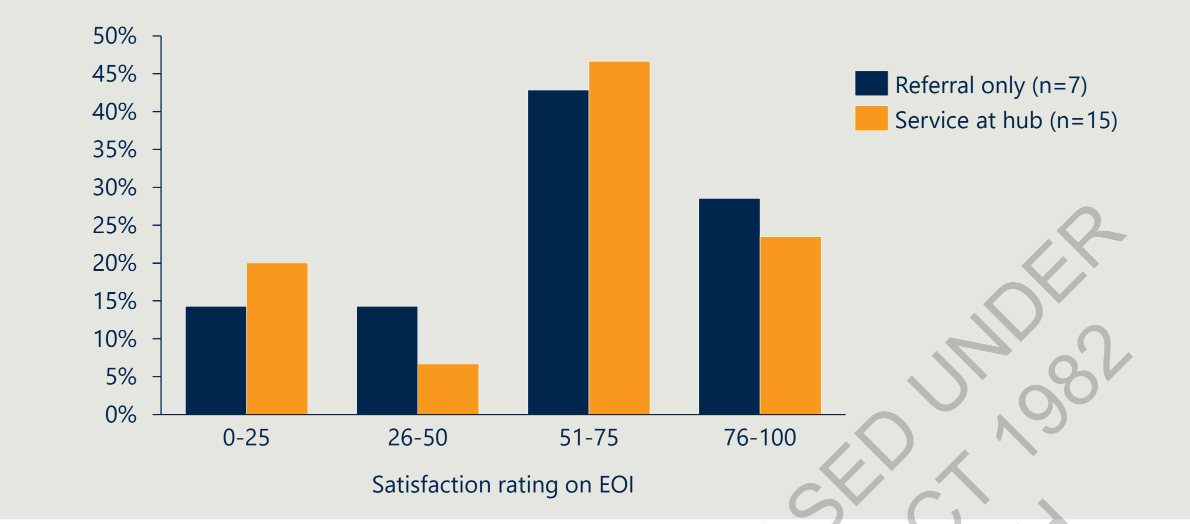


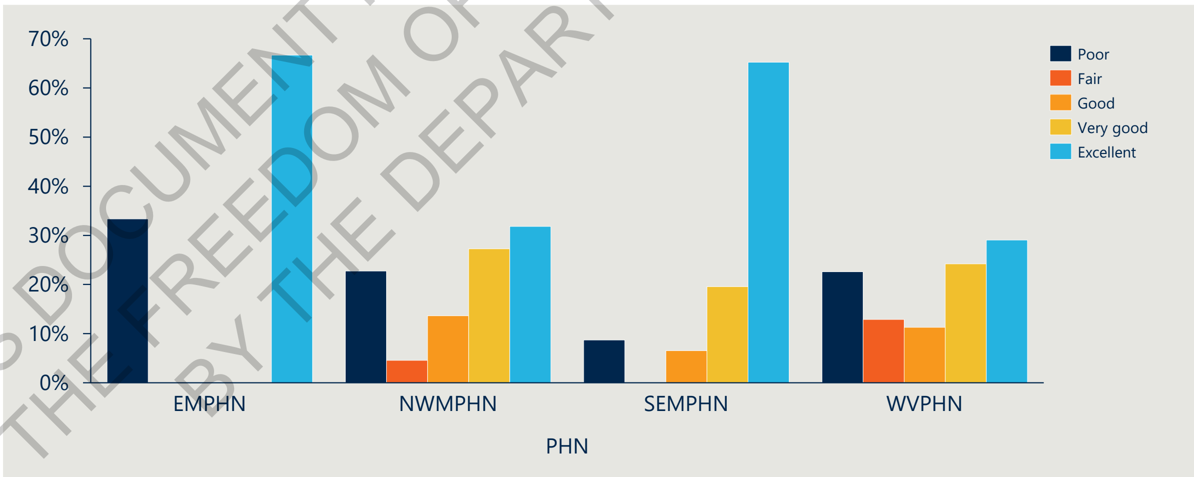
Figure 35 | Satisfaction rating by service type: Support people



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[72]. 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.
- **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

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[72] 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.

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.

- **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.

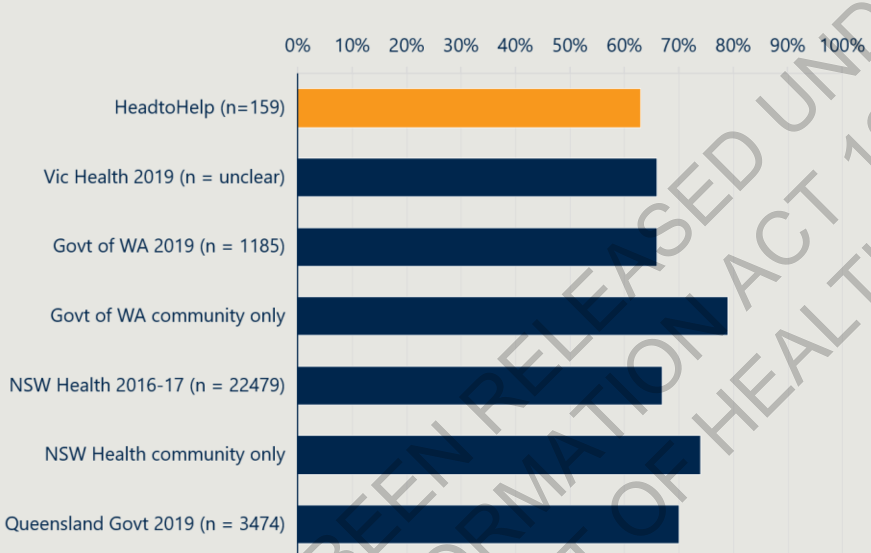
> "If I want to talk about my Aboriginality, they're fine with that but they don't bring it up unless you want to, which is good." – *Participant*

- **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 *HeadtoHelth* 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.

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. 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

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

> "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*

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.
- 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.

> "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*

5.2.3 Impact on system integration

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

> '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*

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.

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.

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.

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[73]. 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.[74]

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.

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[73] PHN flexible funding was excluded in these calculations to best reflect hub operation rather than PHN administration and management.

[74] As intake contacts are not included in the count of service contacts from the PHMC-MDS dataset.

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
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

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[75] 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[76]. 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.

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.

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[75] headspace Evaluation Report, Kristy Muir et al., Social Policy Research Centre, University of New South Wales, 2009.

[76] 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.

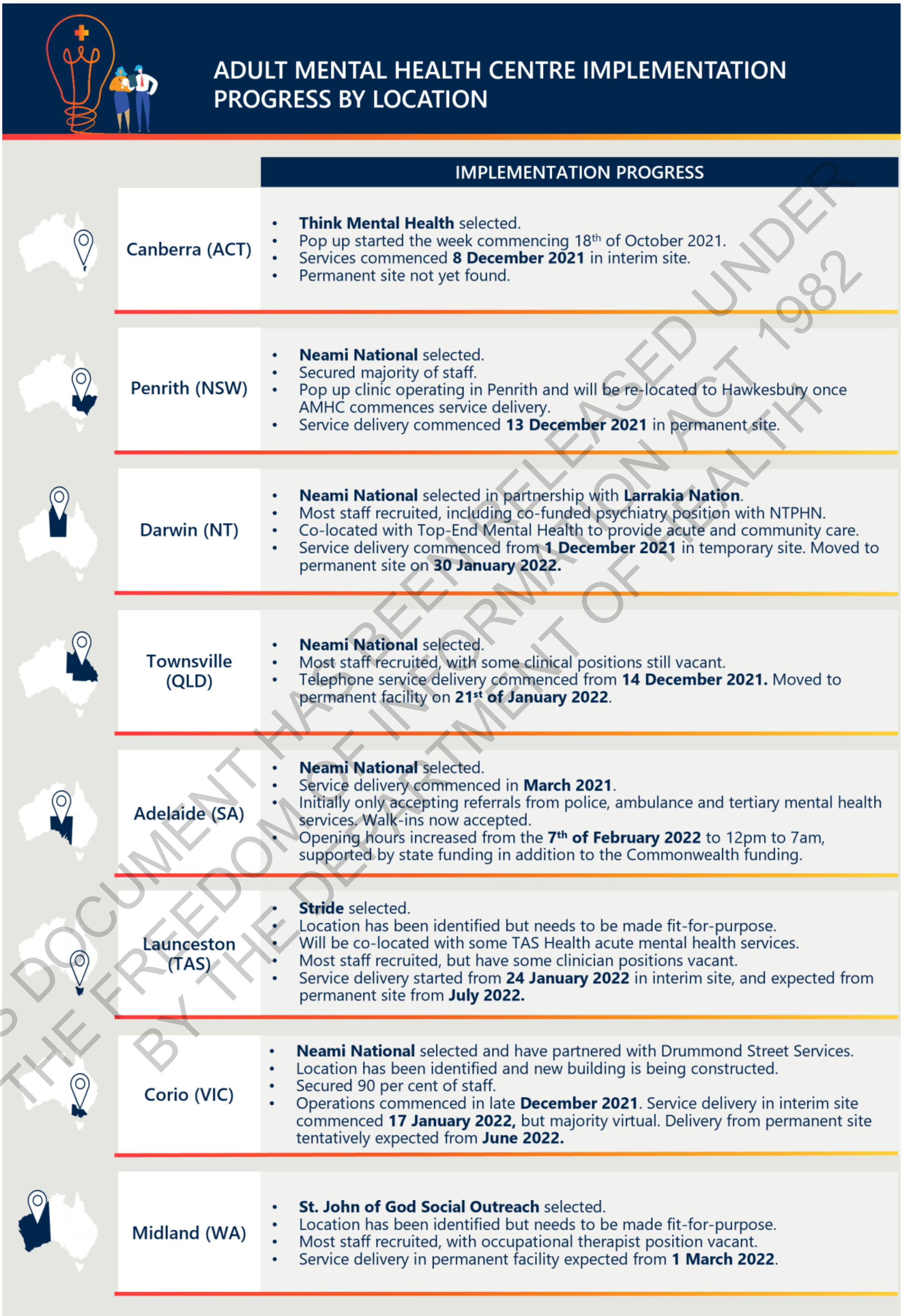
The majority of PHNs reported the 'full commissioning process' set out by the Australian Government Department of Health as a positive experience. Specifically, PHNs provided positive feedback on the timeframe provided, noting that it:

- 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



ADULT MENTAL HEALTH CENTRE IMPLEMENTATION PROGRESS BY LOCATION

	IMPLEMENTATION PROGRESS
Canberra (ACT)	• **Think Mental Health** selected. • Pop up started the week commencing 18th of October 2021. • Services commenced **8 December 2021** in interim site. • Permanent site not yet found.
Penrith (NSW)	• **Neami National** selected. • Secured majority of staff. • Pop up clinic operating in Penrith and will be re-located to Hawkesbury once AMHC commences service delivery. • Service delivery commenced **13 December 2021** in permanent site.
Darwin (NT)	• **Neami National** selected in partnership with **Larrakia Nation**. • Most staff recruited, including co-funded psychiatry position with NTPHN. • Co-located with Top-End Mental Health to provide acute and community care. • Service delivery commenced from **1 December 2021** in temporary site. Moved to permanent site on **30 January 2022.**
Townsville (QLD)	• **Neami National** selected. • Most staff recruited, with some clinical positions still vacant. • Telephone service delivery commenced from **14 December 2021.** Moved to permanent facility on **21st of January 2022**.
Adelaide (SA)	• **Neami National** selected. • Service delivery commenced in **March 2021**. • Initially only accepting referrals from police, ambulance and tertiary mental health services. Walk-ins now accepted. • Opening hours increased from the **7th of February 2022** to 12pm to 7am, supported by state funding in addition to the Commonwealth funding.
Launceston (TAS)	• **Stride** selected. • Location has been identified but needs to be made fit-for-purpose. • Will be co-located with some TAS Health acute mental health services. • Most staff recruited, but have some clinician positions vacant. • Service delivery started from **24 January 2022** in interim site, and expected from permanent site from **July 2022.**
Corio (VIC)	• **Neami National** selected and have partnered with Drummond Street Services. • Location has been identified and new building is being constructed. • Secured 90 per cent of staff. • Operations commenced in late **December 2021**. Service delivery in interim site commenced **17 January 2022,** but majority virtual. Delivery from permanent site tentatively expected from **June 2022.**
Midland (WA)	• **St. John of God Social Outreach** selected. • Location has been identified but needs to be made fit-for-purpose. • Most staff recruited, with occupational therapist position vacant. • Service delivery in permanent facility expected from **1 March 2022**.

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[77], were expected to inform the establishment of the AMHC in ACT.

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[77] 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 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.

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.

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[78]. 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.

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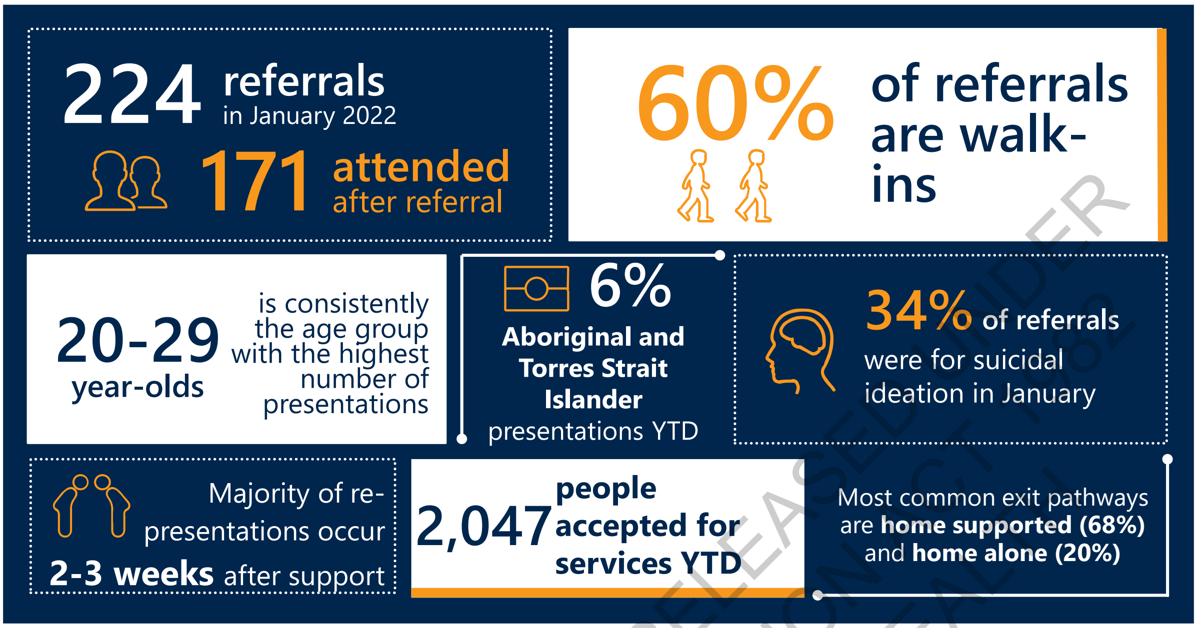
[78] Urgent Mental Healthcare Centre Monthly Report January 22, provided by SA Health

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.[79] 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.

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

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 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)[80] 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'. [81]

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 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.

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[80] Australian Institute of Health and Welfare. National Mental Health Workforce Strategy. Page 8.

[81] Ibid.

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.

1. **CENTRALISED INTAKE PROCESSES**
2. **REMAINING OPERATION AND WITHDRAWAL OF *HEADTOHELP* HUBS**
3. **SUPPORTING SUCCESSFUL *AMHC* IMPLEMENTATION**
   - **3.1** Contracts and accountability
   - **3.2** Service model
   - **3.3** Communication, engagement and integration
4. **SUPPORTING ESTABLISHMENT AND IMPLEMENTATION OF FUTURE PROGRAMS**

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

#	Recommendation	Details
		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

#	Recommendation	Details
		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

	Recommendation	Details
		specification documents. Broadly, time for PHN commissioning should be at least 12 weeks and establishment for service providers at least 16 weeks.

	Recommendation	Details
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,

	Recommendation	Details
		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 changes that may be required to the planned roll-out of AMHCs in that jurisdiction.**	*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 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

#	Recommendation	Details
		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:

Evaluation of the PHNs' Improved Access to Psychological Services in Aged Care Facilities initiative

Technical supplement to the final report

Australian Government Department of Health

16 March 2022

Australian Healthcare Associates
Australia's largest health & human services consulting firm

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Suggested citation: Australian Healthcare Associates, 2022, Evaluation of the PHNs’ Improved Access to Psychological Services in Aged Care Facilities initiative: Technical supplement to the final report, Australian Government Department of Health, Canberra.

AHA Australian Healthcare Associates
Level 6, 140 Bourke St, Melbourne VIC 3000
Locked Bag 32005, Collins Street East, VIC 8006
1300 242 111
aha@ahaconsulting.com.au
www.ahaconsulting.com.au

Acknowledgement of Country

In the spirit of respect and reconciliation, Australian Healthcare Associates acknowledges the traditional custodians of Country, the Aboriginal and Torres Strait Islander peoples, and their continuing connection to land, waters, sea, and community.

Australian Healthcare Associates is located on the lands of the Kulin Nation. We pay respect to Elders past and present.

Abbreviations

Term	Definition
AHA	Australian Healthcare Associates
CALD	culturally and/or linguistically diverse
the department	the Australian Government Department of Health
FY	financial year
GP	general practitioner
the initiative	Primary Health Networks' Improved Access to Psychological Services in Aged Care Facilities initiative
K10	Kessler psychological distress scale (10-item version)
K5	Kessler psychological distress scale (5-item version)
OPMH service	Older Persons Mental Health service
PHN	Primary Health Network
PMHC MCS	Primary Mental Health Care Minimum Data Set
RACF	residential aged care facility
the royal commission	the Royal Commission into Aged Care Quality and Safety

Note: PHNs are referred to throughout this document using a unique identifier created solely for the purposes of this evaluation, using a random number generator.

Contents

Tables

Figures

1 Overview of recent literature

In August 2021, our team at Australian Healthcare Associates (AHA) began a scan of peer-reviewed and grey literature that is relevant to delivering psychological services in residential aged care facilities (RACFs). We focused on publications of any type[1] that were released in the last 5 years and were primarily concerned with the mental health needs and care of residents without significant cognitive impairment.

1.1 Mental health problems in residential aged care

Recent literature confirms that mental health problems are a significant problem in RACFs, highlighting the importance of the Primary Health Networks' Improved Access to Psychological Services in Aged Care Facilities initiative (the initiative). For example, 58% of Australian residents have at least one mental health disorder on admission to aged care (Amare et al. 2020). While previous research focused largely on depression in the residential aged care facility (RACF) population, there is increasing recognition of the prevalence and impact of anxiety, as well as its continued under-reporting and residents' subsequent lack of access to appropriate support (Creighton et al. 2017, Creighton et al. 2018). A national survey of RACF staff provided evidence that residents' mental health concerns were exacerbated by the COVID-19 pandemic, with respondents commonly reporting that residents in their facility experienced increased loneliness (41%), anxiety or stress (33%), or depression (26%) (Brydon et al. 2022).

Emerging evidence suggests that residents may be predisposed to experiencing anxiety in the RACF setting (e.g. due to an anxious attachment style[2] and low sense of control over events) (Creighton et al. 2019). Further, a Melbourne-based study found that lower self-reported health and a perceived decline in physical functioning predicts problems with adjustment, depression, or anxiety upon admission to aged care, and that without intervention these problems are unlikely to improve over time (Davison, McCabe, Busija, Martin, et al. 2021). These results imply a potential role for intake screening or assessment in order to identify residents at risk, and deliver targeted interventions to support their transition to residential care (one example is the intervention recently tested by Davidson and colleagues, discussed in section 1.3). Indeed, the National Suicide Prevention Adviser recommended interventions that support people through transitions - including when commencing engagement with aged or supported care services – as a key area for implementation and evaluation (recommendation 5.3; National Suicide Prevention Adviser 2020).

1.2 Challenges to addressing residents' mental health needs

Recent publications also highlight the known challenges in improving access to and outcomes of appropriate psychological care. These include, for example:

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[1] Including, for example, systematic and narrative reviews, articles describing planned or completed primary research, and opinion pieces and editorials)

[2] Anxious attachment was assessed using the Experience in Close Relationships – Relationship Structures Adult Attachment Questionnaire, and is defined as excessive concern that a partner will not be available to provide support when it is required.

- the historical absence of government-funded psychological services in RACFs (which this initiative is designed to address)[3] that meant that responsibility for mental health care defaulted to RACFs, with a lack of guidance leaving open the door to limited or ad hoc support (Radermacher 2021)
- the potential for mental health care to be a lesser priority than other issues for the aged care sector and its staff, given sweeping reform to the sector as a result of the Royal Commission into Aged Care Quality and Safety (the royal commission), and a necessary shift in funding and human resources to support residents' physical health during the COVID-19 pandemic (Radermacher 2021)
- the lack of a mental health workforce that is able and willing to provide mental health care in RACFs, and insufficient infrastructure to support service delivery (Radermacher 2021, Davison et al. 2017, Looi et al. 2022)
- organisational factors within RACFs, with staff requiring improved mental health literacy, the resources and time required to support service delivery (Kelly et al. 2022) and an environment in which they feel comfortable putting their knowledge and skills to use. Specifically, organisational cultures that foster high job satisfaction, low job stress, and a sense of role autonomy (i.e. where staff feel they have the ability to schedule their own work activities) are associated with increased staff confidence in caring for residents with depression, regardless of level of experience or seniority. Further, staff feel more confident applying their knowledge of depression when they feel supported by their colleagues to do so (McCabe et al. 2017).

While the barriers above affect all aged care residents, members of special needs groups experience additional service gaps. For example, one systematic review highlights that Aboriginal and Torres Strait Islander resident are less likely to receive mental health services than the general resident population (Keelan et al. 2021). This review discussed the importance of having RACF staff and managers that reflect the cultural background of the RACF population they serve, to maximise alignment between the needs and preferences of residents and the services and support available. Similarly, policies and practices that support social and spiritual connections can be particularly important in maintaining or improving wellbeing for residents from culturally and/or linguistically diverse (CALD) backgrounds (Frey & Balmer 2021, Wardle & Bennett 2021).

1.3 Options for effectively responding to or preventing mental illness

Challenges to delivery notwithstanding, there is growing evidence for the appropriateness and effectiveness of a range of psychological therapies in the RACF population. For example, Chan and colleagues (2021) conducted a systematic review of 18 studies (3 Australian) of cognitive behavioural therapy for RACF residents. They found that around three-quarters of eligible residents will accept the offer of face-to-face therapy for anxiety and depression.[4] Therapy was viewed positively by both RACF staff and residents, and was more likely to improve symptoms than not. Better results were achieved when therapy incorporated psychoeducation, pleasant events scheduling, and problem solving, suggesting that these strategies should be considered by service providers that are funded by PHNs (Primary Health Networks) to deliver mental health care in RACFs.

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[3] Radermacher also commented on the relatively low number of services delivered in the first 18 months of the initiative's funding, which as discussed in the final report is not surprising given that many PHNs were focused on service design and commissioning at this time.

[4] One in 5 residents who commenced therapy did not complete it (due to death, hospitalisation, or other medical issues).

Another line of enquiry has been the use of animals to improve RACF residents' mental health and wellbeing. A recent review of 18 studies (1 Australian) found that animal (specifically, dog) assisted therapy is effective in reducing depressive symptoms regardless of the number, frequency, or duration of sessions (Franklin et al. 2022). Sessions conducted twice weekly may also improve residents' overall quality of life. Animal-assisted therapy may be more effective if delivered in a group than an individual setting, and when it involves physical interaction with the animal. However, Newton et al (Newton et al. 2021) identified the potential physical and legal risks associated with animal-assisted therapies. They highlighted a need to ensure that appropriate protections are in place for the welfare of both residents and animals, noting that relevant RACF policies and guidelines are not well established or implemented either in Australia or internationally.

Australian researchers are making substantial contributions to the evidence base, via 2 randomised controlled trials of different approaches to supporting aged care residents' mental health. First, Davison and colleagues (2020, 2021) tested a structured intervention targeted at new residents adjusting to the RACF setting. The intervention comprised: 3 weekly individual therapy sessions, 2 booster sessions (2 and 4 weeks after the final weekly session) to review and modify strategies, and liaison with RACF staff to discuss and implement individually tailored care. The intervention showed promising results, with a significant short-term reduction in depressive symptoms. Case studies highlight additional benefits such as greater participation in RACF activities, increased confidence, improved personal care, and improved awareness of residents' values and beliefs among RACF staff enabling (Kelly et al. 2022).

In a trial currently underway, Doyle and colleagues (2021) are exploring the effectiveness of a 'befriending' intervention in improving residents' depression, anxiety, and loneliness. This low-intensity intervention involves a trained volunteer meeting with a resident every week for 4 months, to discuss neutral, mutually agreed topics of interest. While the trial itself is ongoing, a nested study explored the impact of a change to remote befriending during COVID-19 restrictions (Fearn et al. 2021). Volunteers perceived that while face-to-face support is preferable, remote befriending is better than none at all. Facilitators to remote delivery of the intervention included having at least one face-to-face meeting to establish rapport, securing support from RACF staff to assist with technology, and identifying residents' preferred method of communication (e.g. telephone or video call, letter, text message, or email).

Finally, both new and existing residents may benefit from interventions that address their physical health and environmental health, with flow-on benefits reducing the need for formal, reactive mental health supports. For example, there is some evidence that reablement programs (which aim to promote physical functioning) also improve depression and anxiety (Lewis et al. 2021). An early pilot program (conducted in Victoria in 2010 but not published until 2021) suggested that social workers may have an important role to play in preventing emotional distress by providing practical support to both residents and families, particularly during the transition to residential care (Lee et al. 2022). Consideration could also be given to policy and environmental changes that, to the extent possible, help all residents to maintain their wellbeing, personal relationships, and control over their day-to-day life (Carnemolla et al. 2021, Carver et al. 2020, Sugiyama et al. 2021, Cleary et al. 2019).

2 Stakeholder interviews

This evaluation was informed by 62 interviews with 134 individual participants, all conducted using Microsoft Teams and lasting between 30 and 60 minutes. As reflected below, the interviewees spanned 4 stakeholder groups (PHN representatives, peak bodies, health professionals and service provider representatives, and RACF staff) and we tailored our approach to engaging each of these groups.

2.1 PHN representatives

After the Australian Government Department of Health (the department) sent an introductory email to all PHN CEOs, we emailed interview invitations to nominated staff in each region using a contact list provided by the department. The response rate to this initial email was high and only a small number of PHNs required follow-up before confirming their willingness to participate. We conducted interviews with a total of 67 PHN program leaders, managers, or coordinators, representing all PHNs across Australia.

2.2 Peak bodies

We employed a 2-pronged approach to engaging members of this stakeholder group: the department emailed members of its Aged Care Sector Committee Diversity Sub-group, while we emailed other professional organisations representing service providers or consumers in the health, mental health, and aged care sectors. For simplicity, we refer to stakeholders engaged through either of these channels as peak bodies.

Forty representatives of the health, mental health, and aged care sectors contributed to the evaluation, with one interview conducted with each of the following 21 organisations:

- Aged Care Services Australia
- Allied Health Professions Australia
- Australian Association of Gerontologists
- Australian Association of Psychologists
- Australian Association of Social Workers
- Australian Music Therapy Association
- Australian Psychological Society
- Centre for Cultural Diversity in Ageing
- Exercise and Sports Science Australia
- Helping Hand
- Leading Age Services Australia
- LGBTIQ+ Health Australia
- Mental Health Australia
- Micah Projects
- National Mental Health Consumer and Carer Forum
- Occupational Therapy Australia
- Older Persons Advocacy Network

- Royal Australian College of General Practitioners
- Speech Pathology Australia
- Swinburne University
- TPI Federation.

2.3 Health professionals and service provider representatives

We emailed all PHNs a participant information sheet and link to the online health professional and service provider survey and asked them to distribute these to relevant individuals or organisations in their region. We supplemented this activity by sending information directly to service providers for whom contact details were publicly available.

Representatives of 4 service provider organisations contacted us directly via email to request an interview, and 32 survey respondents expressed interest in an interview by entering their contact details in the final section of the survey itself. We emailed these individuals an outline of the interview questions and an invitation to indicate their preferred interview time(s) in a Doodle poll. The poll included options for after-hours interviews on multiple days. We sent a reminder to non-responders approximately one week after our initial email. We then drew on the poll results to schedule interviews in line with participant preferences, resulting in a mix of group and individual interviews:

- Between 25 and 28 October 2021, we conducted 3 interviews with 4 health professionals (2 general practitioners [GPs] and 2 nurses) with a role in referring residents to the initiative. These individuals represented 3 PHNs, and they reported having worked in residential aged care for between 2 and 35 years. They had between 2 years and 4 months of experience referring residents to the initiative, and they reported referring between 1 and 3 residents per month on average.
- Between 27 October and 4 November 2021, we conducted 4 interviews with 8 mental health practitioners from 6 PHN regions. Participants comprised 5 social workers with mental health training, one psychologist, one mental health nurse and one low-intensity mental health worker. These mental health practitioners had an average of around 15 months' experience delivering services under the initiative (ranging from 3 to 27 months), and they reported delivering services to an average of 27 residents per month (ranging from 5 to 100 months).
- Between 4 November and 9 December 2021, we interviewed 9 program managers from 4 service provider organisations, servicing 10 PHN regions.

2.4 RACF staff

We adopted a multifaceted approach to inviting RACF staff to contribute to the evaluation. This involved:

- requesting that PHNs distribute information about the interview to RACFs in their region, either directly or by asking service providers to perform this task
- sending information about the interview to health professionals and service provider representatives we interviewed, or those for whom contact details were publicly available, and asking that they distribute this information to the RACFs they work with

- contacting RACFs directly where the PHN or service provider provided us with their contact details.

We received expressions of interest from 14 RACF staff, contacted them by phone and/or email to confirm their availability, and sent a reminder to non-responders after approximately one week. As a result of this process, between 9 and 17 November 2021 we conducted 5 interviews with individual RACF staff members, located in 4 different PHN regions. Four of these interviewees held the role of care manager, while one indicated they were a clinical nurse. Participants worked in RACFs that varied both in size (from 70 beds to 134 beds) and complexity of resident needs. For example, one interviewee noted a relatively even one-third split between dementia, high-care beds, and low-care beds, while another shared that approximately 90% of current residents are deemed to have high-care needs.

3 Health professional and service provider survey results

In total, 144 people completed the health professional and service provider survey between 20 September and 20 October 2021,[5] representing 27 PHNs (Table 3-1). Of the 4 PHNs not represented in the survey data:

- 2 did not have a service provider engaged at the time of the survey
- one shared a service provider with other PHNs and the perspectives of this service provider were therefore captured in surveys submitted under these PHNs
- one was focused on the COVID-19 pandemic at the time of the survey, leaving little capacity for survey distribution or completion.

Given that the total population of eligible health professionals, mental health practitioners, and service managers is unknown, we were unable to determine the proportion that comprised our final sample.

Table 3-1: Distribution of survey respondents by deidentified PHN region

PHN region	n	%
PHN 6	17	12%
PHN 27	17	12%
PHN 18	14	10%
PHN 3	12	8%
PHN 7	9	6%
PHN 16	8	6%
PHN 5	8	6%
PHN 15	8	6%
PHN 20	6	4%
PHN 10	6	4%
PHN 22	6	4%
PHN 9	5	3%
PHN 30	5	3%
PHN 31	4	3%
PHN 21	2	1%
PHN 23	2	1%
PHN 1	2	1%
PHN 2	2	1%
PHN 20	2	1%

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[5] The 144 respondents included in our analysis represent 82% of people who accessed the survey. We excluded data from 16 (9%) who opened the survey but did not answer any questions, and 15 (9%) who provided only limited information (their PHN and role).

PHN region	n	%
PHN 11	2	1%
PHN 25	1	1%
PHN 12	1	1%
PHN 8	1	1%
PHN 13	1	1%
PHN 26	1	1%
PHN 17	1	1%
PHN 28	1	1%
PHN 24	0	0%
PHN 14	0	0%
PHN 19	0	0%
PHN 4	0	0%
Total	**144**	**100%**

Half of respondents completed the survey in their role as a mental health practitioner responsible for delivering services under the initiative (most commonly, as a social worker or psychologist), with most of the remainder holding a managerial role in a service provider organisation (Table 3-2). The smallest group of respondents was health professionals who refer residents to psychological services; nurses accounted for two-thirds of this group.

Table 3-2: Respondent profession category and type

Profession category/type	n	%
Health professional: total	24	17%
Health professional: Nurse	15	63%
Health professional: General practitioner	4	17%
Health professional: Other	5	21%
Mental health practitioner: total	73	51%
Mental health practitioner: Social worker (with mental health training)	24	33%
Mental health practitioner: Psychologist	23	32%
Mental health practitioner: Mental health nurse	14	19%
Mental health practitioner: Low-intensity mental health worker	5	7%
Mental health practitioner: Counsellor	3	4%
Mental health practitioner: Other	4	5%
Manager in a service provider organisation: total	47	33%
Total	**144**	**100%**

Note: The 'Other' category contains professions selected by only one respondent. For health professionals who refer to the initiative, this included the professions of psychologist, social worker, and mental health nurse. For mental health practitioners who deliver services under the initiative, this included the professions of occupational therapist (with mental health training), psychosocial support worker, psychiatrist, and social worker.

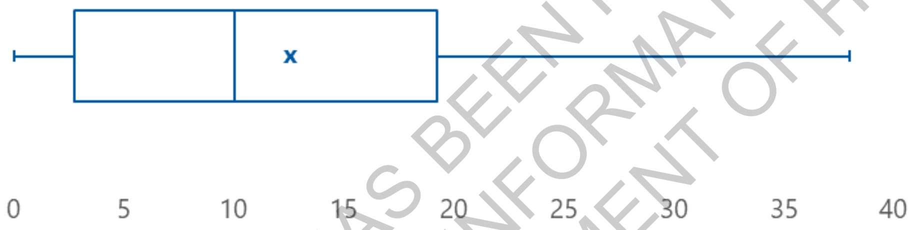
Respondents saw different survey questions depending on which profession category they selected. Below, we present findings for each of these groups in turn.

3.1 Health professionals

3.1.1 Characteristics of respondents and their patients

Our sample of 24 health professionals reported an average of 12 years' experience providing care to aged care residents, with half of respondents indicating that they had worked with this population for between 3 and 19 years (Figure 3-1). Their experience with the initiative was similarly varied, ranging from early adopters who first referred residents to PHN-commissioned services in late 2018, to more recent arrivals whose first referrals coincided with our survey in late 2021.

Figure 3-1: Distribution of health professionals' experience in providing care to aged care residents



All respondents indicated feeling at least some confidence in identifying residents' mental health needs, with the majority feeling moderately or very confident in this respect (Table 3-3). Every respondent who expanded on their response indicated that they were very or extremely confident in identifying residents' mental health needs, and they suggested that their previous experience in mental health (through attaining qualifications or working with mental health specialists) was the reason for this.

Table 3-3: Health professionals' confidence in identifying aged care residents' mental health needs

Level of confidence	n	%
Not at all	0	0%
Slightly	1	4%
Moderately	10	42%
Very	10	42%
Extremely	3	13%
Total	**24**	**100%**

We asked health professionals to provide some high-level information on their residential aged care patients. All health professionals indicated that they provided care to aged care residents from at least 3 (and up to 10) special needs groups, with the 3 most common special needs groups (cared for by more than 90% of respondents) being: people who are financially disadvantaged; veterans, war widows, and widowers; and older people with disabilities (Table 3-4).

Table 3-4: Proportion of health professionals providing care to residents from special needs groups

Special needs group	Yes	No	Unsure
People from Aboriginal and/or Torres Strait Islander backgrounds	29%	58%	13%
People from culturally and/or linguistically diverse backgrounds	83%	13%	4%
People living in rural or remote Australia	42%	54%	4%
People with disabilities	92%	8%	0%
People of diverse sexual orientation and gender identity/identities, including LGBTI	42%	33%	25%
Care leavers, including Forgotten Australians, Former Child Migrants, and members of the Stolen Generations	38%	33%	29%
Veterans, war widows, and war widowers	92%	0%	8%
People who are financially disadvantaged	96%	4%	0%
People who are homeless or facing homelessness	38%	50%	13%
People affected by forced adoption or removal	29%	38%	33%

Note: Percentages are based on the number of respondents that selected each response option, divided by the total number of respondents that answered the question (n = 24).

In terms of their patients' mental health needs, respondents were most likely to indicate that moderate mental illness is the predominant presentation they encounter (Table 3-5). Residents with severe mental illness and those at risk of but not currently experiencing mental illness rarely account for the majority of health professionals' mental health work.

Table 3-5: Most common level of mental illness severity that health professionals encounter in aged care residents

Severity	n	%
At risk	2	8%
Mild mental illness	7	29%
Moderate mental illness	14	58%
Severe mental illness	1	4%
Unsure	0	0%
Total	**24**	**100%**

3.1.2 Awareness of and support in implementing the initiative

To gauge health professionals' perception of the service context in their region, we asked which of the 5 levels of care defined in the PHN stepped care framework are available for the aged care residents they refer. Respondents could select as many levels as they believed applied; they most commonly selected moderate-intensity services, while few were aware of the availability of acute and specialist services (Table 3-6). This suggests relatively good awareness of PHN-commissioned services, given the initiative's focus on level 2 and 3 services. Further, given that respondents considered mild to moderate illness to be most common among their patients, their awareness of services appropriate to this level of need is reassuring.

Table 3-6: Levels of mental health care available for aged care residents, reported by health professionals

Level of care	Available	Not available	Unsure
Level 1: Self-management	54%	25%	21%
Level 2: Low-intensity services	79%	8%	13%
Level 3: Moderate-intensity services	92%	8%	0%
Level 4: High-intensity services	38%	46%	17%
Level 5: Acute and specialist mental health services	8%	71%	21%

Note: Percentages are based on the number of respondents that selected each response option for each level of care, divided by the total number of respondents that answered the question (n = 24).

Respondents reported that they first became aware of the initiative and the availability of PHN-commissioned services for aged care residents through their PHN, either through information sessions or workshops (n = 7; 29%) or written communication (n = 6; 25%) (Table 3-7). Other pathways to awareness included direct contact from service providers, and promotion through other aged care support services such as the Aged Care Emergency service.

Table 3-7: Health professionals' pathways to becoming aware of the initiative

Pathway	n	%
Information session/workshop run by the PHN	7	29%
Written communication from the PHN	6	25%
RACF staff	5	21%
Communication from a professional body (e.g. The Royal Australian College of General Practitioners)	0	0%
Other	6	25%
Total	**24**	**100%**

In relation to support from PHNs to implement the initiative and refer residents to appropriate services, health professionals most commonly indicated that they had received written information about available services (Table 3-8).

Table 3-8: Implementation support provided by PHNs to health professionals

Type of support	n	%
Written resources on available services	14	74%
Involvement in consultations about developing appropriate referral pathways	7	37%
Individual feedback on referrals	7	37%
Professional development/training/workshop	5	26%
Other	1	5%

Note: Percentages are based on the number of respondents that selected each support, divided by the total number of respondents that selected at least one type of support (n = 19).

Two out of five respondents (n = 10; 42%) reported that they had received multiple types of support, while one in five respondents (n = 5; 21%) advised that they had not received any supports or resources from their PHN.

3.1.3 Referral pathways

When asked to indicate the referral pathways that they use for aged care residents who require mental health support, the majority of respondents (n = 19; 79%) selected multiple pathways. This suggests that the respondents tailor their referral approach to the needs of the resident and/or the services available. Respondents reported that they commonly used both PHN-commissioned and non-PHN-commissioned services,[6] with few health professionals indicating that they referred via the Better Access aged care expansion (Table 3-9).

Table 3-9: Mental health referral pathways used for aged care residents, reported by health professionals

Referral pathway	n	%
I refer to other support services	20	83%
I refer to PHN-commissioned services	17	71%
I provide mental health care myself	10	42%
I advise on privately funded mental health care	5	21%
I refer through Better Access	3	13%
Other	3	13%

As well as reporting on their referral pathways overall, we also asked health professionals to indicate the referral pathways they use for members of each of the special needs groups that they provide care to (see section 3.1.1, Table 3-4). The pattern of results mirrored that seen in Table 3-9, with referral to PHN-commissioned services and other support services being the primary pathways. Key differences related to referrals for:

- Aboriginal and/or Torres Strait Islander peoples: Some respondents indicated that they were unsure as to the appropriate pathway or that they refer to Aboriginal mental health services where possible
- veterans, war widows, and war widowers: Respondents indicated a preference to refer to the Department of Veterans' Affairs or other veteran-specific services.

Additionally, we invited respondents to comment further on the referral pathways they use. Their responses highlighted that the ability to select an appropriate pathway hinges on awareness of both the pathways themselves and the services they lead to. Several respondents perceived the scarcity of resources and lack of information on available services to be a barrier to appropriate referral, while others noted that developing good relationships with PHN-commissioned service providers had helped them to gain an understanding of the service landscape. One respondent commented that although they refer to PHN-commissioned and other support services if required, their preferred option is to recommend privately funded care if the resident has private health insurance and a mental health practitioner is available within a timely period (the respondent did not expand further on why this was the case).

3.1.4 Perceived effectiveness of the initiative

The majority of health professionals felt that the initiative has improved the mental health of aged care residents in their region (Figure 3-2). Only one respondent believed that this was not the case, due to services being underutilised by residents, challenges associated with the COVID-19 pandemic, and

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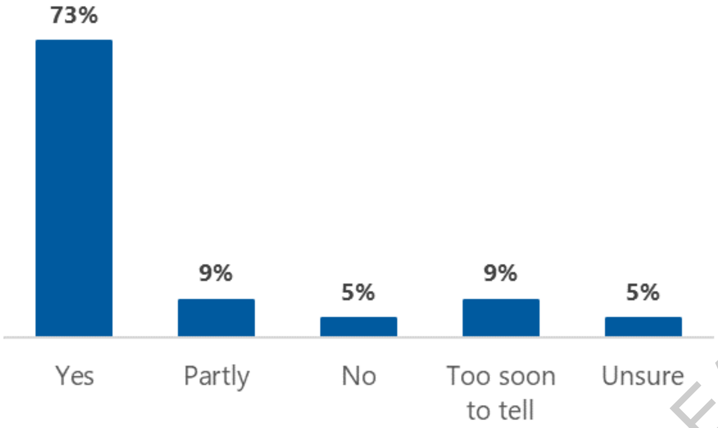
[6] Specifically, respondents reported referring an average of 5 aged care residents each month (range 0 to 40) to PHN-commissioned services. We did not ask what proportion of their total mental health referrals this accounts for, or how many residents are referred through other pathways.

workforce shortages. One person who indicated that the initiative has only partly achieved its objectives reflected that this is due to service capacity in their region being constrained by resourcing limitations.

Figure 3-2: Health professionals' perceptions of whether the initiative has improved the mental health of aged care residents



Note: Percentages are based on the number of respondents that selected each option, divided by the total number of respondents to this question (n = 22).

Lastly, we invited respondents to suggest how the initiative could be improved to better support aged care residents' mental health. Two respondents provided only positive feedback: one indicated that they found the referral process efficient and effective; the other commented on the value of the initiative in providing older people with choice and support that was not previously available. GPs suggested a need for greater promotion of the initiative – noting that they became aware of it only through this evaluation or their own research – and for improved information sharing about their patients' progress and outcomes after referral. Another respondent reflected that although residents could be reluctant to accept help, all those who had accessed the services had experienced benefits; this respondent suggested that better conveying these benefits to other residents could help to improve uptake. Finally, other comments related to the impact of COVID-19 on the uptake of services, the need to support RACF staff as well as residents, the importance of sufficient program funding and mental health practitioner salaries to ensure high-quality care, and the potential to improve crisis support and referral pathways for residents with cognitive impairment.

3.2 Mental health practitioners

3.2.1 Characteristics of respondents and their clients

Nearly the entire sample of 73 mental health practitioners indicated that they are employed (n = 46; 72%) or contracted (n = 15; 23%) by an organisation that has been commissioned by their PHN, with only a handful (n = 3; 5%) being directly contracted by their PHN as a sole practitioner. Nine respondents did not disclose their relationship to their PHN. The duration of respondents' engagement with the initiative varied, from early adopters who first started delivering services to residents in early 2018, to one person who was only just becoming involved at the time of our survey and had not yet commenced service delivery.

As would be expected, mental health practitioners indicated greater confidence in identifying aged care residents' mental health needs than their health professional counterparts, with most feeling very or extremely confident (Table 3-10). Similar to health professionals, those mental health practitioners who expanded on their response suggested that this was due to their previous experience in mental health (through attaining qualifications or working with mental health specialists). Consistent with these perspectives, the one respondent (a counsellor) who was not at all confident in their ability to identify mental health needs attributed this to their limited tertiary-level training in psychology. This individual also had limited work experience in the aged care setting, having commenced working with RACF residents relatively recently.

Table 3-10: Mental health practitioners' confidence in identifying aged care residents' mental health needs

Level of confidence	n	%
Not at all	1	1%
Slightly	1	1%
Moderately	12	16%
Very	37	51%
Extremely	22	30%
Total	**73**	**100%**

Like health professionals, more than half of the mental health practitioners who estimated their clients' level of mental health needs indicated that moderate mental illness is most common (Table 3-11). Few mental health practitioners primarily care for residents at risk of but not currently experiencing mental illness, or those at the other end of the spectrum who are experiencing severe mental illness.

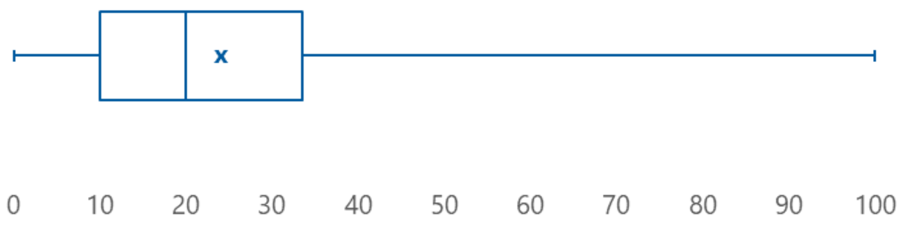
Table 3-11: Most common level of mental illness severity that mental health practitioners encounter in aged care residents

Severity	n	%
At risk	1	2%
Mild mental illness	22	34%
Moderate mental illness	37	58%
Severe mental illness	2	3%
Unsure	2	3%
Total	**64**	**100%**

3.2.2 Service delivery characteristics

On average, respondents reported that they deliver initiative-funded psychological services to 25 residents per month, with half indicating that they see between 10 and 34 residents per month (Figure 3-3).

Figure 3-3: Number of residents seen by mental health practitioners per month



Note: Nine respondents did not provide any information on the number of aged care residents they see under the initiative.

These residents are most frequently referred by RACF staff (Table 3-12), with the majority of practitioners (n = 56; 88%) indicating they receive referrals from multiple sources.

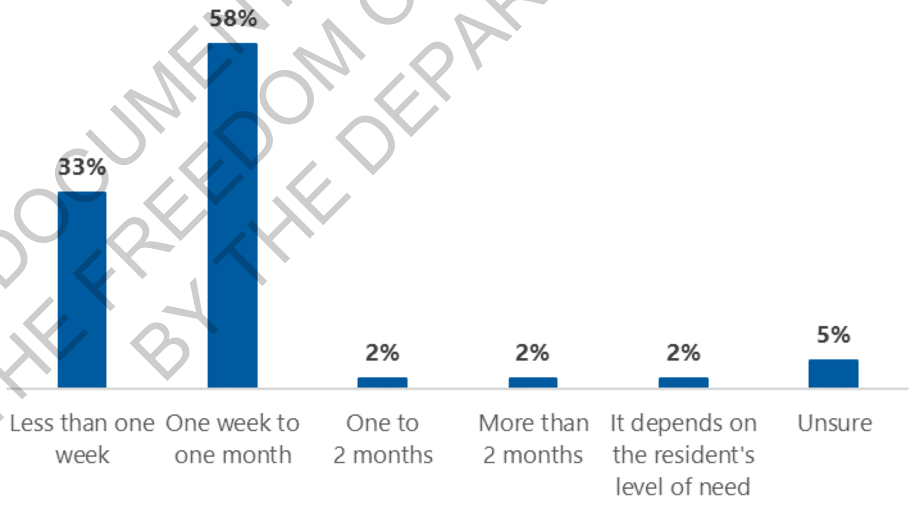
Table 3-12: Sources of initiative referrals, reported by mental health practitioners

Referrer	n	%
RACF staff	55	86%
General practitioners	50	78%
Nurses	43	67%
Residents and/or their family members	29	45%
Social workers	11	17%
Psychologists	9	14%
Occupational therapists	9	14%
Aboriginal health workers	3	5%
Other	5	8%

Note: More than one response option could be selected. Percentages are based on the total number of responses for each option, divided by the total number of respondents for this question (n = 64).

We asked mental health practitioners how long residents need to wait for their first appointment after being referred. Most indicated that the wait time was between one week and one month, with few practitioners indicating that their clients wait longer than one month (Figure 3-4).

Figure 3-4: Mental health practitioner-reported time from referral to first session of mental health care



Note: Percentages are based on the number of respondents that selected each option, divided by the total number of respondents to this question (n = 64).

To gauge in greater detail the type of support that mental health practitioners deliver under the initiative, we asked which of the 5 levels of care defined in the PHN stepped care framework they provide to aged care residents. Respondents could select as many levels as applicable, with most indicating that they provide moderate- or low-intensity services (Table 3-13). This finding is consistent with practitioners' reports that residents typically experience mild to moderate mental illness, and implies that the initiative is meeting its objective to improve access to care for residents with mild to moderate mental health needs.

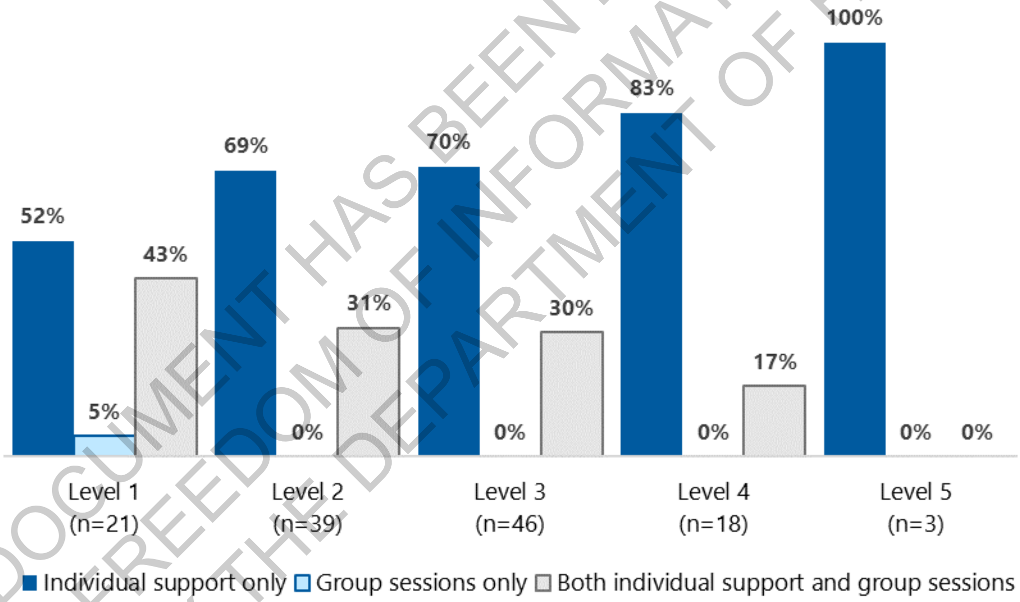
Table 3-13: Levels of mental health care provided by mental health practitioners under the initiative

Level of care	n	%
Level 1: Self-management	21	34%
Level 2: Low-intensity services	39	64%
Level 3: Moderate-intensity services	46	75%
Level 4: High-intensity services	18	30%
Level 5: Acute and specialist mental health services	3	5%

Note: More than one response option could be selected. Percentages are based on the number of responses for each option, divided by the total number of respondents that selected any of the 5 levels of care (n = 61).

To gain a better understanding of what service delivery looks like at different levels of intensity, we asked respondents to indicate the format and modality of support they provide for each level of care that they selected. At all levels, individual support is the most common, but it accounts for an increasing proportion of service delivery as the level of intensity increases (Figure 3-5). In contrast, access to both group and individual support is more likely at lower levels of care.

Figure 3-5: Format of support provided by mental health practitioners to residents, at each level of care



Almost all mental health practitioners offer face-to-face support onsite at residents' RACF, with telephone or video support the next most common (Table 3-14). There was no interaction between the level and modality of care, the one exception being that acute and specialist care is not delivered online.

Table 3-14: Modality of support provided by mental health practitioners to residents, across all levels of care

Modality	n	%
Face-to-face at the RACF	58	91%
Over the telephone	27	42%
Over video	26	41%
Face-to-face at another location	5	8%

Modality	n	%
Online	2	3%
Other	0	0%
Total number of respondents	**64**	**100%**

3.2.3 PHN support for service delivery

One in three (n = 24; 38%) practitioners had received multiple types of support from their PHN to deliver services under the initiative, with the most common type of support being assistance with developing referral pathways (Table 3-15). However another 1 in 3 respondents (n = 22; 34%) advised that they have not received any supports or resources from their PHN, and 2 of the 5 practitioners that indicated an 'other' type of support went on to explain that they have no direct contact with the PHN so are unsure what supports are being provided (i.e. they are unclear whether the PHN or their organisation is responsible for the support that they receive).

Table 3-15: Service delivery support provided by PHNs to mental health practitioners

Type of support	n	%
Assistance with developing referral pathways	21	50%
Assistance with entering minimum dataset data	20	48%
Written resources (e.g. guidance, pamphlets)	17	40%
Professional development/training/workshops	13	31%
Options for stepping clients down or up to other services	11	26%
Clinical supervision	7	17%
Other	5	12%

Note: Percentages are based on the number of respondents that selected each support, divided by the total number of respondents that selected at least one support type (n = 42).

3.2.4 Challenges in delivering services under the initiative

When asked if they have encountered any specific challenges in delivering services to aged care residents under the initiative, 51 of the 63 respondents (81%) answered in the affirmative. For those that expanded on this response, the main challenges identified were associated with characteristics of their organisation and service model, RACFs and staff, and residents themselves. Several mental health practitioners reported that these difficulties were compounded by the impact of COVID-19.

At the organisational and service model level, practitioners experienced difficulties with a lack of flexibility. They felt trapped by 'guidelines that are rigid and do not take into account the individual', and they wanted greater freedom to tailor the number of sessions and the type and timing of assessments to residents' needs and abilities. Moreover, some respondents reported a 'morale-destroying' focus on numbers and throughput, and one felt that the administrative burden associated with PHN reporting reduces the time that they can dedicate to resident care. Some respondents noted challenges associated with referral pathways, such as the need for a GP referral, processes being 'clunky' and off-putting for RACF staff, and a service gap meaning that residents with more severe presentations have nowhere to be stepped up to.

In terms of RACF staff, a key barrier to service delivery for mental health practitioners was a lack of awareness of the initiative and gaps in knowledge of the mental health issues of the resident population. Due to high staff turnover and demanding workloads, respondents found it difficult to raise awareness of the initiative and provide staff with training to address the gaps in knowledge. One respondent also noted that time constraints are a barrier to RACF staff supporting recommended management strategies (e.g. behavioural activation). Respondents had also experienced challenges related to the RACF environment, such as the need to fit appointments in around the facility's schedule (e.g. shower and meal times) and visits from family or other health practitioners. Further, respondents identified that some RACFs lack an appropriate, confidential location for service delivery. One individual noted that face-to-face sessions must often be conducted in the resident's room, but that this may not be the resident's preference. Another respondent commented that telehealth appointments are conducted in more public spaces in RACFs that do not have telephone or internet access in resident rooms. During COVID-19, practitioners found restrictions on face-to-face visits and the transition to telehealth particularly challenging, noting that staff assistance is often required to set up technology and that telehealth appointments are more easily missed or forgotten than those conducted onsite.

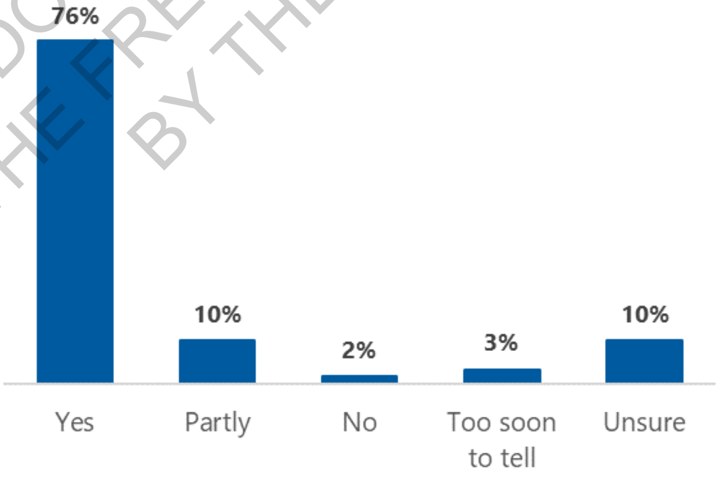
> The older population are so much more resilient than younger people and often tell me that I should not waste time with them as there must be other people who need my help more than they do. They are very selfless, so getting through that barrier takes time.
>
> *Social worker with mental health training*

In terms of resident characteristics, mental health practitioners suggested that aged care residents can be more hesitant than other populations to engage in mental health services, due to stigma about mental health specifically and a reluctance to accept help more generally. Further, residents' *ability* to effectively engage is often impeded by cognitive and physical decline. Respondents noted that residents with dementia experience difficulties understanding and retaining awareness of supports available under the initiative, and that mental health care can be hampered by many other obstacles – from hospitalisations for acute and episodic health issues, to sub-optimal management of chronic and relatively uncomplicated issues (e.g. hearing loss).

3.2.5 Perceived effectiveness of the initiative

Overall, mental health practitioners felt that the initiative has improved the mental health of aged care residents in their region (Figure 3-6). Only one respondent indicated otherwise, commenting that they have not yet received any referrals under the initiative.

Figure 3-6: Mental health practitioners' perceptions of whether the initiative has improved the mental health of aged care residents



Note: Percentages are based on the number of respondents that selected each option, divided by the total number of respondents for this question (n = 63).

Practitioners provided several suggestions for how the initiative could be better designed, promoted, or supported to address aged care residents' mental health needs. Several respondents identified a need for service models to incorporate a more holistic approach to care – for example, by expanding to include more narrative and reminiscence therapies, group sessions, and music, art and animal-assisted therapy. These aspects of service design were seen as important supplements to more traditional psychological services, with benefits including increased social connection and enhanced outcomes for residents.

Not surprisingly given the challenges noted above, practitioners frequently suggested that raising mental health literacy and awareness of available supports among RACF staff would be beneficial in increasing referrals and service uptake. Some respondents provided examples of how this could be achieved, such as requiring RACFs who wish to take part in the initiative to make their staff available for training, or to include information about the service and referral pathways as part of staff induction processes. One individual also suggested they would like to see staff training expanded to address topics such as grief and loss, and a more collaborative approach where mental health practitioners attend RACF clinical meetings.

Lastly, respondents felt that improving provision of psychological services within RACFs requires additional funding to enable more practitioners to visit RACFs more regularly and provide more sessions. Individual practitioners also noted a need for increased funding to:

- better support practitioners with access to relevant resources and paid clinical supervision
- support assistive technology to improve residents' ability to engage in telehealth
- support RACF staff, particularly lifestyle teams, to better manage residents' mental health needs
- address structural issues in the way that RACFs are designed and operate, which impact residents' mental health and the effectiveness of available supports (see challenges discussed in section 3.2.4).

3.3 Service provider managers

3.3.1 Commissioning and service delivery arrangements

One-quarter (n = 11; 23%) of the 47 service provider managers who completed the survey advised that they have been commissioned by more than one PHN to deliver services under the initiative, and just under three-quarters (n = 33; 70%) reported that they also receive PHN funding to deliver psychological services in other settings. As expected, most managers indicated that their organisation is commissioned to deliver low- to moderate-intensity services, while a handful indicated that they also offer acute and specialist services (Table 3-16).

Table 3-16: Levels of mental health care offered by service providers under the initiative

Level of care	Offered	Not offered	Unsure
Level 1: Self-management	55%	40%	4%
Level 2: Low-intensity services	89%	9%	2%
Level 3: Moderate-intensity services	94%	6%	0%
Level 4: High-intensity services	30%	62%	9%
Level 5: Acute and specialist mental health services	9%	87%	4%

Note: More than one response option could be selected. Percentages are based on the number of respondents that selected each response option for each level of care, divided by the total number of respondents that answered this question (n = 47).

Reach and throughput of services was highly varied, with respondents indicating that since first being commissioned under the initiative, their organisation has supported between 0 and 3,000 residents

(M = 488, SD = 706) from between 0 and 202 RACFs (M = 46, SD = 57). Four out of five (n = 79%) respondents indicated that their organisation engages multiple types of practitioners to deliver these services, with social workers with mental health training and psychologists being most common (Table 3-17).

Table 3-17: Types of practitioners engaged to deliver mental health services under the initiative

Type of practitioner	n	%
Social workers with mental health training	35	74%
Psychologists	33	70%
Mental health nurses	28	60%
Low-intensity mental health workers	15	32%
Occupational therapists with mental health training	5	11%
Psychosocial support workers	5	11%
Peer support workers	5	11%
GPs	4	9%
Psychiatrists	3	6%
Other medical specialists	3	6%
Aboriginal and/or Torres Strait Islander health/mental health workers	0	0%
Other	6	13%

Note: Respondents could select multiple options. Percentages are based on the number of respondents that selected each option, divided by the total number of respondents to this question (n = 47).

3.3.2 Support to implement the initiative

One in 10 service provider managers (n = 5; 11%) reported they have not received any support from their PHN to assist in the initiative's implementation. The remainder had received a range of supports, the most common being assistance with developing referral pathways and entering data into the Primary Mental Health Care Minimum Data Set (PMHC MDS) (Table 3-18).

Table 3-18: Supports provided by PHNs to service providers to assist with implementing the initiative

Support	n	%
Assistance with developing referral pathways	24	60%
Assistance with entering PMHC MDS data	24	60%
Written resources (e.g. guidance, pamphlets)	23	58%
Professional development/training/workshops	16	40%
Options for stepping clients up or down to other services	12	30%
Clinical supervision	2	5%
Other	7	18%

Note: Respondents could select multiple options. Percentages are based on the number of respondents that selected each support type, divided by the total number of respondents that selected at least one support type (n = 40).

We then asked managers about the support that their organisation has provided to the practitioners they engage to deliver services under the initiative. Almost all managers indicated that they assist with developing referral pathways and provide written resources such as pamphlets (Table 3-19), although a small number of respondents (n = 2; 4%) reported that they were not aware of any support available to practitioners engaged by their organisation.

Table 3-19: Supports provided by service provider organisations to assist mental health practitioners to deliver services under the initiative

Support	n	%
Assistance with developing referral pathways	40	93%
Written resources (e.g. guidance, pamphlets)	40	93%
Professional development/training/workshops	36	84%
Assistance with entering minimum dataset data	36	84%
Clinical supervision	35	81%
Options for stepping clients down or up to other services	30	70%
Other	8	19%

Note: Respondents could select multiple options. Percentages are based on the number of respondents that selected each support type, divided by the total number of respondents that selected at least one support type (n = 43).

Strategies to raise awareness of services and encourage referrals

Nine out of ten (n = 37; 93%) managers advised that their organisation raised awareness of available supports among RACF staff and residents via a multifaceted approach, with written communication from the service provider being more common than activities led by the PHN (Table 3-20). Only 2 respondents indicated that they were not aware of any strategies in place to raise RACF awareness of the initiative.

Table 3-20: Strategies to raise awareness of available supports among RACF staff and residents

Awareness-raising strategy	n	%
Written communication to RACFs from the service provider	37	88%
Information sessions or in-services run by the service provider	36	86%
Promotion on the service provider's website	29	69%
Written communication to RACFs from the PHN	19	45%
Promotion on the PHN's website	18	43%
Information sessions or in-services run by the PHN	13	31%
Other	5	17%

Note: Respondents could select multiple options. Percentages are based on the number of respondents that selected each strategy, divided by the total number of respondents that selected at least one strategy (n = 42).

Managers also indicated that their organisation used multiple strategies to encourage referrals to the service from GPs and others, with written communication from the service provider to RACFs again being the most common strategy (Table 3-21). Four respondents (9%) could not identify any activities that their organisation or PHN used to encourage referrals.

Table 3-21: Strategies to encourage GPs and others to refer to initiative-funded services

Strategy to encourage referrals	n	%
Written communication to RACFs from the service provider	34	85%
Information sessions or in-services run by the service provider	31	78%
Promotion on the service provider's website	28	70%
Promotion on the PHN's website	23	58%
Written communication to GPs from the service provider	22	55%
Written communication to RACFs from the PHN	18	45%
Written communication to GPs from the PHN	17	43%
Information sessions or in-services run by the PHN	16	40%
Other	4	8%

Note: Respondents could select multiple options. Percentages are based on the number of respondents that selected each strategy, divided by the total number of respondents that selected at least one strategy (n = 40).

3.3.3 Challenges in delivering services under the initiative

Just under two-thirds (63%) of respondents indicated that adapting their organisation's model of service delivery for residential aged care was a challenge. These managers identified several similar issues to those raised by mental health practitioners, including:

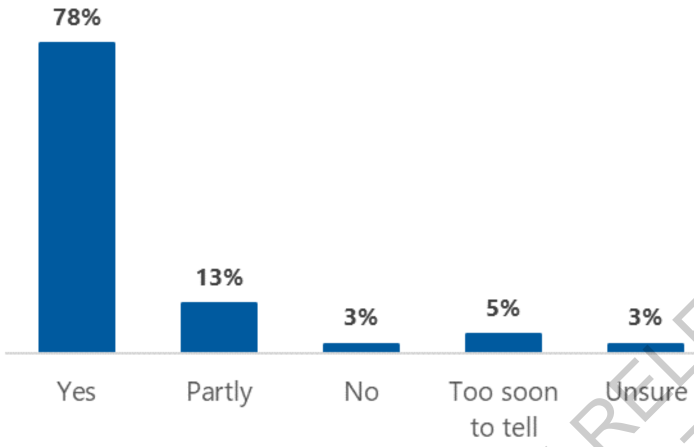
- the impact of RACF structure, staff workload, and staff turnover on staff members' ability to participate in capacity-building sessions, facilitate telehealth appointments, and support residents to implement self-management strategies. One respondent noted that the time required to collaborate with RACF staff to ensure that residents are well supported has been a factor that they had not initially considered
- scheduled appointments being disrupted by hospital admissions, impromptu family visits, and personal care
- the stigma associated with mental health in the older population and their declining physical and cognitive abilities, which present additional considerations for consent processes and power imbalances, and increase the time required to build rapport
- uncertainty over how to select and administer outcome measures that are suitable for the resident population. Respondents considered the K10 to be too long and confusing for older people, but these respondents were also unsure of an appropriate alternative.

In addition, managers discussed several challenges not reported by mental health practitioners – most notably, a shortage of these practitioners, an unsustainable funding structure, and the geographic distance between RACFs and the associated travel burden. One respondent also reflected that the stepped care model is new to RACFs and is not well suited to this setting, but this manager did not elaborate on why this may be the case.

3.3.4 Perceived effectiveness of the initiative

As with health professionals and mental health practitioners, the majority of service managers felt that the initiative has improved the mental health of aged care residents in their region (Figure 3-7). Four of the 5 individuals who believed that this objective has only partly been met explained why this is the case. They reiterated the challenges associated with limited RACF time to facilitate referrals and support residents to implement self-management strategies, COVID-19 lockdowns limiting RACF access, and competing demands on RACFs in the wake of the royal commission. One manager also reflected that the initiative has only been partly effective due to stigma-related barriers to engaging residents; however, this manager noted that these issues are resolving after the program name was changed to relate to 'wellbeing' rather than mental health.

Figure 3-7: Service provider managers' perceptions of whether the initiative has improved the mental health of aged care residents



Note: Percentages are based on the number of respondents that selected each option, divided by the total number of respondents for this question (n = 40).

Finally, as well as calling for guidance on appropriate outcome measures (echoing their identification of current measures as a significant challenge to date), managers resoundingly called for increased and ongoing funding to improve the initiative and better support aged care residents' mental health. Like mental health practitioners, they identified that expanded funding would allow their organisation to engage with more RACFs and more residents and to provide a more holistic suite of support options (including formal psychological services and complementary approaches such as befriending and music and animal therapies). Further, a small number of respondents suggested that ensuring RACFs are adequately resourced is key to enhancing the initiative's impact. As one individual commented, 'We just need to ensure that there are no gaps in mental health services to RACFs. They have incredibly difficult jobs and need to be supported as much as possible, so that the residents are supported.'

4 Resident survey results

Between 11 and 21 November 2021, we received a total of 162 resident survey responses. Of these, we excluded 41 (25%) from the analysis due to insufficient data (defined as less than 50% of questions completed), leaving a final sample of 121 surveys. Most of these surveys were completed in full, as shown in Table 4-1.

Table 4-1: Proportion of surveys completed by respondents included in analysis

Proportion of survey completed	n	%
50% to 74%	4	3%
75% to 99%	9	7%
100%	108	89%
Total	**121**	**100%**

We calculated descriptive statistics for each multiple-choice question and used thematic analysis for open-ended questions. Within the completed surveys, the number of respondents per question varied due to: skip logic (i.e. a question being displayed to only a subgroup of respondents, based on their answers to previous questions); respondents choosing not to answer a particular question; or respondents leaving the survey early. We analysed each question independently, irrespective of response patterns to the survey overall, to ensure that no information was lost. As such, the denominator for analysis varies in the analyses presented below.

4.1 Respondent characteristics

Although the survey was targeted at RACF residents, we provided options for residents to be supported to complete it, due to the particular needs and preferences of this population. Around one-quarter of surveys (n = 29; 27%) were completed by the resident alone, while half (n = 56; 51%) were completed by the resident with assistance. Less often, the survey was completed by a supporter on the resident's behalf (n = 14; 13%) or an 'other' respondent type (n = 9; 8%). Where respondents selected the 'other' category, they either declined to provide further information or indicated their relationship to the resident, implying that the survey was completed with assistance or on the resident's behalf without specifying which of these was the case. As shown in Table 4-2, RACF staff members were the most likely to have either lent assistance or completed the survey on the resident's behalf (n = 34; 45%), followed by mental health care providers (n = 31; 41%). The latter included both mental health practitioners and other representatives of the service provider organisation (specifically, a stakeholder engagement coordinator).

Table 4-2: Types of supporters who assisted residents to complete the survey or filled it out on their behalf

Supporter type	**n**	**%**
RACF staff member	34	45%
Mental health care provider	31	41%
Family or friend	5	7%
GP or other health professional	1	1%
Other	5	7%
Total	**76**	**100%**

Note: Respondents who chose not to provide information on who completed the survey, and those who indicated they were an aged care resident who completed the survey alone, were excluded from this analysis. 'Other' supporter types included volunteer and guardian (no further details were provided for either).

We did not identify any systematic differences between responses submitted by residents alone and responses submitted with support. We have therefore collated the information from all participants in the results that follow.

In terms of geographic distribution, we received survey responses from 12 of the 31 PHN regions, located in 5 of Australia's 8 states and territories. PHN 27 had the highest number of responses, accounting for one-quarter of completed surveys overall (Table 4-3).

Table 4-3: Resident surveys received, by deidentified PHN region

PHN region	**n**	**%**
PHN 27	27	24%
PHN 9	23	21%
PHN 24	17	15%
PHN 6	16	14%
PHN 2	7	6%
PHN 17	5	4%
PHN 20	4	4%
PHN 29	3	3%
PHN 7	3	3%
PHN 23	3	3%
PHN 4	3	3%
PHN 8	1	1%
Total	**112**	**100%**

Note: Residents were asked to provide their postcode, which we mapped to PHNs using the department's concordance table: https://www.health.gov.au/resources/publications/primary-health-networks-phn-concordance-files-postal-areas-2017 (accessed 22 November 2021). Residents who did not provide their postcode (n = 9) were excluded from this analysis.

All survey respondents identified as either male (n = 42; 35%) or female (n = 79; 65%), although they also had the option to disclose a different gender identity or decline to answer. Just over half of respondents (n = 62; 51%) identified as being a member of one or more of the special needs groups defined in the Aged Care Act 1997 and/or My Aged Care system.7 These respondents identified as members of between one (n = 42; 68%) and 4 (n = 2; 3%) special needs groups, most commonly indicating that they have a disability, come from a CALD background, or are financially disadvantaged (Table 4-4). In subsequent analyses, we considered differences in response patterns between these 3 special needs groups, between residents identifying as a member of any special needs group and not, and between men and women. For brevity, in the sections that follow we report the results of these analyses only where differences between subgroups were observed. Note that small numbers mean that these findings should be interpreted with caution.

Table 4-4: Residents' self-reported membership of aged care special needs groups

Special needs group	n	%
Has a disability	35	56%
Comes from a CALD background	19	31%
Is financially disadvantaged	16	26%
Lives in a rural or remote area	8	13%
Is a veteran, war widow or war widower	8	13%
Is Aboriginal and/or Torres Strait Islander	2	3%
Is lesbian, gay, bisexual, trans, intersex, or another diverse sexual orientation or gender identity	1	2%
Is homeless or facing homelessness	1	2%
Is a Care Leaver, including a Forgotten Australian, Former Child Migrant, or member of the Stolen Generations	0	0%
Has been affected by forced adoption or removal	0	0%
Any special needs group	**62**	**51%**

Note: Respondents could select more than one group. Percentages are based on the number of respondents that selected each option, divided by the total number of respondents who selected at least one group (n = 62).

4.2 Awareness of available mental health support

Because of the regional differences in branding, we were unable to assess residents' awareness of the initiative specifically. Instead, we asked if they were aware, prior to the survey, of a program to provide mental health care to aged care residents. Over half of the survey respondents indicated that they were aware of such a program (n = 69; 57%), with awareness slightly higher among women (n = 48; 61%) than men (n = 21; 50%). Additionally, people who identified as a member of at least one special needs group were more likely to report awareness of a mental health program (n = 28; 45%) than those who reported no special needs group affiliation (n = 41; 69%). There were also variations in awareness among specific special needs groups; those who identified as coming from a CALD background were more likely to be aware of available mental health care than those who are financially disadvantaged or have a disability (Figure 4-1).

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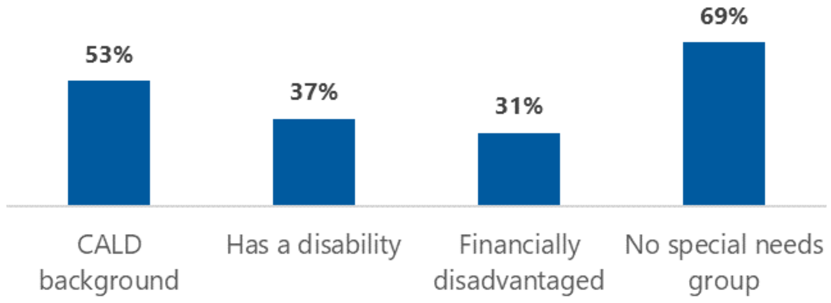
[7] Older people with disabilities are not specified as a special needs group in legislation, but are considered as such within the My Aged Care system and so are included here. One-third (n=41; 34%) of respondents did not identify with any special needs groups, 9 (7%) were unsure, and 9 (7%) preferred not to say.

Figure 4-1: Proportion of residents who are aware of a program for mental health care, by special needs group



Note: Percentages are based on the proportion of people within each group who responded to this question. CALD background, n = 19; has a disability, n = 35; financially disadvantaged, n = 16; no special needs group, n = 59.

We were also interested in how residents find out that mental health care is available within their RACF. As shown in Table 4-5, RACF staff play by far the most important role in raising awareness, with doctors and other health professionals a distant second. Eight residents indicated that they learned of their options for mental health care through some other source; the most common of these 'Other' responses was via a visit to the RACF from the PHN's commissioned provider.

Table 4-5: How residents found out about the options for mental health care at their RACF

Response	n	%
Told by a member of RACF staff	59	56%
Told by doctor or other health professional	19	18%
Information around the RACF (e.g. posters, newsletters)	12	11%
Told by a family member or friend	8	7%
Told by another resident	3	3%
Information in the media or online	2	2%
N/A, not aware of mental health care at the RACF	6	6%
Unsure	8	7%
Other	12	1%
Prefer not to say	1	1%

Note: More than one response option could be selected. Percentages are based on the number of respondents that selected each option, divided by the total number of respondents for this question (n = 106).

4.3 Experiences of mental health care in RACFs

Just over two-thirds of residents indicated that they have received mental health care since moving into their current RACF (n = 82; 68%). Mental health care was slightly more common among residents who identified with at least one special needs group than those who did not (73% vs 63%), with this difference driven by higher rates of care among residents reporting financial disadvantage (88%) or a disability (83%). The majority of respondents had most recently received mental health care in 2021 (Table 4-6) and, consistent with the initiative's gradual rollout, this most recent episode was also the only time that most (n = 54; 66%) had accessed mental health support since moving into residential care.

Table 4-6: Year that respondents most recently received mental health care

Response	n	%
2021	72	88%
2020	6	7%
2019	2	2%
2018 or earlier	1	1%
Unsure	0	0%
Prefer not to say	1	1%
Total	**82**	**100%**

Note: Respondents who had not received mental health care, or were unsure if they had, were excluded from this analysis (n = 39).

For the reasons noted in section 4.2, we could not ask residents specifically about their experiences of mental health care under the initiative. However, to gauge whether their feedback was likely to relate to PHN-funded support, we invited residents to provide the name of their service provider. Over half of the respondents who had received mental health care remembered which organisation their mental health practitioner was from (n = 44; 55%), and all but one of those who expanded on their response specified service providers that are commissioned to deliver services under the initiative. Consistent with residents from PHN 27 representing the largest proportion of respondents, the program delivered in this region was the most commonly named (n = 12). A service provider operating in PHNs 20 and 24 (among other PHNs not represented in the survey data) was the second-most frequently mentioned, with 10 residents recalling that their mental health practitioner came from this organisation.

4.3.1 Help-seeking and referrals

When asked why they sought help for their mental health, more than half of residents indicated that they did so because a staff member at their RACF suggested it, while a little over one-third reported that they were not coping with day-to-day life (Table 4-7). Note that these options are not mutually exclusive, and residents could report that multiple factors influenced their decision to seek help. Of the residents who selected ‘other’ and elaborated on their response, some suggested they were unsure about their reasons for accessing mental health care while others hinted at ongoing mental health issues or previous engagement with mental health care, or mentioned physical injuries impacting mental health. One resident indicated that they had not chosen to seek help but had been referred by a staff member without being consulted.

Table 4-7: Residents' main reason for seeking help with mental health

Reason for seeking mental health care	n	%
Staff at the aged care home suggested it	46	57%
I felt I was not coping with day-to-day life	29	36%
I experienced something that was very upsetting	23	28%
My symptoms were getting worse	19	23%
I felt I needed professional help	19	23%
A GP or other doctor suggested it	14	17%
A friend or family member suggested it	8	9%
Other	8	12%

Note: Respondents could select more than one option. Percentages are based on the number of respondents that selected each option, divided by the total number of respondents for this question (n = 81).

Consistent with their role in raising awareness of available mental health supports and suggesting to residents that they access them, RACF staff appeared to play a critical role in subsequently initiating referrals. They represented by far the most common referral source (Table 4-8), although it is worth noting that this may also be a function of the lack of visibility of the referral process to residents and the frequency of their interactions with RACF staff compared to GPs.

Table 4-8: Source of referral for mental health care

Referrer	n	%
RACF staff	56	68%
GP	6	7%
Another health professional	5	6%
Self	4	5%
Family member or friend	4	5%
Other	4	5%
I prefer not to say	2	2%
Unsure	1	1%
Total	**82**	**100%**

4.3.2 Satisfaction with information provided

Only half of residents felt that they were provided with all the information they needed about what to expect from their referral to a mental health practitioner (Table 4-9). This information was provided by their mental health care practitioner, RACF staff, or both. Moreover, other residents indicated that RACF staff were not able to provide much detail about the service, and one resident had asked their GP and been left with unanswered questions. Where residents expanded on what specifically they would have liked to know more about, they suggested a need for further information about how the service could help them and how much time it would take. There was one respondent who indicated that the service 'came as a knock on the door', suggesting they had either been provided with no information about what to expect, or that the information was presented in a way that was not meaningful or memorable.

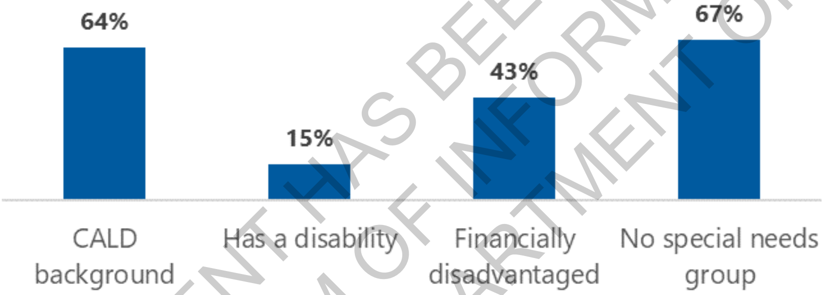
Table 4-9: Resident perspectives of the adequacy of information given upon referral to mental health care

Response	n	%
Yes, I was provided with all the information I needed	39	49%
I was given some information, but it didn't answer all my questions	18	23%
I didn't get any information about what to expect from the referral	11	14%
Unsure	11	14%
Total	**79**	**100%**

Residents who did not identify as a member of any of the special needs groups were more likely to feel satisfied with the information they received (n = 24; 67%) than their counterparts who belonged to at least one of these groups (n = 15; 35%) (Figure 4-2). Of particular concern, only 15% (n = 4) of those with a self-reported disability indicated that they were provided with all the information they needed about what to expect from their mental health referral. In contrast, residents from a CALD background were almost as likely to be satisfied with the information they received as residents with no special needs group membership. An important caveat here, however, is the impact of cultural differences on willingness to express dissatisfaction with health or other care.

Figure 4-2: Proportion of residents satisfied with the information they received about what to expect from their referral to mental health care, by special needs group

Figure 4.1 is bar chart showing the percentages



Note: Percentages are based on the proportion of people within each group who responded to this question. CALD background, n = 11; has a disability, n = 27; financially disadvantaged, n = 14; no special needs group, n = 36.

Respondents appeared to be generally satisfied with the way that their mental health practitioner explained their practitioner role when they first met, with close to 80% reporting that the practitioner had done so 'very' or 'somewhat' well (Table 4-10). Among the respondents in special needs groups, residents from a CALD background were more likely to be satisfied with how their mental health practitioner explained their practitioner role (n = 9; 91%), while those with a disability were, again, generally less positive about the information they received (n = 19; 64%). Residents with a disability did not provide any explanation as to why this may be the case.

Table 4-10: Resident perspectives of how well mental health practitioners explained their practitioner role

Response	n	%
Very well	47	59%
Somewhat well	16	20%
Moderately well	4	5%
Slightly well	3	4%
Not well at all	1	1%
Unsure	9	11%
Total	**80**	**100%**

4.3.3 Service characteristics

About half of residents who had received mental health care waited between one week and one month for their first session after being referred to the service (Table 4-11). Many were unsure of the wait time, perhaps reflecting, as noted in section 4.3.1, a lack of visibility of and information about the referral process. Compared to females, males were more likely to report that their first session was less than a week after referral, but males were also more likely to be unsure about how long they waited for services to commence. Residents who indicated an 'other' wait time suggested that they experienced delays in service commencement not attributable to the service itself, such as COVID-19 lockdowns and their own health problems.

Table 4-11: Resident-reported time from referral to first session of mental health care

Response	Female	Male	Total
Less than one week	17%	25%	20%
Between one week and one month	59%	29%	49%
More than one month	2%	0%	1%
Other	2%	11%	5%
Unsure	20%	32%	24%
I prefer not to say	0%	4%	1%
Total number of respondents	**54**	**28**	**82**

The majority of respondents felt that their wait time was about right (n = 47; 59%) with only 4 people (5%) thinking that it was too long and one person considering it to be too short (the remainder were unsure; n = 27; 34%). Interestingly, among residents in special needs groups, the proportion of residents who felt that they waited too long for their first session was higher among those living in rural or remote areas (n = 2; 25%).

For most respondents, mental health care entailed individual, face-to-face support delivered at their RACF (Table 4-12). The 12% of respondents who received telehealth support typically did so in addition to, rather than instead of, face-to-face sessions. Some of the 'other' responses included speaking to staff and family, and receiving telephone follow-ups to previous services.

Table 4-12: Resident reports of the type of mental health care received

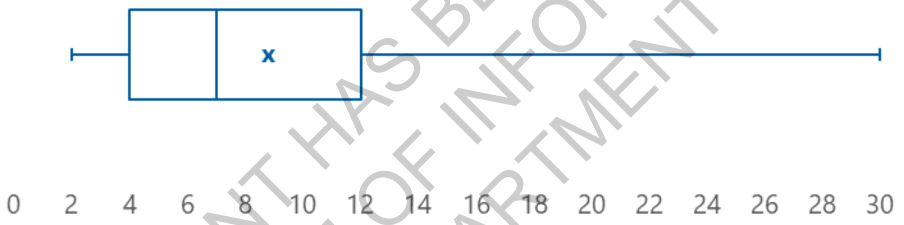
Type of mental health care	n	%
Individual support, face-to-face onsite at the RACF	77	94%

Type of mental health care	n	%
Group support	6	9%
Individual support, over the telephone	6	7%
Individual support, over video	3	4%
Individual support, face-to-face offsite	1	1%
Self-help via an online program or app	1	1%
Other	4	5%
I prefer not to say	1	1%

Note: Respondents could select more than one option. Percentages are based on the number of respondents that selected each option, divided by the total number of respondents for this question (n = 82).

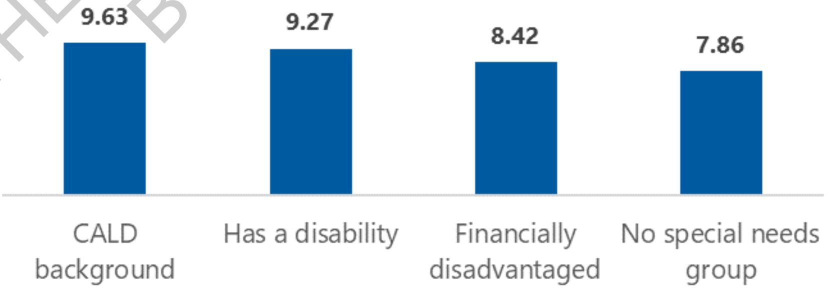
At the time of the survey, residents had met with their mental health practitioner 8.8 times on average, with the majority having participated in between 2 and 12 sessions (Figure 4-3). Six residents (7%) had seen their mental health practitioner for more than 20 sessions. It is important to note that residents may have still been receiving mental health care at the time of the survey, so these figures could underestimate the total number of sessions delivered once all current episodes of care have concluded.

Figure 4-3: Distribution of number of sessions with a mental health practitioner, as reported by residents



Residents who identified as being a member of one or more special needs groups reported more sessions with a mental health care practitioner on average (M = 9.58) compared to those who did not identify as a member of any of these groups (M = 7.86). Looking at common special needs groups, the reported number of sessions on average was highest among residents from a CALD background and lowest among those who reported being financially disadvantaged (Figure 4-3).

Figure 4-4: Mean number of sessions with a mental health practitioner, by special needs group



Note: Means are based on data provided by those within each group who responded to this question. CALD background, n = 8; has a disability, n = 22; financially disadvantaged, n = 12; no special needs group, n = 29.

4.3.4 Service impacts and opportunities for improvement

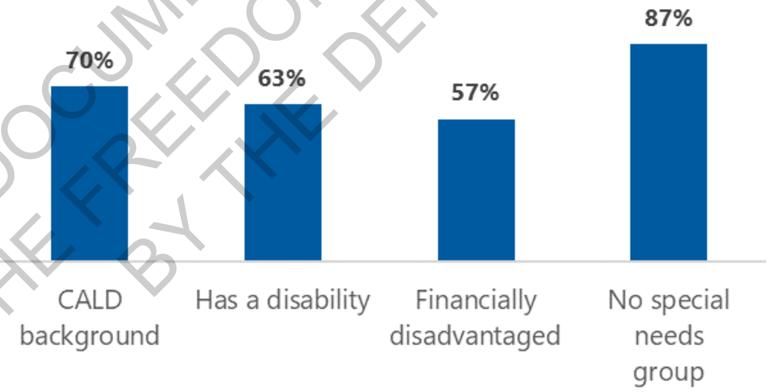
Overall, services delivered under the initiative appear to have had a positive impact on the residents' overall wellbeing, with 78% (n = 61) reporting that they felt 'better' or 'much better' after receiving mental health care (Table 4-13). Reassuringly, there were no respondents who reported feeling 'worse' or 'much worse'.

Table 4-13: Residents' self-rated impact of mental health care on their overall wellbeing

Impact of mental health care	n	%
Much better	35	45%
Better	26	33%
About the same	10	13%
Worse	0	0%
Much worse	0	0%
Unsure	4	5%
I prefer not to say	3	4%
Total	**78**	**100%**

Residents who identified as a member of at least one special needs group were less likely (71%; n = 30) to report that their wellbeing was 'better' or 'much better' as a result of the mental health care they received, as compared to those who did not identify as a member of any special needs groups (86%; n = 31). Residents who identified as being financially disadvantaged were least likely to report a positive outcome after receiving mental health care (Figure 4-5), although it is worth noting that they also did not feel that their wellbeing had deteriorated (recall that no residents reported worse mental health, as shown in Table 4-13).

Figure 4-5: Percentage of residents who felt 'better' or 'much better' after receiving mental health care, by special needs group



Note: Percentages are based on the proportion of people within each group who responded to this question. CALD background, n = 10; has a disability, n = 27; financially disadvantaged, n = 14; no special needs group, n = 36.

We also asked whether residents felt that the service they received was appropriate for their needs, with particular reference to their status as a member of special needs groups, if applicable. Ninety percent of residents indicated that the service met their needs (Table 4-14); this proportion was consistent across the subgroups of residents who identified and did not identify as belonging to any special needs groups.

Table 4-14: Resident reports of whether the mental health care they received was appropriate for their needs

Response	n	%
Yes	74	90%
No	1	1%
Unsure	4	5%
Prefer not to say	3	4%
Total	**82**	**100%**

Residents were able to elaborate on why they felt the service was appropriate to their needs. A key theme was that the service was culturally appropriate. For example, one resident indicated that they were able to reflect on their cultural background which made them feel comfortable to talk freely; another resident appreciated their service provider helping them to contact family overseas and changing the language settings on their web browser to help them understand things they were looking for online. Respondents also reflected on other characteristics of the service – for example, the service being provided directly to them in their RACF while giving them someone to talk to who was external to the RACF. Other respondents gave examples of the positive impacts that the service had as evidence of it meeting their needs; for example, that it had helped to provide comfort and support, strategies to overcome problems with sleep and nerves, and assistance to process grief. However, some respondents felt that their problems had not been adequately addressed by the care they had received, and they would have liked more regular support.

Unsurprisingly given the improvements in residents' wellbeing and their perceived appropriateness of services, residents reported high levels of satisfaction with the mental health care they received (Table 4-15).

Table 4-15: Residents' level of satisfaction with mental health care

Level of satisfaction	n	%
Very satisfied	45	58%
Satisfied	27	35%
Neither satisfied nor dissatisfied	4	5%
Unsatisfied	0	0%
Very unsatisfied	0	0%
Unsure	0	0%
I prefer not to say	2	3%
Total	**78**	**100%**

When asked to reflect on what was good about the experience of receiving mental health care in their RACF, residents commented along some similar lines as above: they liked having someone independent to talk to and the convenience of someone coming to their RACF. In addition, some residents reflected that they enjoyed the group sessions, appreciated that they were able to access confidential support, and liked the fact that the service was free.

The main feedback from residents on how the service could be improved was simply that there should be more of these services available, offering a higher number of sessions, longer session times, and more face-to-face sessions. One person commented that there should be fewer questionnaires and 2 residents suggested that having a mental health care provider based onsite would be helpful.

4.4 What are the reasons that residents do not access mental health care?

Thirty residents (30%) reported that they had not received mental health care since moving to their current RACF. Acknowledging that there may be many reasons for this, we asked residents what the primary influences were for them. Encouragingly, no residents reported that they were actively discouraged from seeking help or made to feel unwelcome when they did.

Instead, residents most commonly indicated that they did not seek help because they were not concerned about their mental or emotional wellbeing (Table 4-16), providing some reassurance that services are generally being accessed appropriately and in response to identified need. Supporting this theory, 2 residents explained that they get the support they need from RACF staff or friends and families; for these residents, additional formal supports were perceived to be unnecessary. However, just over one-third of respondents suggested that they prefer to manage mental or emotional issues on their own, and another indicated that they do not like to talk to strangers about personal matters, suggesting a potential barrier to care associated with stigma.

Table 4-16: Residents' reasons for not accessing mental health care

Response	n	%
I haven't had any concerns about my mental or emotional wellbeing	20	61%
I prefer to manage these things on my own	12	36%
I didn't think it was appropriate for me	8	24%
I didn't know that it was available	6	18%
I didn't think it would help	6	18%
My physical health problems were a higher priority	6	18%
I was too embarrassed	3	9%
I was worried about the cost	3	9%
I don't know	3	9%
I was too nervous or afraid	1	3%
I don't have the technology (e.g. a mobile phone or computer) to access the mental health care that was available/recommended to me	1	3%
I'm not confident using technology to access the mental health care that was available/recommended to me	1	3%
Other	1	3%
Someone told me not to	0	0%
I tried to access mental health care but didn't feel welcome	0	0%
I didn't think I would be able to access support in my language	0	0%

Note: Residents could select more than one option. Percentages are based on the number of respondents that selected each option, divided by the total number of respondents for this question (n = 33).

We invited residents who had not received mental health care to provide general feedback on the way that mental health is supported in their RACF. Those that commented indicated that they liked the fact that:

- support is available to everyone and residents are able to ask for help when required
- staff are supportive and invested in helping residents to feel well

- residents have access to activities such as social groups and gardening within the RACF
- their RACF offers external programs to help with mental health concerns.

Two residents commented that there are no changes needed to improve the way that mental health is supported in their RACF, while others suggested variations on a theme in calling for ‘more’: more awareness of the help available, more opportunities for regular support (suggestions included more frequent visits from external services and access to a dedicated mental health practitioner onsite), more time for care staff to talk to residents, and more activities and outings.

> People should not be ashamed to talk about things like that and should be made aware that help is available and that people are there to help them.

5 Selected results from analysis of PMHC MDS data

We received the PMHC MDS data extract on 4 November 2021. The data extract comprised 9 separate files. This included data for all individuals who have received PHN-commissioned mental health care and consented to their anonymised data being released – a total of 352,778 people who received approximately 3.3 million service contacts.

The PMHC MDS includes data on:

- client characteristics: date of birth, gender, Aboriginal and/or Torres Strait Islander status, English language proficiency, principal diagnosis
- practitioner characteristics: profession, gender, Aboriginal and/or Torres Strait Islander status, completion of Aboriginal and Torres Strait Islander cultural competency training
- services delivered: contact date, duration, modality, participants, postcode, venue (for face-to-face services), whether or not an interpreter was used
- clinical outcomes: collection timepoint (i.e. beginning, middle, or end of an episode of care), score on the 10-item (K10; Kessler et al. 2002) or 5-item (K5; Australian Institute of Health and Welfare 2009) Kessler psychological distress scale.

As the PMHC MDS contains no specific indicator of initiative-funded services, in order to identify services most likely to have been funded by the initiative we filtered for those delivered:

- in residential aged care
- since July 2018
- to people aged 65 or older (or 50 years for people of Aboriginal and/or Torres Strait Islander origin).

The resulting dataset relates to 11,850 clients (8,623 unique individuals) who received approximately 70,000 service contacts over 10,551 episodes of care. We also retained the remaining data to explore differences between the initiative and other services, including those delivered in RACFs before and after the initiative's introduction.

We conducted preliminary analysis and cleaning to check for invalid responses and ensure missing data were recognised and handled appropriately (e.g. K10 scores fall between 10 and 50 inclusive and scores of 99 are recognised as missing values and ignored). We then explored client, referral, practitioner, and service characteristics, and the impact of services on clients' psychological distress. We also conducted a blunt costing analysis, drawing on funding information provided by the department. All analyses were conducted overall and by financial year (FY). Selected results of these analyses are presented below; please note that we submitted more comprehensive findings to the department in the form of an interactive online dashboard, as per the schedule of deliverables for this evaluation.

5.1 Client characteristics

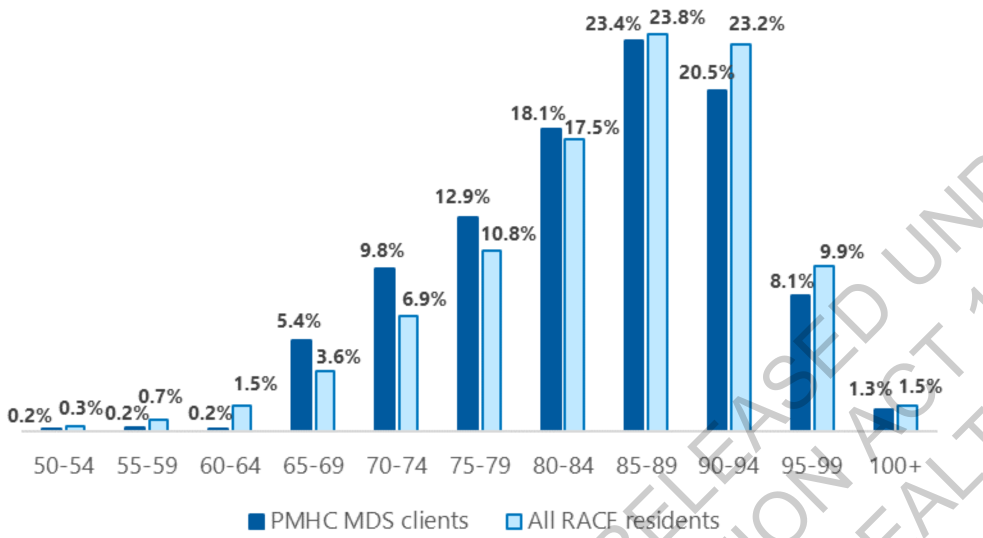
The initiative's introduction saw a marked increase in the number of clients seen in RACFs, from a total of 78 across all PHNs in FY 17–18 to 1,005 in FY 18–19. Client numbers have continued to climb with each year of the initiative's operation, with an average annual growth of 491% (Table 5-1). Four PHNs, however, have recorded a decrease in the number of clients receiving services in RACFs.

Table 5-1: Number of clients seen in RACFs, by financial year and by percentage growth over time

PHN region	FY 18–19	FY 19–20	FY 20–21	% growth
PHN 6	0	2	73	n/a
PHN 17	2	100	320	15,900%
PHN 27	1	1	71	7,000%
PHN 1	4	95	240	5,900%
PHN 16	3	63	144	4,700%
PHN 13	2	47	72	3,500%
PHN 29	9	70	283	3,044%
PHN 28	3	37	63	2,000%
PHN 5	19	135	370	1,847%
PHN 22	4	4	65	1,525%
PHN 21	8	119	127	1,488%
PHN 20	41	317	647	1,478%
PHN 11	18	99	267	1,383%
PHN 8	60	417	687	1,045%
PHN 25	1		11	1,000%
PHN 19	1	2	11	1,000%
PHN 3	5	3	47	840%
PHN 30	21	64	174	729%
PHN 23	7	12	57	714%
PHN 24	67	291	498	643%
PHN 7	10	4	64	540%
PHN 2	17	29	107	529%
PHN 15	61	101	269	341%
PHN 12	243	525	588	142%
PHN 9	131	202	264	102%
PHN 10	14	17	28	100%
PHN 18	182	337	359	97%
PHN 14	22	19	20	-9%
PHN 31	17	34	15	-12%
PHN 4	23	11	3	-87%
PHN 26	9	22	0	-100%
Total	**1,005**	**3,179**	**5,944**	**491%**

Clients' mean age at the time of their most recent service contact was 84.8 years. The age distribution of people receiving psychological services in RACFs is generally similar to the resident population at large, although clients are slightly more likely to be aged between 65 and 84 and less likely to be aged 90 or more (Figure 5-1). The filters we applied to the data mean that the small number of clients aged between 50 and 64 are of Aboriginal and/or Torres Strait Islander origin; however the broader population of RACF residents in this age group may include some individuals who do not identify as Aboriginal and/or Torres Strait Islander.

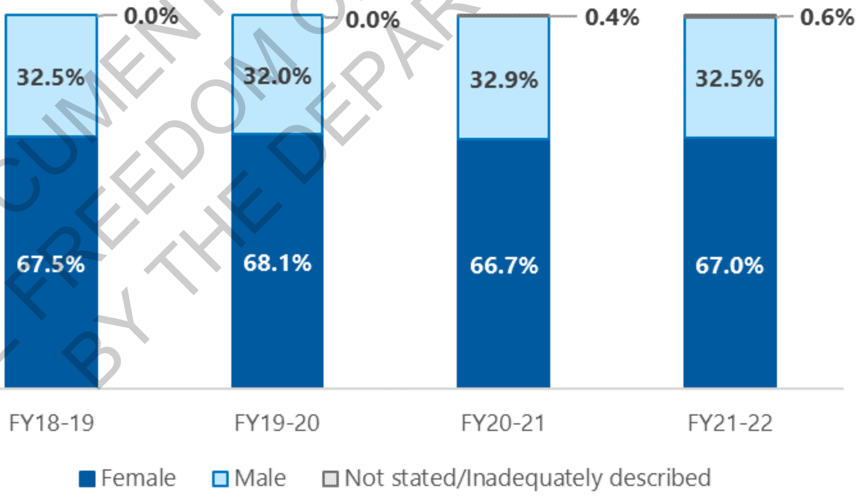
Figure 5-1:Age distribution of clients receiving psychological services in RACFs



Note: The age distribution of RACF residents reflects the population as of 30 June 2020 and is sourced from GEN aged care data (Australian Institute of Health and Welfare 2021).

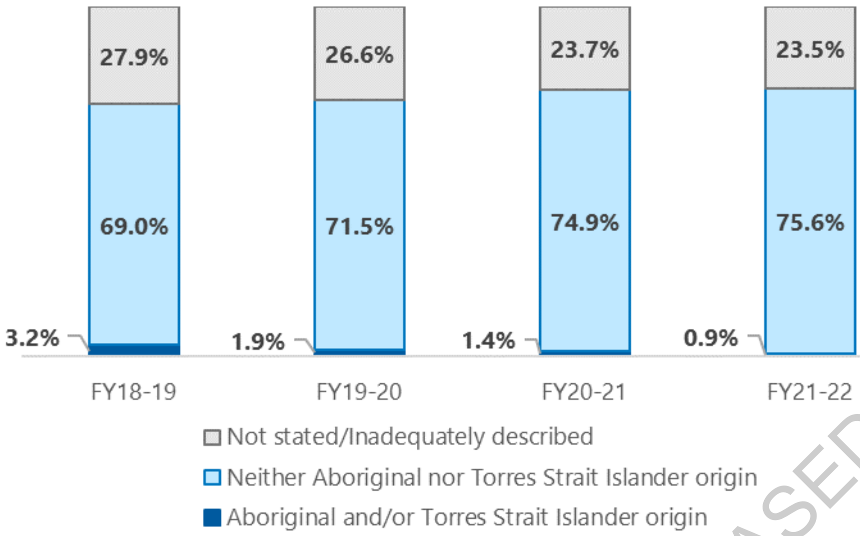
As shown in Figure 5-2, women consistently account for around two-thirds of people receiving mental health care in RACFs. This aligns with the gender profile of the residential aged care population, where women also have a two-thirds majority (Australian Institute of Health and Welfare 2021). No aged care clients have been recorded under the 'other' gender category since the initiative was introduced.

Figure 5-2: Client gender, by financial year



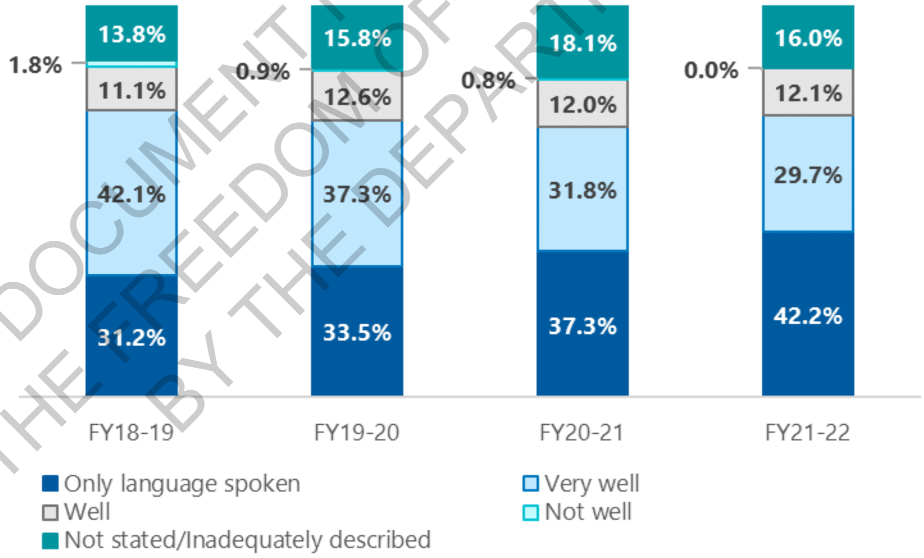
Aboriginal and/or Torres Strait Islander Australians accounted for 1% of aged care residents overall in FY 18–19 (the most recent year for which data are available; Department of Health 2019) and there is no reason to suspect this figure is markedly different in 2022. However, the proportion of people of Aboriginal and/or Torres Strait Islander origin receiving PHN-funded mental health services in residential aged care has decreased since the initiative's introduction (Figure 5-3).

Figure 5-3: Client Indigenous status, by financial year



Although English is not the preferred language for 9% of aged care residents overall (Australian Institute of Health and Welfare 2021), few PMHC MDS clients reported that they are unable to speak English well (Figure 5-4). While this may suggest that residents from CALD backgrounds are underrepresented among people accessing mental health care, it is important to note that *preferring* to speak a language other than English does not necessarily equate to a lack of English language proficiency. Further, the ability to speak English was not stated or inadequately described for between 13% and 18% of PMHC MDS clients. It is possible that many non-English speakers are being recorded here, in which case this group might account for a larger proportion of mental health clients than it appears.

Figure 5-4: Client self-reported ability to speak English, by financial year



Depressive, mixed anxiety and depressive, and anxiety symptoms are the most common primary presentations among aged care residents (Table 5-2), accounting for two-thirds of diagnoses at the beginning of an episode of care. Diagnostic information was missing for one in fourteen clients.

Table 5-2: Ten most common principal diagnoses at service commencement

Principal diagnosis	n	%
Depressive symptoms	756	27.0%
Mixed anxiety and depressive symptoms	632	22.6%
Anxiety symptoms	365	13.1%
Other	221	7.9%
Adjustment disorder	219	7.8%
Missing	202	7.2%
Stress-related	153	5.5%
Major depressive disorder	120	4.3%
Generalised anxiety disorder	101	3.6%
Depressive disorder not otherwise specified	83	3.0%
Total	**2,796**	**100.0%**

5.2 Referral characteristics

Just over 4% of episodes of care were initiated by residents themselves, indicating that they are heavily dependent on those who manage their care, health and wellbeing to refer them to psychological services. Most episodes delivered in RACFs were initiated by someone in an 'other' profession (Table 5-3). We assume that this category is capturing registered nurses and other aged care staff, given the absence of these groups from the specific referrer types available within the PMHC MDS and their prominence in referrals as highlighted by participants in this evaluation (see for example the survey findings discussed in sections 3 and 4).

Table 5-3: Professions of referrers who initiate episodes of care

Referrer profession	Episodes of care	%
Other	1,709	57.0%
GP	703	23.4%
Not stated	159	5.3%
Other medical specialist	147	4.9%
Self-referral	123	4.1%
Psychologist	76	2.5%
Mental health nurse	53	1.8%
Social worker	47	1.6%
Maternal health nurse	14	0.5%
Psychiatrist	6	0.2%
Total	**2,999**	**100.0%**

On average, residents receive services more quickly than people accessing PHN-funded mental health care in other settings, waiting an average of 20.6 days between referral and their first service contact compared to 44.9 for other clients (Table 5-4). This trend is seen across all PHNs except PHN 28, where services commence later in RACFs than other settings (32.6 and 28.3 days respectively).

Table 5-4: Mean days between referral and commencement of an episode of care for RACF clients and all clients recorded in the PMHC MDS, by deidentified PHN

PHN region	Number of RACF clients	Mean days from referral to service for RACF clients	Total number of clients	Mean days from referral to service for all clients
PHN 29	334	8.2	7,485	22.2
PHN 9	528	13.6	14,355	66.2
PHN 7	79	14.3	6,730	43.2
PHN 8	937	15.0	7,752	25.4
PHN 17	344	15.5	6,497	57.5
PHN 27	72	15.7	5,794	43.6
PHN 21	200	15.8	4,509	42.1
PHN 22	72	16.4	6,770	37.7
PHN 6	77	17.3	6,727	65.1
PHN 23	71	17.9	7,650	35.3
PHN 24	736	18.4	12,967	25.8
PHN 2	125	18.7	4,734	20.5
PHN 25	12	18.7	3,480	41.3
PHN 10	49	19.3	17,939	31.4
PHN 15	404	19.3	15,831	27.2
PHN 11	328	19.8	4,508	42.5
PHN 12	1,143	19.8	10,570	32.7
PHN 14	43	20.4	6,750	32.8
PHN 5	439	21.6	4,421	36.8
PHN 31	57	21.8	4,970	38.9
PHN 20	831	23.2	11,418	51.6
PHN 16	175	24.4	20,517	40.8
PHN 1	325	27.4	4,541	42.9
PHN 26	22	27.5	4,852	119.7
PHN 13	117	31.4	12,530	57.7
PHN 28	88	32.6	5,571	28.3
PHN 30	238	33.4	11,731	79.0
PHN 18	691	38.7	22,195	48.3
PHN 3	54	39.3	5,889	61.5
PHN 19	13	42.7	2,611	50.9
PHN 4	28	44.8	12,963	65.7

PHN region	Number of RACF clients	Mean days from referral to service for RACF clients	Total number of clients	Mean days from referral to service for all clients
All PHNs	**8,632**	**20.6**	**275,257**	**44.9**

5.3 Practitioner characteristics

Almost half of the service contacts that have taken place in RACFs were delivered by general psychologists or low-intensity mental health workers (a category that includes provisional psychologists) (Table 5-5). Consistent with the initiative's primary target population of residents requiring low- to moderate-intensity intervention, psychiatrists have been involved in a very small proportion of services delivered. Three-quarters of service contacts have been delivered by female practitioners, while practitioner gender has not been recorded for one out of every 8 service contacts (Table 5-6). It may be that some practitioners are recording their gender only for one service contact out of an episode of care.

Table 5-5: Number and proportion of service contacts, by practitioner type

Practitioner type	Service contacts	%
General psychologist	17,438	27.1%
Low-intensity mental health worker	13,532	21.1%
Other	12,584	19.6%
Not stated	7,015	10.9%
Social worker	6,808	10.6%
Mental health nurse	3,361	5.2%
Clinical psychologist	1,833	2.9%
Psychosocial support worker	526	0.8%
Aboriginal and Torres Strait Islander health/mental health worker	499	0.8%
Peer support worker	332	0.5%
Occupational therapist	139	0.2%
GP	99	0.2%
Psychiatrist	58	0.1%
Other medical	43	0.1%
Total	**64,267**	**100.0%**

Table 5-6: Number and proportion of service contacts, by practitioner gender

Practitioner gender	Service contacts	%
Female	48,872	76.1%
Not stated/inadequately described	8,045	12.5%
Male	7,350	11.4%
Total	**64,267**	**100.0%**

A very small proportion of RACF services are delivered by a practitioner identifying as Aboriginal and/or Torres Strait Islander (Table 5-7). It is worth noting that Indigenous status was not stated or inadequately described for over one-quarter of service contacts; it is possible that some practitioners of Aboriginal and/or Torres Strait Islander origin are being recorded here.

Table 5-7: Number and proportion of service contacts, by practitioner Aboriginal and/or Torres Strait Islander status

Practitioner Aboriginal and/or Torres Strait Islander status	Service contacts	%
Neither Aboriginal nor Torres Strait Islander origin	44,818	69.7%
Not stated/inadequately described	18,497	28.8%
Aboriginal but not Torres Strait Islander origin	891	1.4%
Both Aboriginal and Torres Strait Islander origin	61	0.1%
Total	**64,267**	**100.0%**

Just under half of services have been delivered by practitioners who have completed cultural awareness training (Table 5-8). As with the practitioner characteristics above, information on training completion status was missing for a substantial number of service contacts; more complete data may present a different picture of the workforce responsible for delivering services to aged care residents.

Table 5-8: Number and proportion of service contacts, by practitioner completion of cultural awareness training

Training completed	Service contacts	%
Yes	31,189	48.5%
Missing/not recorded	19,664	30.6%
No	13,093	20.4%
Not required	321	0.5%
Total	**64,267**	**100.0%**

5.4 Services provided

Psychological therapy and low-intensity interventions account for over 90% of treatment provided to clients under the initiative (Table 5-9), as would be expected given the initiative's objective of improving access to low- to moderate-intensity interventions. However, a very small number of episodes of care have focused on the delivery of more complex interventions, including clinical care coordination and complex care packages.

Table 5-9: Principal focus of treatment for episodes of care

Treatment focus	n	%
Psychological therapy	4,859	55.8%
Low-intensity intervention	3,369	38.7%
Psychosocial support	282	3.2%
Clinical care coordination	66	0.8%
Complex care package	8	0.1%

Treatment focus	n	%
Other	118	1.4%
Total	**8,702**	**100.0%**

Clients receiving psychological therapy and low intensity interventions are likely to have a broadly similar experience of care, which differs from those receiving less common, more intensive forms of support. Those receiving clinical care coordination, for example, may have a particularly lengthy wait for service commencement and receive a small number of longer service contacts (Table 5-10). This may reflect a lack of service provider capacity to respond to residents with higher needs.

Table 5-10: Selected service characteristics by principle focus of treatment

Characteristic	Psychological therapy	Low intensity intervention	Psychosocial support	Clinical care coordination	Other
Mean days between referral and service commencement	20.7	17.5	26.4	89.0	9.8
Mean service contacts per client	7.8	6.6	9.7	5.9	6.4
Service contact duration	n/a	n/a	n/a	n/a	n/a
<30 mins	14.6%	18.8%	17.6%	20.4%	10.1%
31-45 mins	12.6%	18.0%	45.3%	4.6%	16.8%
46-60 mins	64.0%	52.2%	28.9%	32.1%	53.2%
61-75 mins	3.9%	4.3%	2.3%	11.2%	16.5%
>75 mins	4.9%	6.7%	6.0%	31.6%	3.4%
Total service contacts	**37,785**	**22,302**	**2,738**	**392**	**760**

Note: Percentages may not sum to 100 due to rounding. Given the small number of clients receiving complex care packages, this treatment focus is not included in the table above.

Services are delivered primarily in a face-to-face setting (Table 5-11). However, there was a small and temporary increase in sessions conducted via telehealth in FY 19–20, likely reflecting the impact of COVID-19 and the restrictions in place in RACFs.

Table 5-11: Modality of service contacts, by financial year

Modality	FY 18–19	FY 19–20	FY 20–21	Total
Face-to-face	97.5%	94.0%	97.6%	96.6%
Telephone	0.5%	2.4%	1.1%	1.4%
Video	0%	1.2%	0.4%	0.6%
Internet-based	<0.1%	0.6%	0.3%	0.4%
No contact took place	2.0%	1.8%	0.5%	1.0%

Note: Percentages are based on the number of service contacts delivered in each modality, divided by the total number of service contacts for that financial year. In FY 18–19, n = 4,247; in FY 19–20, n = 18,082; in FY 20–21, n = 41,938; overall, n = 64,267.

In line with the vanishingly small proportion of clients who reported not being proficient in English, since the initiative was introduced less than one percent of service contacts in RACFs have been conducted with an interpreter. While it remains uncommon for interpreter use to be unstated, the use of this response option has increased markedly since 2018.

Table 5-12: Proportion of service contacts conducted with an interpreter, by financial year

Interpreter used	FY 18–19	FY 19–20	FY 20–21	Total
Yes	1.2%	1.2%	0.6%	**0.8%**
No	98.6%	97.4%	97.2%	**97.3%**
Not stated	0.2%	1.4%	2.2%	**1.8%**

Note: Percentages are based on the number of service contacts in which an interpreter was used, not used, or the usage not stated, divided by the total number of service contacts for that financial year. In FY 18–19, n = 4,247; in FY 19–20, n = 18,082; in FY 20–21, n = 41,938; overall n = 64,267.

5.5 Client outcomes

A note on interpreting K10 scores

The findings below relate to client's scores on the K10 measure of psychological distress. The K10 is scored from 10 to 50, with higher scores indicating more severe distress. Therefore, an increase in scores represents deterioration, while a decrease indicates improvement. Scores can be interpreted on a continuous scale or used to categorise the likely severity of mental disorder, as follows (Australian Bureau of Statistics 2012):

- scores between 10 and 19 = likely to be well
- scores between 20 and 24 = likely to have a mild mental disorder
- scores between 25 and 29 = likely to have a moderate mental disorder
- scores between 30 and 50 = likely to have a severe mental disorder.

In addition to calculating average change in psychological distress, we also explored the proportion of residents experiencing clinically meaningful change over the course of an episode of care, defined as follows:

- improvement: a decrease of at least 5 points
- deterioration: an increase of at least 5 points
- no change: a change of between -5 and +5 points.

Our analysis of client outcomes was conducted with the subset (n = 1,248; 14.5%) of records with complete K10 data at the start and end of an episode of care. We therefore present results with the caveat that they may overstate or understate the true impact of the initiative. With that in mind, clients reported an average K10 score of 24.2 at service commencement and 20.0 at completion, demonstrating a 4.2-point or 17.5% improvement. This effect was consistent over time; clients reported a mean improvement of 4.1 points in FY 18–29 and 4.4 points in FY 20–21. As such, for the remainder of this section we present data collapsed across financial years.

Table 5-13 shows average client outcomes by PHN; these data should be interpreted with caution as most PHNs have a small number of clients with complete K10 data. Thus, the very small and very large changes evident towards the bottom of the table reflect the experiences and characteristics of individual clients rather than the (in)effectiveness of the services delivered in these regions.

Table 5-13: Change in psychological distress over episodes of care, by deidentified PHN

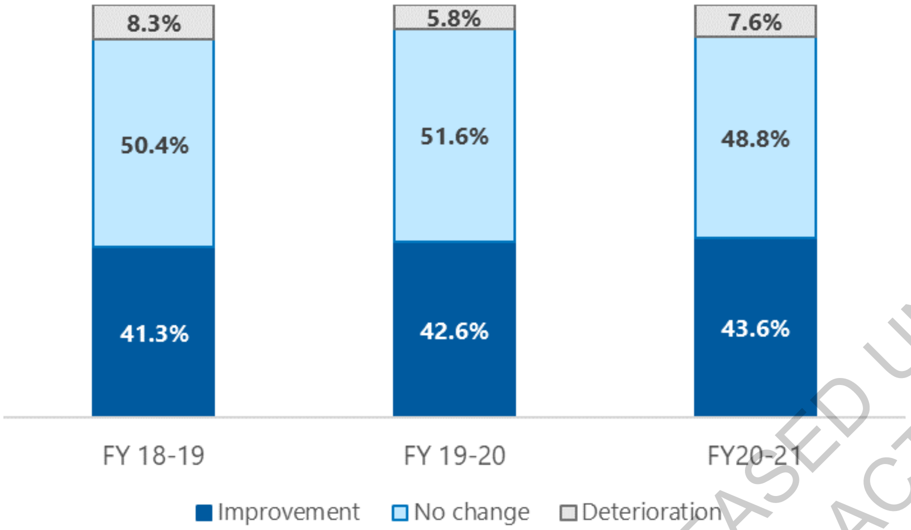
PHN region	Number of clients	K10 at episode start	K10 at episode end	% change
5	175	25.1	20.4	-18.7%
17	151	24.5	18.8	-23.3%
12	143	22.0	20.3	-7.7%
11	143	23.4	20.2	-13.7%
29	107	23.9	20.8	-13.0%
9	103	22.8	17.7	-22.4%
15	64	24.8	21.9	-11.7%
7	54	23.8	17.4	-26.9%

PHN region	Number of clients	K10 at episode start	K10 at episode end	% change
30	45	23.8	19.1	-19.7%
2	34	25.6	22.6	-11.7%
24	33	24.0	20.3	-15.4%
31	30	28.7	24.8	-13.6%
1	27	20.4	18.0	-11.8%
13	23	23.7	17.4	-26.6%
23	22	23.1	14.2	-38.5%
10	18	27.2	23.9	-12.1%
8	15	25.9	23.1	-10.8%
6	14	24.4	21.0	-13.9%
14	10	28.2	24.1	-14.5%
25	7	31.2	21.1	-32.4%
3	6	22.9	15.2	-33.6%
20	6	22.1	22.0	-0.5%
22	4	28.7	21.0	-26.8%
18	3	26.4	27.0	2.3%
27	3	26.7	16.0	-40.1%
4	2	33.0	19.5	-40.9%
21	1	42.0	31.0	-26.2%
26	1	21.5	20.5	-4.7%
19	1	21.0	13.0	-38.1%
28	1	41.0	22.0	-46.3%
All PHNs	**1,248**	**24.2**	**20.0**	**-17.4%**

Note: Only clients with complete K10 data at the beginning and end of an episode of care are included in these calculations.

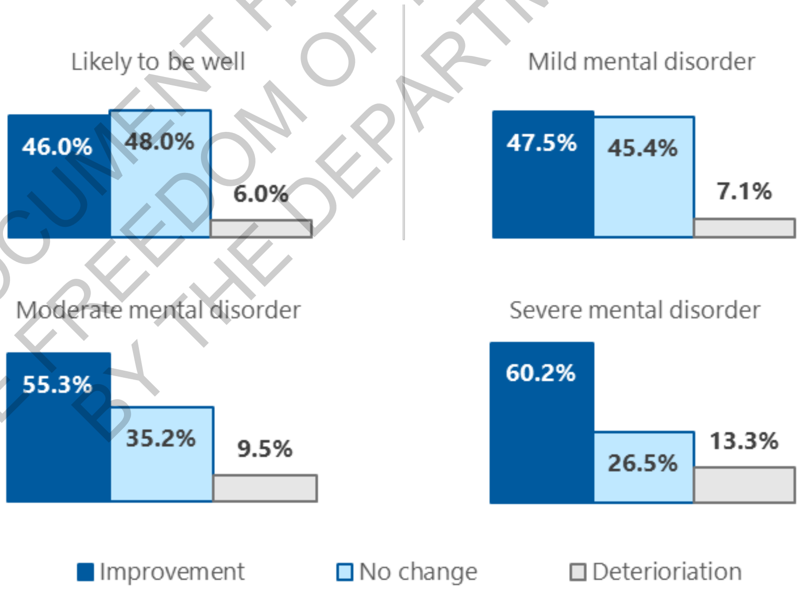
Of course, average change is a relatively blunt measure of service impact. Using our pre-specified criteria for meaningful change, we found that around half of aged care residents for whom data were available experienced neither improvement nor deterioration in their symptoms over the course of an episode of care (Figure 5-5). Most of the remainder demonstrate reduced psychological distress, with this pattern of results consistent over time. As discussed in the final report (section 4.1.8), symptom maintenance maybe an appropriate and positive outcome for many residents; particularly for those who are experiencing low levels of distress at service commencement and therefore have limited scope to improve.

Figure 5-5: Proportion of clients showing improvement, deterioration, or no change in psychological distress, by financial year



To demonstrate the impact of initial K10 scores on service outcomes, we calculated the proportion of residents demonstrating meaningful change by their likely severity of mental illness at service commencement. As seen in Figure 5-6, those with severe illness at the start of their care are more likely to improve than their counterparts who are likely to be well. However, they are also more likely to deteriorate. Given the limitations of the PMHC MDS we are unable to explore the factors that predict poorer outcomes in more detail, however it would be interesting to explore the degree to which the RACF environment and individual characteristics (e.g. changes in cognitive or physical functioning) impact the direction and magnitude of changes in psychological distress.

Figure 5-6: Mental health outcome by likely disorder severity at episode of care commencement



5.6 Costing analysis

The costing analysis shown in Table 5-14 should be evaluated conservatively, as it reflects the total funding provided to each PHN, rather than breaking down their operational and service delivery costs. To remove outliers and nonsensical values, we have restricted our analysis to funding received and services delivered in FY 20–21, and present metrics only for PHNs that recorded more than 100 clients in that year. For these PHNs, initiative funding resulted in services being delivered to an average of 334 clients, at an average cost of $3,513 client or $570 per service contact. Of note, the 4 PHNs with the lowest costs per service contact share a service provider, as do 2 of the next 3. PHN 1 has a relatively low cost per client but high cost per service contact, reflecting a lower-than-average number of service contacts per client.

Table 5-14: Cost metrics for PHNs recording more than 100 clients in FY 20–21

PHN region	Clients	Mean $ per client	Mean $ per episode	Mean $ per service contact
8	687	$881	$862	$120
20	647	$1,444	$1,422	$170
12	588	$1,503	$1,488	$175
24	498	$1,913	$1,865	$241
5	370	$2,173	$1,971	$343
17	320	$2,405	$2,339	$417
24	267	$3,134	$2,999	$437
29	283	$3,591	$3,354	$509
2	107	$2,983	$2,513	$536
9	264	$5,691	$5,444	$550
1	240	$1,624	$1,617	$642
15	269	$5,510	$5,489	$656
18	359	$4,899	$4,872	$755
30	174	$4,530	$4,331	$928
16	144	$5,957	$5,429	$1,191
21	127	$7,971	$6,981	$1,442
Mean	**334**	**$3,513**	**$3,311**	**$570**

6 Additional information on service models

In this concluding chapter, we build on our overview of the service models currently in place (see section 4.1.1 of the final report). We begin by exploring the approaches that PHNs took to designing these service models and how the mental health workforce responsible for delivering services is being supported.

We then expand on the evidence underpinning the 4 characteristics of effective services (as presented in section 4.1.2 of the final report).

6.1 Approach to designing the service model

All but 2 PHNs reported that their service model was informed by consultation or co-design activities. In most cases, these activities were conducted as a standalone piece of work prior to service commencement, although in a handful of PHNs they occurred as part of a pilot phase of service delivery. All told, around two-thirds of PHNs piloted their service model in a small number of RACFs prior to embarking on a broader rollout, using the learnings to refine the service model and develop commissioning specifications. In addition, several PHNs conducted or commissioned a literature review to inform their service model.

Consultation activities included inviting input via email, conducting surveys, holding meetings with individual stakeholder groups, and bringing different stakeholder groups together for roundtable meetings or workshops. PHNs most frequently reported consulting with RACF representatives, GPs, and psychological service providers and/or allied health professionals in their region. Other commonly engaged stakeholder groups included Older Persons Mental Health services (OPMH services) and local health districts, dementia support services (e.g. Dementia Australia), and residents and/or family members. One PHN reported that their service model was informed by consultation with 'local Aboriginal health organisations'[8] and another consulted with CALD community leaders.

A small number of PHNs engaged with peak bodies representing aged care providers, but none indicated that they consulted with peak bodies in the health or mental health sectors. In our interviews, representatives of these peak bodies confirmed their lack of involvement in the service design phase of the initiative.

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[8] It is unclear whether this individual was referring to Aboriginal Community Controlled Health Services, community clinics, or other government or non-government funded organisations specialising in Aboriginal health.

6.2 Building mental health workforce capacity

While RACF capacity building is a feature of service models in most regions, activities to build capacity of the health or mental health workforce are less common. Where this is a feature of the service model, it typically hinges on the service provider's use, training, and supervision of provisional psychologists. Along similar lines, in one region, the service model includes support for social workers to obtain mental health accreditation; in another region, the service provider offers placements for university students enrolled in a mental health discipline.

There is a small number of inter- and intra-PHN communities of practice for mental health practitioners delivering psychological services to aged care residents. These have been established by PHNs or service providers. Some service models specify the availability of specialist advisors for case consultation.

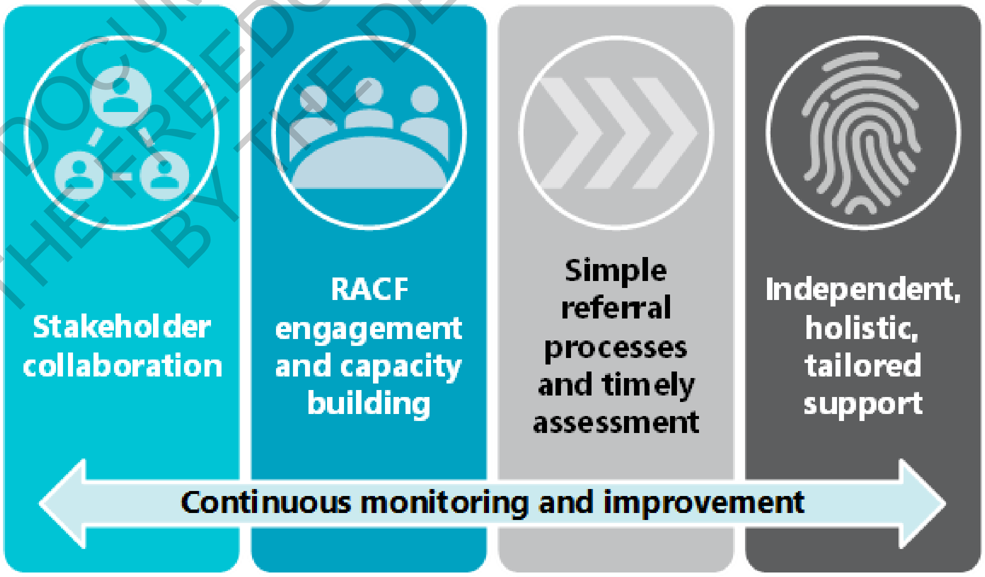
Finally, individual PHNs indicated that the following resources have been developed or made available to support their region's health and mental health workforce:

- Australian Psychological Society e-learning modules in Applied Mental Health in Residential Aged Care
- a low-intensity intervention that can be delivered by local care workers under psychologist supervision
- a phone line for GPs and clinical RACF staff that provides advice and support on diagnosis, medication, therapeutic management, and referral pathways.

6.3 Characteristics of effective service models

Effective service models are those that perform well across multiple domains, across all stages of implementation, and are subject to continuous monitoring and quality improvement. As discussed in section 4.1.2 of the final report, they can be understood in terms of 4 key characteristics (Figure 6-1), each of which is discussed in turn below.

Figure 6-1:Characteristics of effective service models



6.3.1 Stakeholders work collaboratively

Representatives of several stakeholder groups – including PHNs, service providers, and RACF staff – highlighted that effective service models are characterised by a 'partnership model'. For example, as one PHN commented:

> [Our service provider] has appreciated our flexibility and openness to trial and change the approach as needed. They have appreciated our willingness to take on an action research approach and learn as we go along and reflect together in partnership and modify KPIs accordingly. So, we are working in a partnership mode, rather than solely as a transactional funding body.
>
> *PHN representative*

Importantly, this sentiment was echoed by the service provider in question.

Representatives of PHNs that had commissioned multiple service providers reflected that these different organisations work collaboratively, resulting in a consistent service model across the region and a common approach to overcoming challenges as they arise. Meanwhile, the importance of service providers and RACF staff working in partnership and communicating effectively was highlighted both by representatives of these groups and peak bodies. They, and PHNs, felt that a service model that includes a designated mental health practitioner for each RACF supports collaboration because relationships and trust between the practitioner, RACF staff, and visiting health professionals develop over time.

6.3.2 RACF engagement and capacity building are prioritised

PHNs, service providers, and RACF staff alike considered that securing RACF buy-in to the initiative is essential, and that this is best achieved through engagement and capacity building. These activities require significant time and effort at the outset to bring RACFs on board, and an ongoing investment to maintain buy-in and build capacity over time. One PHN noted that their pilot phase was unsuccessful because they underestimated the importance of, and resources required for, these components of the service.

Further, a small number of service providers and PHNs commented that fee-for-service models are ineffective because they do not account for the work involved in engagement and capacity building, despite these activities being critical to the initiative's success. On the other hand, in regions where RACF engagement was perceived to be high, PHNs and service providers attributed this to the establishment of a dedicated RACF engagement role, usually located within the service provider organisation. We also heard that working with RACFs to identify staff members who can act as mental health or wellbeing 'champions' and drive the initiative internally is an effective way of encouraging buy-in among other staff.

There was general agreement that it is important for RACFs and service providers to have a shared understanding of the service arrangements, although opinions were mixed on the extent to which a shared understanding should be formalised. For example, some PHNs and service providers considered memoranda of understanding to be effective in defining roles and expectations, while others felt they were too restrictive and introduced unnecessary delays in establishing services. Interestingly, one PHN commented that commissioning an organisation that both provides psychological services and manages RACFs did not result in improved staff engagement within that organisation's facilities. This model also raises questions about the degree to which the mental health practitioner is independent from the resident's day-to-day care (see section 6.3.4).

> The capacity building has been a key component of the program, not just in terms of providing support to staff and families and carers, but it also helped to integrate the program into the RACF environment in the region.
>
> *PHN representative*

Service models with an emphasis on capacity building were seen to improve the overall effectiveness of the service for several reasons. For example, staff training was perceived to provide a 'hook' to encourage RACFs to enrol in the initiative, and to increase the number and appropriateness of referrals. Training was generally well received by participating staff, with features of effective training including: face-to-face delivery in brief, small-group sessions that fit into the RACF schedule; delivery to staff at all levels; and content addressing mental health literacy, available services and referral pathways, and topics of broader importance such as cultural awareness and trauma-informed care. One PHN had trialled a model in which a separate training provider was responsible for capacity building, and found this to be unsuccessful as this organisation did not have established relationships with the RACFs involved.

> We have done training sessions with executive directors right through to kitchen staff … those kitchen staff see everything, and they are the staff who residents feel really safe with. So often they are the ones who may see if there are any concerns.
>
> *Service provider representative*

6.3.3 Simple referral processes facilitate timely assessment

Across stakeholder groups, there was a view that effective service models are those with few barriers to referral – where referrals are accepted directly by the provider, from multiple sources, and without a requirement for detailed paperwork. One service provider, commissioned by multiple PHNs with different referral protocols, reflected that they prefer the direct-to-provider pathway (and subsequent direct-to-referrer follow-up) as this enables more timely service provision.

> Streamlining the referral pathway has resulted in increased referrals, increased registrations and increased stability in the team.
>
> *PHN representative*

Ease of referral is an especially important aspect of the service for RACF staff in particular, who may be less familiar with mental health referrals than GPs. RACF staff identified simple strategies that had made the referral process easier – for example, including forms in the referral folder stored within each wing of the RACF so they are easily accessible to and routinely seen by nursing and care staff.

> Our service provider has a nominated referral person in each facility, which streamlines the process.
>
> *PHN representative*

Importantly, effective referral processes are those that remove barriers to residents being assessed and triaged to an appropriate intervention or level of care; they are **not** those that expediate the commencement of services without due consideration of the resident's treatment needs. Regardless of how a resident was referred and by whom, service providers require clear guidance on how to determine first, whether the resident is suitable for their service and second, the type of support within their scope of practice that is most likely to be of benefit.

> If the provider undertakes an assessment and the potential client is more than mild or moderate, then the provider does not deliver the service and refers onwards.
>
> *PHN representative*

6.3.4 Residents have access to independent, holistic, tailored support

> The other thing which has worked really well is that the service provider has become part of the team and just for the residents to know that there is a familiar face who they can talk to who is completely confidential; I think this has been really important to them.
>
> *RACF staff member*

Service providers, RACF staff, and residents alike considered the service provider's independence from the RACF a particularly important aspect of the service model as it ensures that residents can speak confidentially with someone not involved in their day-to-day care. At the same time, they noted that it is important for mental health practitioners to be highly visible within the facility in order to build trust with residents (and support collaboration with staff, as mentioned in section 6.3.1). Allowing additional time to build trust and rapport with residents was also seen as critical to providing appropriate and effective support, especially for residents with cognitive impairment. Representatives of several stakeholder groups highlighted the benefits of giving residents some control over their own care – for example, by ensuring the mental health practitioner has the resident's direct contact number and, following the initial assessment, liaises with them directly to schedule appointments.

Effective services were also seen to offer multidisciplinary care, appropriately tailored to meet resident, staff, and family need. Representatives of PHNs, peak bodies, and service providers consistently identified that adopting a holistic approach to supporting residents' mental health is crucial, and requires going beyond diagnostic manuals to recognise and respond to a broad spectrum of wellbeing needs. Capacity to address issues with adjustment, grief and loss, and loneliness was seen as particularly essential. However, some PHNs expressed uncertainty over the extent to which the department's guidance allows them to expand their service model and incorporate alternative supports.

> In some instances, psychological therapies are not necessarily what the residents need. We felt constrained to that, but we were getting feedback that this service was not necessarily helpful for some. Without being able to support everyone and have multiple treatment options it can be quite challenging in a sense that you are almost limiting consumer choice.
>
> *PHN representative*

We also heard of the value of a mixed service model, in which both individual support and group support are available.[9] For example, some residents commented that they 'felt more comfortable [alone] than in a group' as they could open up and discuss more personal issues, while others felt that 'meeting in a group gave a sense of support and cooperation'.

Although its delivery has been somewhat disrupted to date, stakeholders across the board noted that group therapy is particularly useful for RACF residents, for several reasons. For example:

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[9] And further, that residents have the choice of face-to-face or telehealth services.

- By mirroring the format of many lifestyle programs available within RACFs, group services:
    - offer a model of care that residents are familiar and confident with
    - can facilitate seamless transitions between PHN-funded and existing supports.
- Groups have the added benefit of addressing loneliness and residents' need for social connection, without requiring residents to explicitly discuss these issues.
- Music therapy (a common element of current service models under the initiative) was seen to be a particularly important component of mental health care in aged care, due to its accessibility by people who do not speak English, are unable to communicate verbally, or have cognitive difficulties.

Opinions were mixed on whether group therapy is more effective when delivered before or after individual support. Several PHNs and peak bodies indicated that groups (including music therapy and other options such as yoga, gardening, or book clubs) offer a less stigmatising pathway into care for many older people. On the other hand, some service providers felt that groups are more effective for residents who have already participated in individual therapy, as the mental health practitioner then understands resident need and can design and conduct group sessions accordingly. Importantly, service providers and RACF staff highlighted that even residents with high-level needs can benefit from low-intensity, lifestyle, or environmental interventions (see section 4.1.8 of the final report). However, it is worth noting that one GP commented on the potential duplication of services, with this individual perceiving that low-intensity services are already available through RACFs and therefore are an unnecessary component of PHN service models.

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