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EASTERN MELBOURNE

An Australian Government Initiative

Annual Evaluation 2019-2020 Report

October 2021

Acknowledgements

We acknowledge and pay our respects to the Wurundjeri people and other peoples of the Kulin Nation on whose unceded lands our work in the community takes place. We respectfully acknowledge their Ancestors and Elders past, present and emerging.

We recognise and value the knowledge and wisdom of people with lived experience, their supporters and the practitioners who work with them. We celebrate their strengths and resilience in facing the challenges associated with their recovery and acknowledge the important contribution that they make to the development and delivery of health and community services.

Eastern Melbourne PHN values inclusion and diversity and is committed to providing safe, culturally appropriate, and inclusive services for all people, regardless of ethnicity, faith, disability, sexuality, gender identity or health status.

This report was completed with the assistance of the service providers involved in the delivery and evaluation of these programs.

We would like to extend our gratitude and appreciation to consumers, carers and general practitioners who contributed to these evaluations. We thank them for their time and insights and trust that their views are adequately represented in this report.



Contents

Abbreviations and acronyms

EMPHN	East Melbourne Primary Health Network
IDEAS	Integrated Diabetes Education Assessment Service
YETTI	Youth Engagement & Treatment Team Initiative
YFlex	Flexible Intensive Support for Young People program
MHSCM	Mental Health Stepped Care Model
DHHS	Department of Health and Human Services
EMR	East Melbourne Region
HTS	Health Tech Solutions
PAID	Problem Areas in Diabetes
PEQD	Patient Evaluation of the Quality of Diabetes Care
CYMHS	Child Youth Mental Health Service
LGA	Local Government Area
K10	Kessler Psychological Distress Scale
NAMHS	Northern Area Mental Health Service
PSS	Psychosocial Support Service
NDIS	National Disability Insurance Scheme
PIR	Partners in Recovery
PHaMs	Personal Helpers and Mentors
D2DL	Day to Day Living
PSWs	Peer Support Workers
MS Teams	Microsoft Teams
CRSWs	Certified Recovery Support Worker
PTP	Psychosocial Transition Program
CRIR	Consolidated Framework for Implementation Research
MHNIP	Mental Health Nurse Incentive Program
ATAPS	Access to Allied Psychological Services
KPI	Key Performance Indicator

Foreword

I'm pleased to deliver EMPHN's first annual evaluation report of four key projects we have undertaken over the past two years.

The core role of primary health networks is to ensure we utilise Commonwealth funds to deliver efficient and effective health services to enable the best possible health outcomes for our communities. We do this by commissioning and supporting primary health care programs and support services that deliver evidence based, cost effective services that meet the needs of our community, where and when they need them.

Critical appraisal and evaluation is an important part of this process; it helps us determine whether we are meeting our objectives and gives us important insights into how effectively our programs are being delivered, whether the aims and goals of the program are being met and if these services actually lead to improved health outcomes in our communities, on an individual and population-wide basis.

In this inaugural report, we have focused on four EMPHN commissioned programs from two of our strategic priority areas – mental health and chronic care. The Youth Engagement and Treatment Team Initiative (YETTI) and the Flexible Intensive Support for Young People Program (YFlex), Psychosocial Support Service (PSS) and Mental Health Stepped Care Model (MHSCM) programs support improved mental health outcomes in our community; with YETTI and YFlex designed specifically for young people to mitigate the risk of continued mental ill-health into adulthood. The Integrated Diabetes Education Assessment Service (IDEAS) service provides multidisciplinary team based care to people with diabetes, with a focus on individuals actively participating in managing their own health.

I would like to thank our health care providers, practitioners and consumers who have all contributed greatly to the findings and learnings outlined in the four evaluations described here, and for their openness to public disclosure of the results. I would also like to thank our external evaluators who supported the rigour with which these evaluations were conducted.

As an organisation, EMPHN has spent much time preparing these evaluations and ensuring all data collected is accurate and relevant to our program aims. These reports will continue to form part of our measurement of continuous improvement for the health services we commission. I hope you find it worthwhile reading.

Janine Wilson

Introduction

This is EMPHNs first annual evaluation report. It presents a snapshot of evidence generated by the evaluation of East Melbourne Primary Health Network's (EMPHN) commissioned programs completed and finalised in the 2020 financial year. The purpose of this report is to showcase key evaluation findings providing transparency to our funders, key stakeholders, partners and consumers, and promoting a culture of high quality, robust, and well-designed evaluations.

Four external evaluations are presented in this report. Three of these evaluations were undertaken between 2019 -2020. Firstly, the Integrated Diabetes Education Assessment Service (IDEAS) Expansion project; second, the Youth Engagement and Treatment Team Initiative (YETTI) and the Flexible Intensive Support for Young People Program (YFlex); and third the Psychosocial Support Service. The fourth evaluation - the Mental Health Stepped Care Model (MHSCM), one of EMPHN's flagship programs, was evaluated just outside the 2020 financial year reporting period and is included in this report to share these important findings with you.

The Annual Evaluation report is presented in two parts. Part 1 explains the purpose of evaluation and how it is evolving at EMPHN and part 2 reports on the four key evaluations undertaken in 2019-2020. These evaluations are structured by a brief description of the program, evaluation approach and aims, key findings, implications or recommendations, improvements made to the program in response to the evaluation and next steps.

Part 1:

Evaluation with EMPHN

Evaluation within EMPHN

EMPHN acknowledges the importance of ensuring that primary care programs and services are well designed, implemented and effective in facilitating sustainable health system improvement for people in eastern and north eastern Melbourne. Evaluation of primary care programs helps us understand what is happening in our programs, identifies risks and gaps, informs program improvements and guides EMPHN on how we can support services.

Evaluation is an in-depth process for determining the merit and worth of programs and policies. Evaluation involves systematic collection of information about an intervention (a program, a project, a policy, a practice or a strategy) to:

1) Describe the way in which it works to achieve intended outcomes,
2) Assess its appropriateness, effectiveness and efficiency according to agreed criteria,
3) Improve it, and/or
4) Inform decisions about its future.

Evaluation within EMPHN is underpinned by a utilisation-focused approach. This approach values the production of high-quality evidence that is useful, timely, relevant, and appropriate to inform decision making about the commissioning of primary health services. Evaluation can be focused on accountability, as well as learning and improvement, and understanding how interventions work. Evaluation provides detailed and rigorous information to answer key questions and inform decisions at critical times.

Over the last year EMPHN has developed a Monitoring & Evaluation Framework that will be shared with our partners and key stakeholders in the coming months. The Framework aims to strengthen and support existing processes for commissioning programs, reporting on performance and achieving strategic and transformational goals. A number of evaluation processes and practices have also been developed to address the following fundamental questions:

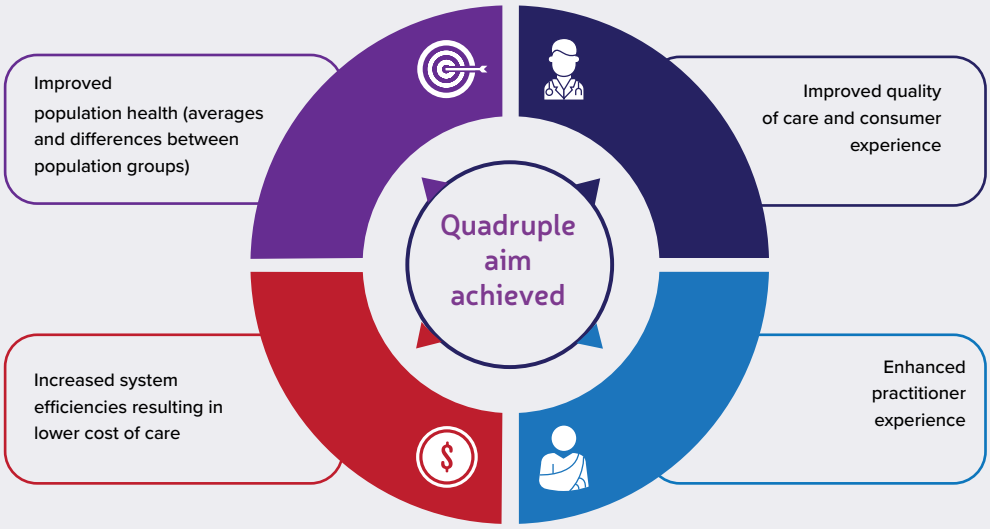
1) Are we designing and commissioning the right programs?
2) Are we delivering these programs well?
3) Are these programs making a difference?
4) Are there better or more efficient ways to achieve outcomes?
5) Are programs equitable, culturally responsive and sustainable?

The Framework identifies outcomes aligned with the Institute for Healthcare Improvement's quadruple aims, a well-established approach that is strongly supported by the Commonwealth to maximise health system performance. The quadruple aim approach seeks to address the impact of the program on firstly population health (consumer outcomes), second consumer experience, third practitioner and stakeholder experience and 4) health system efficiencies (lower cost of care) (see Figure 1). Working collaboratively with service providers ensures relevant information is gathered that aligns to the quadruple aims. This approach is also central in ensuring equal weight is given to consumer experiences and the importance of gathering this information, as well as clinical outcome measures, a recommendation also highlighted by the National Mental Health Commission.[1]

[1] National Mental Health Commission. Monitoring mental health and suicide prevention reform: National Report 2020. Sydney: NHMRC; 2021

Figure 1

Quadruple aim approach



The evaluations summarised in this report commenced prior to the development of the Framework and hence have different approaches. The IDEAS Expansion project applies the quadruple aims approach, while the Psychosocial Support Service evaluation focused on consumer and staff experiences. The approach to the Yetti and YFlex; and the Mental Health Stepped Care evaluations is on implementation and delivery of the models, consumers and practitioner experience and health outcomes with future plans for an impact and value for money and cost effectiveness evaluations.

Looking to the 2022 financial year there are a number of evaluations currently being planned that will commence in the coming months, namely the Right Care = Better Health program, the Psychiatric Advice and Consultation service and the Healthy Ageing Service Response program. We are also working with the University of Melbourne to develop an evaluation approach specifically for our Aboriginal and Torres Strait Islander focused programs and partners and we hope to share the learnings from this work in the next annual evaluation report.

Part 2:

Key Evaluations for 2019-2020

Integrated Diabetes Education & Assessment Service – IDEAS EXPANSION PROJECT

About the project

The Integrated Diabetes Education Assessment Service (IDEAS) service delivery model design is informed by international and Australian literature supporting the need for effective team based care for people with diabetes. It is based upon the principles of care outlined in the Victorian Community Health Integrated Program guidelines[2] and the Department of Health and Human Services (DHHS) endorsed Wagner Chronic Care Model and was cited as a case study within the DHHS "Care for people with chronic conditions - Guide for the Community Health Program"[3].

IDEAS brings together specialist medical and allied health services to provide integrated multidisciplinary team based care in a community setting, with the person with diabetes supported to be an active participant in the management of their own health. IDEAS service delivery model was developed by Carrington Health and Eastern Health in 2009 and replicated in 2011.

Expansion of IDEAS – Diabetes Diversion Project

The initial IDEAS Expansion project began in July 2017 supported by Eastern Melbourne Primary Health Network (EMPHN) funding. Subsequent extension of project resulted in ongoing work across 2018, 2019 and 2020. The IDEAS Expansion (diabetes diversion) Project involved a partnership between Eastern Health, Carrington Health (as lead agency), EACH, Access Health and Community and Inspiro, community health services.

The aims of the expansion project were to:

- Expand the existing Eastern Melbourne service system responses to Type 2 diabetes that reduce pressure on hospitals by providing eligible people with diabetes integrated wrap-around support in community settings
- Share this expertise with other health care agencies across the broader catchment with a view to developing partnerships in the market for future commissioning and innovation.

Key areas of focus were the diversion of referrals from EH diabetes outpatients to IDEAS, GP engagement and referral, effectiveness of the service and sustainability.

New sites were established via phased rollouts, with three sites commenced during a four month period in 2017-2018 and the final site commencing in late 2018. IDEAS is now providing consistent integrated team based service for people with Type 2 diabetes from six different locations in the East Melbourne Region, with half day sessions across four days of the week.

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[2] Victorian Community Health Integrated Program guidelines – direction for the community health program. (2015). State of Victoria: Department of Health and Human Services.

[3] Care for people with chronic conditions – guide for the Community Health Program. (2016).Victoria: Department of Health and Human Services.

Figure 2

Project timeline

Enabling Provision of Integrated Care

The primary health care literature identifies three levels at which integration between professions, providers and settings must occur and enablers are evident within IDEAS across all levels:

An existing ten year partnership between Carrington Health and Eastern Health has piloted and rolled out a solution for provision of care for a significant chronic health condition across a whole of health service region. Partnership commitment by community health services in the EMR has been critical to this success with EACH, Access Health & Community and Inspiro engaging at clinical, operational and senior management levels, a fundamental requirement for effective integrated care.

Evaluation approach

The RE-AIM evaluation framework was used to develop the IDEAS expansion evaluation framework. Dimensions included reach, effectiveness, adoption, implementation and maintenance. In the third year of the project, analysis of the effectiveness of the IDEAS Expansion project as a whole was also considered from a quality improvement perspective using the Quadruple Aim which looks at improving health outcomes, experience of care, reducing cost of care and experience of workforce.

Figure 3

Key findings

Better Outcomes

Service utilisation/access to effective diabetes care

In 2019-2020 IDEAS received 638 referrals, provided service to 650 individuals, during 4004 consultations, with an average fail to attend rate of only 11%. Across the three year project period 1632 individuals received 8576 consultations.

Clinical Outcomes

In the first year, the project work was undertaken with Health Technology Solutions (HTS) to develop and create a function within the community health based TrakCare health record program to enable entry of clinical data. Carrington Health also developed an appropriate SQL[4] script to allow for extraction of clinical outcome data reports. The application of the SQL script at each site has made it possible to report these outcomes by site and provide an aggregated view of the outcomes within IDEAS across the region.

In June 2020, 206 clients had data sets which included assessment and review data at a six month review point; 60% had at least a 0.5 improvement in their HbA1c (with project target 75%) and 74 clients had an improved HbA1c of ≥ 1% representing 49% of the total eligible data set.

Clinical trials tend to use the mean change in HbA1c, rather than the number of people who change, as a marker. Utilising mean change in HbA1c, the IDEAS Expansion project data indicates the mean change in HbA1c for the 2017-2020 project term was 1.3% (with project target 1%).

Findings related to weight change show a positive trend however continue to be small and not significant; consideration of weight loss of ≥5kg, indicating metabolically significant weight loss, 11% of the total 206 clients within the data set achieved this outcome. PAID (Problem Areas in Diabetes) changes are encouraging with findings trending positively.

Improved Client Experience

Previous findings of positive client experience obtained in the 2012 'Building the Evidence' Randomised Control Trial/Cross Sectional study and 2017 Client Experience Qualitative study have again been confirmed as IDEAS was replicated to a further four sites.

The assessment of client experience was undertaken via the Patient Evaluation of the Quality of Diabetes Care (PEQD), a validated and reliable tool specific to the client cohort. IDEAS has achieved extremely positive findings of client experience, which have been consistently maintained as each new service site was established, with client experience (that is good or better) ratings of 92% in 2015 RCT across two sites, 94.2% in 2018 across five sites and 94.1% in 2020 inclusive of all six IDEAS sites.

[4] SQL is a domain-specific language used in programming and designed for managing data held in a relational database management system.

Improved Staff Experience

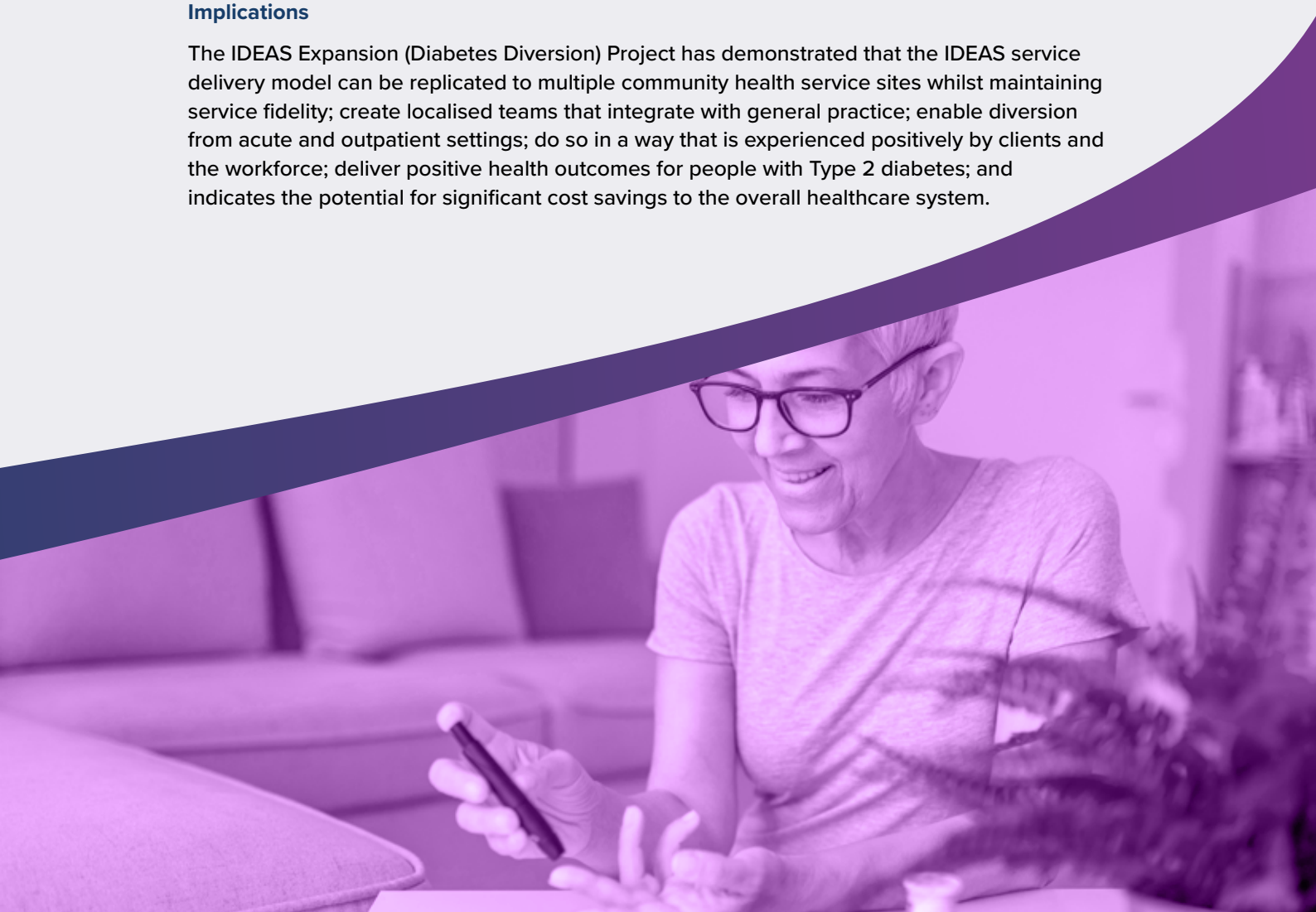
Overall, clinicians (medical and allied health) expressed high levels of confidence and satisfaction in their experience of working within IDEAS. Administered to 25 staff with an 80% return rate, 100% of respondents indicated a clear understanding of their role in a multidisciplinary team; 92% considered multidisciplinary team based care important in diabetes; and 89% of staff survey respondents reported their experience as very good to excellent.

Reduced Care Costs

A study of IDEAS data comparing people who access IDEAS with people accessing outpatients and people who access no service after an index admission provided extremely encouraging results. Although the total number and percentage of people ultimately readmitted were not different between groups, the time to readmission was significantly delayed by attendance at IDEAS (260 days compared with 85 days for patients without outpatient contact) and specialist clinics (187 days). Preliminary data analysis demonstrates a 10-fold difference in use of health services and costs comparing people accessing IDEAS to those who do not have contact with IDEAS after an index admission. Our calculations suggest that this translates into a saving of $27,000 per person or about $7M per year in the Eastern Health catchment alone. It should be noted that this comparison is uncorrected for potential confounders such as co-morbidity or age. Funding is being sought for a more rigorous comparison between groups trying to isolate the effect of IDEAS attendance.

Implications

The IDEAS Expansion (Diabetes Diversion) Project has demonstrated that the IDEAS service delivery model can be replicated to multiple community health service sites whilst maintaining service fidelity; create localised teams that integrate with general practice; enable diversion from acute and outpatient settings; do so in a way that is experienced positively by clients and the workforce; deliver positive health outcomes for people with Type 2 diabetes; and indicates the potential for significant cost savings to the overall healthcare system.



Improvements made to the service as a response to the evaluation

The steering group which includes representation from all participant organisations has undertaken a continuous quality improvement approach throughout the expansion project.

Examples include:

- changes to data entry and interrogation to improve accuracy of reporting across sites;
- review and modification of the care planning process to include plainer language;
- additional specialist endocrinologist/registrars introduced as part of the scale up to add client volume which in turn improves the medical financial modelling – this continues to be evaluated in terms of sustainability for all partners;
- trial of digital capture of client experience data;
- creation of communities of practice/network opportunities for allied health assistants undertaking the connection/integration roles at each service site;
- systems improvements relating to the interface between EH and CHSs, including implementation of a digitised/electronic workflow with enhanced security, tracking and monitoring; and
- improvements in the quality of referral information and accompanying documentation.
- rapid respond to COVID and a reorientation to online service provision across all sites.

Next steps

The existing IDEAS model of service, in place for over ten years, represents a strong basis from which to leverage/grow. Opportunity exists to now embrace the potential for change that is inclusive of digital based service provision, enabling greater service access to clients, particularly to endocrinologist review appointments. There is opportunity to now review the service delivery model and consider redesign to support continuous improvement, including:

- Establishment of new data set, collection and real time reporting;
- Undertake study/research of findings related to weight loss, PAID changes and behaviour/ lifestyles changes;
- Investigation of the impact of sulphoylureas or insulin on weight loss findings;
- Further analysis of existing data set to discern potential confounders such as comorbidity or age to enable a more rigorous comparison between groups, isolating the effect of IDEAS attendance on people's use of emergency and acute care services;
- Ongoing developmental work to develop/redesign the referral and approach to shared care with general practice; and
- Ongoing contribution to the evidence related to provision of integrated service for people with chronic health conditions.

YETTI & YFLEX evaluation

About the Project

The Youth Engagement and Treatment Team Initiative (YETTI) and the Flexible Intensive Support for Young People Program (YFlex) are two youth mental health programs commissioned by the Eastern Melbourne Primary Health Network (EMPHN) that were piloted between 2017-2020. The programs provide clinical and psycho-social support to young people aged 12-25 who are experiencing sub-clinical forms of serious mental illness, or who are experiencing symptoms which place them at ultra-high risk of developing such an illness.

Approach to the evaluation

The evaluation was designed with a utilisation focus - an approach based on the principle that all decisions made during the evaluation design and execution are closely guided by the intended use of the evaluation products and findings. The findings from this evaluation will be used as an evidence base to inform the ongoing funding of the Youth Enhanced Services in EMPHN catchment and will also be used to inform systematic decisions relating to the design, implementation and delivery of youth mental health services operating within a stepped care model.

The evaluation was completed over four distinct stages.

Phase 1: Immersion was completed in July 2018 and comprised of the project inception meeting and development of the project plan.

Phase 2: Development of evaluation plan and framework was completed from August to October 2018 and included data gathering activities, development of the evaluation plan, program logics, evaluation framework and Human Research Ethics Committee submission.

Phase 3: Data collection was conducted over two rounds and comprised of the following elements:

- Consumer consultation comprised of Young person (n =27) and family/carer (n= 20) 30 minute interviews
- One hour telephone interviews with representatives of the broader youth service system (n=10)
- On-site and telephone interviews with service provider leaders and delivery staff (n = 16).

During this phase program data for both YETTI and YFlex were also analysed to identify reach and outcomes. The data range included in the analysis was from October 2018 to April 2020.

The evaluation concluded with Phase 4: Analysis and reporting which involved processes of data synthesis and analysis to inform final reporting.

Key evaluation questions and aims

The evaluation was conducted between July 2018 and July 2020, and addressed the following Key Evaluation Questions (KEQs):

1. How effective was the implementation and delivery of the models against the intended objectives of the service model, including delivering on the service implementation/ project plans and the service outputs?
2. What has been the user experience of the service by young people, families and stakeholders?
3. To what extent has the integration and collaboration with other services/stakeholders, in particular general practice and headspace centres, been achieved in meeting the principle objectives of the service model?
4. How effective have the models been in improving access and early intervention and treatment for the targeted at-risk groups of young people experiencing severe mental illness?

Key findings

There were *seven* key findings that came out of the evaluation:

1. *Target cohort is being reached, and the services have increased access to support this group*

   A total of 271 young people have been engaged by YETTI and 227 by YFlex for treatment since the programs were implemented. A further 351 young people have received primary or secondary consults from the YETTI team since the program's implementation. Both programs are reaching young people who present with moderate to high levels of mental health need, including complex presentations such as school refusal and eating disorders. This indicates that both programs are successfully reaching their target cohort.

2. *Mental health awareness and understanding has increased for the target cohort*

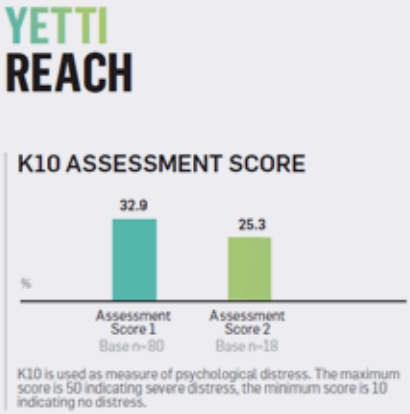
   A key outcome delivered by both programs is that young people and their families report a greater level of understanding of their mental health issues and symptoms. This understanding then supports young people's emotional regulation, and enables parents and families to better support their child.

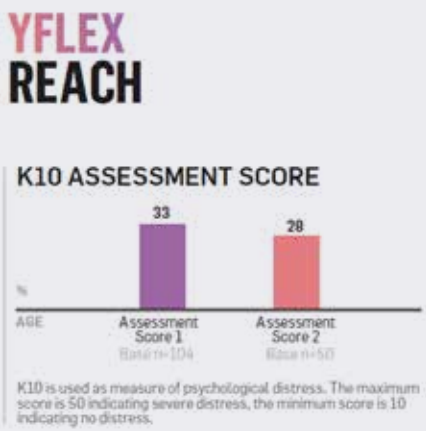
3. *Social connection and community participation has also increased*

   A further critical outcome delivered by both programs is an increase in young people's social connections and engagement with activities outside the home (including increased participation at school). This increase in engagement is often instrumental to furthering mental health outcomes, and reflects that both programs are helping young people to build confidence to engage in activities which are meaningful to them.

4. *Mixed evidence of improvements in mental health symptoms*

   Both YETTI and YFlex achieved significant reductions in K10 score between intake and follow up assessment (see below), indicating overall effectiveness in reducing psychological distress. Within the qualitative data, there was mixed feedback for both programs regarding their impact on reducing mental health symptoms. Some young people and families reported significant change in their symptoms while others reflected that while some areas of their mental health had improved, they still required further help to address their presenting issues. This finding most likely reflects the complexities involved in supporting the target cohort, and may indicate that more intensive support is required for young people with particularly complex needs.





5. *Both programs are integrating well with the broader landscape, although are not meeting the level of community need*

   Partners of both programs reflected that YETTI and YFlex have successfully integrated into the broader youth mental health landscape and are providing much needed support between early intervention and tertiary services. As with the reach findings, this feedback indicates that the programs are supporting their target cohort. Partners also reported the demand for these services exceeded the capacity of YETTI and YFlex, indicating the need for more services for this cohort.

6. *Three key strengths of the models were identified*

   Feedback from young people and parents reflect a number of key areas of strengths for the programs which enabled outcomes. Both YETTI and YFlex were reported to provide consumers with practical strategies to address their symptoms, as well as meaningful, safe engagement between workers and young people. YETTI also received feedback that the program's focus on providing whole-of-family support through dedicated clinicians working with family members in parallel to other YETTI clinicians working with young people was a key strength and enabler of outcomes.

7. *Systemic challenges in meeting demand were noted*

   There was minimal constructive feedback received about either service, but Partners did report that the demand for these services currently exceed the capacity of YETTI and YFlex. This feedback indicates that there is an ongoing need for more services for this cohort.

Recommendations

Eight recommendations were made as a result of the evaluation:

Recommendation 1

To ensure the needs of young people experiencing or at risk of severe mental illness continue to be addressed, EMPHN should continue funding services targeted at the cohort too complex for primary care but insufficiently acute to be eligible for Child Youth Mental Health Support (CYMHS).

Recommendation 2

To support a program that is accessible, equitable and integrated with the wider system, a future model should incorporate:

- catchment-wide strategies for co-location or in reach to headspace, community health and general practice locations
- negotiation of 'step up/down' protocols with CYMHS to formalise and make consistent relationships across the catchment
- flexibility in the provision of services to enable supportive outreach services for families for whom attendance at services is a barrier to engagement.

Recommendation 3

To ensure that the program is equitably distributed, EMPHN should develop clear estimates of the level of need for Youth Enhanced Services within each LGA as part of its next needs assessment, and consider locality specific service benchmarks for contracted providers.

Recommendation 4

To ensure value for money informs decision making about program funding models, EMPHN should complete a cost-effectiveness analysis of the two programs. This might include, for example, determining the cost per consumer, and the cost per consumer achieving a reduction in K10 score of five points or more.

Recommendation 5

To improve the utility of program data, EMPHN should consider strengthening guidance on assessments to reduce variance in the timing of reassessments, and potentially increase the frequency of reassessments.

Recommendation 6

To maximise value for money in future program delivery, EMPHN should undertake a multi-criteria analysis of commissioning options focusing on equity (with respect to geography and demography), effectiveness (consumer and family benefits achieved), cost-effectiveness (maximising benefits secured per dollar).

Recommendation 7

To minimise the disruption of a transition to a new model (if adopted), EMPHN should invest in change management in close collaboration with existing providers.

Recommendation 8

If a new model is adopted, inclusion of key YETTI and/or YFlex model or delivery elements which have demonstrated efficacy should be considered for inclusion. These include: a dynamic demand management referral model, not holding a waitlist, continued delivery of psychiatry services and family support, continued focus on practical strategies and relationship building for consumers, and sector-capacity building, and delivery of cost-effective outreach services.

Improvements made to the service as a response to the evaluation

Following this evaluation, a number of changes to the service have been made such as:

- YETTI has been working to increase its existing service reach to Yarra Ranges and Mount/Glen Waverley clients and families through liaising with both the new Lilydale and Syndal headspaces, as well as commencing a relationship with the new youth hub at Lilydale.
- Increase in the number of YETTI staff who have worked within Victorian Child & Youth Mental Health Services bringing expertise from that sector to the young people and their families. Where required and available we step up clients to CYMHS and/or engage with other specialists (e.g. paediatricians for young people with disordered eating) to become part of the YETTI recovery team.

- YFlex now has built strong and established relationships with important and relevant stakeholders within the stepped care system. Notably YFlex has built a very strong rapport and referral pathways with Austin CYMHS, Goulbourn Valley CYMHS, Northern Area Mental Health Service (NAMHS) and Nexus Primary Health. Alongside this YFlex attends headspace Greensborough's clinical review on a weekly basis and also attends a working group and network meeting with headspace Craigieburn. As YFlex's catchment area includes three different areas, mental health services, strong collaboration and open referral pathways are necessary.
- In relation to K10 outcome measures, YETTI have introduced an additional measure of functioning, as well as increasing the completion of all outcome measures to 3 monthly, to more accurately track client experience, symptoms and functional progress.
- In response to young people experiencing wait times to accessing support, YFlex has changed how they manage active bridging support for those young people referred to the service. At the point of referral and initial assessment young people are offered active support provided by the YFlex Peer Support Worker, which can be delivered flexibly through face to face, outreach or telehealth support depending on the preference of the young person.
- YFlex has significantly increased its capacity for providing family support. YFlex now has a clinician that dedicates 0.3 FTE of her role to providing specific family support to families and carers at the point of referral to assist in early engagement with families, who are often experiencing their highest levels of distress when initially accessing support. In addition, all staff have now been trained in family therapy through the Bouverie Centre, and all staff have been trained in Single Session Family Consultations, also through the Bouverie Centre.

EMPHN response to the evaluation recommendations

- EMPHN are in the process of planning its re-design / co-design process, in order to recommission its youth enhanced services to deliver services in line with stakeholder input and evaluation recommendations.
- There is a plan for population and service data to be gathered in order to inform the future distribution of Youth Enhanced Services and possible development of locality specific targets.
- There is a plan underway to include cost effectiveness measures into the evaluation frameworks of the two programs.
- Discussions with service providers have occurred on the ways to improve the utility of program data such as strengthening guidance on assessments to reduce variance in the timing of reassessments, and increasing the frequency of reassessments.

NEAMI Psychosocial Support Service evaluation – Consumer and Staff Experiences of Service

Psychosocial Support Service (PSS) is for people with severe mental health issues who are not supported by the National Disability Insurance Scheme. PSS provides time-limited interventions to support psychosocial capacity and has a recovery and trauma-informed focus. PSS is underpinned by the following principles of care:

- It is consumer focused. The consumer is at the centre with an understanding of connection to family, friends, peers, and the community.
- It is recovery focused. The supports are specific to the person and their needs, promoting recovery and self-care.
- It is flexible. The service provides the right support, at the right time, in the right way, and is simple to access.
- It is collaborative and whole-of-person: The service works in partnership with other key services, families, and individuals.
- It has skilled staff. A well-trained, multidisciplinary workforce, inclusive of peers, is a hallmark of the service.
- It promotes safety and quality. The service operates to the highest standards of safety and quality in the delivery of services and support to the consumer.

Approach to the support:

The fundamentals of the approach used by all staff connected to the Psychosocial Support Service and Psychosocial Transitional Programs is recovery orientated practice with a focus on capacity building. Recovery orientated practice is underpinned by two core principles.

Principle 1 – Recovery as an Individual Process: Recovery is a unique and personal journey towards hope, meaning, identity and responsibility for self. The CRM focuses on increasing wellbeing rather than decreasing symptoms and aims to promote the processes of psychological recovery.

Principle 2 – Collaboration and Autonomy Support: The strength of the relationship that exists between an individual living with a mental illness and the people that are supporting that person has a significant influence on mental health outcomes.

Capacity building is defined as a process that enhances the ability of the individual to strive genuinely in their recovery, identify and address new challenges or improve control over their lives in a sustainable manner within dynamic contexts.

Support is time limited, based on individual need and delivered across tiered levels of support packages (can include a visual representation of a consumer journey). A consumer can be supported to only attend groups keeping the philosophy of capacity building in mind. Tiered levels of psychosocial support packages are as follows and are determined at assessment:

- Intensive supports: for up to 12 months, with reduction over time as the individual's capacity for self-care/self-management improves
- Moderate: Medium-term supports for up to six (6) months, which might encompass flexible 1:1 individualised and/or group-based supports
- Low: Short-term support, which might encompass a four to eight-week wellness recovery program, support to link to mainstream community groups, or one-off support to address a pressing need such as housing.

These support packages could be interchanged as people's needs changed and are delivered via a mix of modalities, e.g. face-to-face, phone, video call, and groups.

Background

The Commonwealth provided funding to PHNs to commission psychosocial support services for people with severe mental illness who are ineligible for the NDIS. These new services address the needs of people who are new to mental health services, as well as people who have received support under previous Commonwealth programs, namely Partners in Recovery (PIR), Personal Helpers & Mentors (PHaMs), and Day to Day Living (D2DL).

The PHN-commissioned psychosocial support services address the gaps that have arisen for people with severe mental illness who are not supported by the NDIS and who have unmet psychosocial needs.

The Commonwealth recognised that psychosocial support service providers have an ongoing role in ensuring that consumers do not 'fall through the gaps', particularly those formerly supported by Commonwealth funded programs (PIR, PHaMs and D2DL). The PSS program works collaboratively with the NDIS, supporting clients to test or re-test for NDIS eligibility (if appropriate) or to transition to other services.

Evaluation Approach

The focus of the evaluation was on consumer and support worker experiences of the service over the period April 2019 to May 2020, with a quality improvement lens applied. Qualitative interviews were used to test the assumptions underpinning the service model. The evaluation directly asked for both consumers and support workers experience in a number of areas, as well as, what quality improvements they would like to see.

The areas of enquiry focused on 4 main areas:

1. Overall experience of support
2. Effectiveness of the support
3. The Model of Support, particularly Length of Episode of Care
4. Effectiveness of written materials including assessments

Methods

The Consumer Interview Questions were developed in collaboration with Peer Support Workers (PSWs). Feedback was gathered through one-to-one and group interviews conducted by PSWs over MS Teams. 14 consumers participated in the interviews: 9 in the one-to-one interviews (7 PSS, 2 PTP) and 5 (5 PSS) in the two focus groups. Consumers were recruited through an expression of interest and received remuneration for their time. The average length of individual interviews was one hour, with group interviews taking two hours.

Feedback from a representative number of support workers was gathered through an online focus group using the MS Teams platform. The focus group ran for two hours and was facilitated by a Senior Practice leader with a Service Manager that did not have direct line supervision of the participants to reduce any bias. There were 5 staff members interviewed in the focus group: 4 CRSWs and 1 PSW. The support worker questions were adapted from the consumer interviews and sought to examine support workers experience of the service model.

Key Findings

1. **Overall experience of service and service provision by consumers and support worker was positive** with over 60% of consumers reporting the service was explained in a way that they could understand what was on offer, it was flexible to their needs, safe and inclusive. Over 80% of consumers said the service met their expectations of the service, with 20% stating more practical support would have met their expectations e.g. transport to appointments, financial support and linkages to support for family members.
2. **Over 600 consumers have been supported by the program with nearly 9000 sessions of support being provided to them**. 385 Consumers have accessed support through the Transitional Support arrangements. Of those consumers 426 were female (66%) and 209 (33%) were male. The majority of consumers were aged between 46-65 and live in the Outer East portion of the catchment. 245 PSS consumers received intensive support packages (between 6-12 months in length).
3. **The flexibility of service provided added to the value of the support being made available.** Consumers appreciated the flexibility of their support. This included changing appointments, as well as the ability to dictate time and frequency of appointments. In person and in the community, support was valued over phone support by some consumers; 100% of consumers appreciated the flexibility to opt to engage over text for various reasons: for reminders, cancellations and rescheduling, when they didn't feel like talking over the phone or in person or when they were having a bad day. Consumers felt comfortable directing this. This was reinforced by workers with 100% of workers agreeing that flexibility in the types of support offered, the autonomy of the role, and being within a predominately mobile team are aspects that are supportive to consumers and to the delivery of the support.

4. **Elements of the coaching approach were valued and were effective in increasing consumer capacity.** This included encouragement and support to make changes, breaking down tasks to be more manageable, visioning for the future, connecting/reconnection to consumers abilities and resources, focusing on strengths not weaknesses, receiving reminders and check-ins around goals and the worker initiating follow up discussions in proceeding appointments. Working collaboratively and being updated on progress when there were behind the scenes work going on - e.g. NDIS evidence gathering - made consumers feel included and respected.
5. **The way that the service has been delivered has been inclusive and safe.** Consumers identified listening, rapport, choice, respect and non-judgementalism were important elements of respect and safety within the service. Over 60% of consumers reported feeling comfortable with their support worker, and safe to share vulnerabilities or comfortable to not share when they weren't feeling safe. However, feedback on the model of support identified over 60% of consumers did not feel like the time they had was enough time with the service or that by the time they built rapport and started to make goals they then had to exit the service. Over 20% of consumers reported the time frame made them feel rushed or pressured to get their issues resolved. This was reinforced by support workers with 100% stating that overall the length of the support packages is not long enough for consumers and noted the majority of their consumers reported the same.
6. **There is a need for psychosocial capacity building support, and this is an effective support for consumers.** Feedback highlighted expectations of offering emotional support and practical support as part of capacity building support as being important to consumers, however only 14% of consumers felt they didn't receive enough emotional support. Workers being able to switch between goal-focused work and emotional support was valued when there were issues coming up for consumers.

Lessons learned

COVID-19

The interviews were conducted during a period of service restriction due to COVID-19 and consequently this may have impacted consumer's perceptions of the service and psychosocial support needs during that time. At the time of interviews, service provision was conducted primarily over phone or telehealth platforms. The method and process of data collection was also adapted due to the requirements of COVID Safe support which will have impacted on the quality of the data gathered.

Psychosocial Transition Program participants

It is worth noting that the experience of participants that entered the service through the Psychosocial Transition Program (PTP) funding stream were different from consumers that have not had an experience of psychosocial type supports prior to engaging with the service. Changes in workers and the change in providers for PTP consumers created challenges to establishing a sense of consistency for consumers. PTP consumers felt the service was different to what was offered by their previous provider; some found this an easy transition and others felt that PSS offered less support than they had received before.

In light of this evaluation, the following recommendation have been made:

Recommendations

1. More opportunities for consumer participation in service development including but not limited to co-design of group programs; to ensure that programs are meeting needs. Consumers raised themes on the number and focus of groups as an area that could be improved i.e. including more groups focused on recreation rather than psychoeducation. Group programs to consider online learning as a modality.
2. Exploration of more formal partnerships between PSS and local community groups. Consumers were seeking a broadening of partnerships to include a variety of groups e.g. Men's Sheds, animal shelters, charity services.
3. Updating Neami PSS Guidelines and conducting Professional Development Sessions with staff to ensure the service model is explained at intake as well as at the 3 and 6-month marks, including a focus on the Peer Support Worker role, time frames of support, episode of care and better explanations of assessments.
4. Review of required assessments and lengths of support packages.

Conclusions

Key themes that were highlighted across the consumer and support worker feedback include:

1. Trust and rapport are integral parts of a productive and supportive working relationship and there is tension between the time required to build this and the time available to provide support based on a short-term support model.
2. There is great value in support being made available in ways which are flexible and specific to the consumer and their needs. PSS does this well.
3. The way in which support is offered to consumers is broad, requiring a combination of care coordination, emotional support and capacity building in balance with addressing and managing issues as they unfold. The right support, at the right time, and in the right way is at times a challenging balance to strike with the time available for support.
4. While the time framed nature of support presented as a key challenge, the impact of the support was meaningful and reflects the broader processes of recovery, including hope, positive identity, meaning and empowerment.
5. The peer support worker role can be better articulated at the service entry point to ensure these roles are utilised to the best of their ability.
6. The model can be explained better at the beginning and throughout the episode of care.

Improvements made to the service as a response to the evaluation

Following this evaluation, a number of changes to the service have been made such as:

- Consumer participation working group has co-designed several pieces of work including surveys and evaluation tools. This helps ensure consumer voice and their needs are represented during planning of groups including a section to identify consumer interest in co-design/ facilitation of groups.
- Family and Carer Working group meetings with Carer consultants. They are in the final stages of developing a PSS Info sheet to give to Family and Carers at the start of engagement with consumers.
- Co-facilitation of groups with other organisations such as Banyule Community Health to increase integration with other organisations and community. Staff have also been completing portfolio activities with target population groups and bringing back information to the team.
- Teams now hold professional development sessions where various services come and share information which strengthens relationships and referral pathways.
- Length of support is now clearly discussed with consumers during intake. Also the introduction/completion of the Collaborative Care Plans have supported discussions with consumers around support needs and effective exits.

Evaluation of the Mental Health Stepped Care Model

The Mental Health Stepped Care Model (MHSCM) is an ambitious reform package that is being rolled out across the Eastern Melbourne PHN catchment. Stepped Care is an evidence-based, staged system, comprising a range of help and support options of varying intensity to match the level of need and complexity of conditions experienced by consumers.

Background

The MHSCM launched in the north east region in January 2018, outer east in July 2018 and inner east in January 2019. In total, 4,350 consumers have accessed Stepped Care services over the period January 2018 to June 2020.

Person-centred	Clinical staging	Integrated care pathways
Matching services to consumer need	Collaborative care planning	Suite of evidence-based services

Ensuring that every person with a mental health need receives the right care, at the right time, from the right person, in the right place

Approximately 5,594 referrals were made to the program over the period from 1 January 2018 to 30 June 2020, 78% of which resulted in services. Around 47,460 sessions were offered, with an average of 11 sessions per consumer. Overall, 62% of consumers were female, 8% under 17 years of age and 3% were either Aboriginal and/or Torres Strait Islander or both. Just over 15% of consumers were employed and around half were on low incomes.

The most common intervention delivered was psychological therapy (69%) for depression and/or anxiety disorder. The average waiting time was 18.29[5] days and average length of care was 43 days. Around 48% of referrals were processed by the provider's intake team and 52 percent processed by Eastern Melbourne PHN referral and access team, with just over one-third of all referrals received from general practice.

About the evaluation

ARTD Consultants in partnership with the Melbourne School of Population and Global Health were commissioned to evaluate the implementation of the MHSCM between July 2018 and September 2020. The evaluation provides insights from services providers, consumers, general practice and Eastern Melbourne PHN staff to inform continuous improvement and future evaluation of the impact and cost effectiveness of the MHSCM.

[5] Considerable care should be taken when interpreting wait time data given variability in the quality of the data and recording practices.

Data sources and methods

The evaluation used a range of data sources and quantitative and qualitative methods such as service provider reports, interviews with PHN staff, consumers and general practitioners, and survey and focus groups with service providers.

Key findings

Consumer experience of the service is positive

Outcome measures were only available for 11.6% (or 464 of 4,350) of consumers who took up the service.[6] Approximately 71% of the sample who had taken K10 surveys two or more times showed a significant improvement in scores, 19% showed no change and 10% showed significant deterioration.

Consumers report high levels of satisfaction with the care received (n=31). Interviews indicate that the MHSCM provides accessible, tailored and person-centred care. There are three key strengths of the model from a consumer perspective.

1) **Care coordination:** The inclusion of care coordination as a component of the model has been highly successful in empowering consumers to identify, access and engage in supports that address their individual needs. The Care Coordinator is integral to driving the care team and supporting consumers through provision of practical assistance with employment, housing, financial challenges and co-occurring conditions such as physical health and disability that affect mental health and wellbeing.
2) **Tailored support options:** Having a variety of care options was central to the success of consumer engagement and treatment in the stepped care service. Peer support workers and group-based programs were highlighted as valuable treatment modalities because they facilitated recovery by enhancing social inclusion and instilling a positive sense of self.
3) **Ease of access:** The co-location of stepped care services in community organisations and health hubs has made access more streamlined and efficient for consumers to connect with a variety of services in one location. Similarly, the no-cost service reduces financial barriers to mental health treatment for a population group that would otherwise not be able to afford counselling through a private practitioner.

Consumers would like to see improvements in promotion of the service among general practice and the wider community, more timely access to the service, clarity around how to re-engage following completion of an episode of care and more certainty around the future of the stepped care program.

[6] Low completion rates of K10 should be investigated further. Possible reasons include: consumers not having reached the time in their treatment where a second outcome measure was required, different counting rules and practices being applied in FIXUS and when analysing paired samples, inconsistent application by service providers who reported that K10 administration can affect treatment engagement and is not a valid success measure for the MHSCM, and consumers exiting the program before a second outcome measure could be administered.

Service providers felt their work is making a difference, but aspects of delivery are challenging

Practitioners delivering stepped care reported a high level of support for the model with 85% (n=27) agreeing that it is a professionally rewarding and satisfying program to deliver. When asked to rate the quality of implementation within their organisation on a scale of 1 to 10, practitioners provided an average score of 7.42 (n=26, SD=1.7).

Positive results were also found when assessing MHSCM implementation against components of the Consolidated Framework for Implementation Research (CFIR).[7] The strongest factors related to implementation success were alignment of the model with staff values and preferred ways of working with consumers, leadership support, fit with organisational priorities and presence of a stepped care champion.

Practitioners report that the stepped care model is achieving positive outcomes, but more support is required from general practice and tertiary services. There were four key challenges reported by practitioners.

1) Information management systems: The FIXUS client information management system does not adequately capture the nature of work involved in delivering the MHSCM. It also drives reporting requirements that are administratively burdensome with no clear connection to service improvement and enhanced consumer outcomes.

2) Consumer demand: The number of consumers presenting with moderate to severe levels of mental health distress and complexity was unanticipated[8]. This is creating pressure on service providers to meet demand for higher intensity services that are more costly to deliver than self-help resources and psychosocial services for at-risk groups and individuals with mild mental illness. Almost one-third of practitioners felt their caseload was unmanageable.

3) Collaborative care: While working in multi-disciplinary teams was highlighted by both service providers and consumers as being highly beneficial, there is further work required in determining adequate processes that can support collaborative care in practice. This is particularly important for staff located offsite to enhance connections with the team and engagement with external agencies such as general practice.

4) Workforce shortages: While there is diversity among the stepped care mental health workforce, there are serious shortages in some specialities and locations across the Eastern Melbourne PHN catchment. Areas of need include Child Psychologists, Psychiatrists, dual diagnosis and Aboriginal Mental Health Practitioners[9]. The value of lived experience was recognised, with potential to expand and better support peer workers.

[7] CFIR draws together key insights from over 50 years of research on implementation to provide a systematic process for assessing multilevel factors that influence intervention delivery and effectiveness in health settings (see https://cfirguide.org/).

[8] Section 3.5 provides explanations that might account for the higher than anticipated proportion of moderate to severe consumers presenting to the service.

[9] Psychiatry is not part of the MHSCM, but was identified as an area of need by service providers.

General practice awareness and confidence in the model is improving

Uptake of Stepped Care has been challenging, with General Practitioners (GPs) expressing some frustration at the loss of existing services such as the Mental Health Nurse Incentive Program (MHNIP) and Access to Allied Psychological Services (ATAPS) that occurred following transition of these primary mental health programs to stepped care.

Awareness of the MHSCM among GPs appears to be slowly improving as a result of communication and engagement efforts by service providers and Eastern Melbourne PHN. Of those GPs who have used the service, referral rates were typically three to four consumers a month.[10] However, several GPs reported lack of clarity around eligibility criteria and referral processes, with some finding the paperwork time consuming and expressing concern that they could not specify which service provider or practitioner their patient was being sent to.

> *"I think it's a good service, it saves the patients a lot of costs. And they've had really good experiences with some of the practitioners that they've been matched to. They really have been helped by those sessions."*

A key mechanism that will drive greater adoption is confidence in the model. This is enhanced when GPs are able to interact directly with service providers, share information and hear positive outcomes firsthand from patients and colleagues. Similarly, GPs who have witnessed mental health programs 'come and go' are more likely to refer to a service when assured of its sustainability.

Mental health care transformation takes time to implement

Systemic reform involves more than tinkering around the edges. Findings from the *Royal Commission into Victoria's Mental Health System* interim report emphasise the challenge of delivering stepped care within the context of a system that is not well aligned to the requirements of a person-centred, integrated model that addresses the needs of individuals at all stages of illness.

> *"Sustained investment and collaboration will help to maintain momentum and capitalise on what has been achieved in the past two and a half years of establishing the stepped care model."*

It is anticipated that the Commission's final recommendations will provide a stronger enabling environment for effective implementation of the MHSCM.

Service providers endorse the principles underpinning the MHSCM. They are committed to working alongside Eastern Melbourne PHN to embed the model and transition the primary care sector from a fragmented, episodic style of service delivery to one that provides accessible and high-quality continuity of care to consumers.

[10] There was a low GP response rate to the evaluation despite persistent efforts and the use of incentives. Results are based on a sample size of 21 GPs and care should be taken when interpreting findings. Given the low number it was not possible to calculate a Net Promoter Score, although the data available points toward a moderate likelihood of recommending the service to colleagues.

Key recommendations

Overall, the MHSCM is supported by consumers, service providers, general practice and Eastern Melbourne PHN staff. During the course of the evaluation, we observed consistent positive feedback about the potential of the stepped care model to strengthen service integration and improve the mental health and wellbeing of consumers.

However, the first two and a half years of operation have not been smooth sailing. This is to be expected when introducing rapid, large-scale change in primary mental health care services. Several obstacles to effective establishment and implementation of the model have been encountered, some of which have been addressed or are currently being remedied. However, a number of implementation challenges requiring attention still remain.

Priority areas for action over the next 6-12 months

1. **Review intake and assessment procedures.** There are mixed reports and data about the timeliness and quality of access and referral to the program from consumers and general practice in relation to both the centralised Eastern Melbourne PHN and local service provider systems. Based on available evidence, we are not able to make a clear recommendation on which system is better or whether both systems should continue to co-exist. The review should address areas of administrative duplication, efficiency and effectiveness of centralised and local intake systems, consistency in assessment practices, communication around eligibility, implications of extended wait times following initial assessment for both consumers and clinicians, and ways to reduce the need for consumers to re-tell their story.
2. **Review data collection systems.** Data integrity, feasibility of collection and utility in supporting the MHSCM needs urgent review. Careful consideration should be given to the nature and quality of data fields captured through both service provider systems and FIXUS, including interoperability of systems. The value of data-driven decision making should continue to be clearly communicated to service providers, accompanied by ongoing training and support as needed. Better data capture will drive improvement efforts, reduce administrative burden on service providers and Eastern Melbourne PHN,

and provide a common language for measuring performance and quality of care. Changes to data systems provide an opportunity to enhance alignment with unique elements of stepped care, such as clinical staging, collaborative care practices, management of consumers across services, consumer and carer experience, outcome measures and costs of different treatment options.

3. **Address service gaps in the stepped care model.** A critical component of the MHSCM is flexibility to address differentiated consumer needs across a spectrum of care. As such, it is important to ensure that service relationships integral to the model are facilitated to deliver whole of population care. Collaboration between Eastern Melbourne PHN and providers is required to strengthen access to specialist workforces such as psychiatry and child psychology, enhance integration with tertiary care and identify opportunities to step up and down between service systems.
4. **Develop a general practice engagement plan.** There is a need to raise the profile of the stepped care program to increase awareness, particularly among General Practitioners through a marketing and engagement campaign. Strategies to increase adoption among GPs should consider targeted education around the benefits of a stepped care approach for mental health consumers, the use of GP opinion leaders as guest speakers at events and forums, differentiation of the program from existing services such as Better Access, clear referral pathways and provision of consistent communication processes with service providers to support collaborative care practice.
5. **Develop a monitoring and evaluation plan.** The ARTD Consultants and University of Melbourne evaluation considered the first two years of operation with a focus on supporting refinement of MHSCM implementation. A forward evaluation plan should be developed that includes a strategy for internal performance monitoring and external evaluation. It is recommended that an independent supplier be appointed to evaluate impact and value for money, commencing in 2022. This will allow time to consolidate the stepped care model, action findings from this evaluation, improve data and monitoring systems and procure an appropriate supplier.

Improvements made to the service as a response to the evaluation and next steps

EMPHN are working with providers to consider the following elements of the service and how they could be improved:

- EMPHN to undertake some level of re-design of mental health commissioned services to address deficiencies and build on strengths identified in the evaluation.
- Deep GP engagement in the co-design – including using our POLAR data to identify those GP partners who have a significant mental health caseload.
- Engagement in the design process of our Clinical Council and Community Advisory Committee.
- Need to give equal weight to building in patient experience measures along with clinical outcome measures.
- Critically examining the role of our referral and access, providers referral and access, and other alternatives for 'entry points' and assessment, including the previously discussed Link-me pilot results.
- Building into the model streamlined and effective KPIs and data capture (that can allow effective reporting to the Commonwealth (aligned with their requirements), real-time measurement of patient reported outcome and experience measures, and real-time understanding of value-for money.

Discussion and conclusion

These evaluations generate strong evidence for the contribution of these programs and reports on areas where it is critical to maintain and build upon, as well as areas for improvement.

The IDEAS expansion evaluation showed what an important program it is with 94.1% positive consumer experience, 89% positive staff experience rating, improved range of clinical health outcomes for people with diabetes (reduced HbA1c, PAID (distress) and weight) and improved understanding of community based care cost savings which will contribute to driving health system sustainability through better system utilisation and optimising resources. There was an estimated cost saving of $27K per person and approximately $7 million/annum in the Eastern Health catchment. There are significant opportunities to leverage digital health data and technology for wider health outcomes in the future.

The Yetti and YPlex evaluations reported the target cohort is being reached, and the services have increased access to support this group. The programs have been successful in increasing mental health awareness, social connection and community participation in the target cohort. There was mixed evidence of improvements in mental health symptoms regarding K10 results and qualitative feedback from young people indicating more intensive help may be needed for young people with complex needs. Both YETTI and YFlex were reported to provide consumers with practical strategies to address their symptoms, as well as meaningful, safe engagement between workers and young people. YETTI also received feedback that the program's focus on providing whole-of-family support through dedicated clinicians working with family members in parallel to other YETTI clinicians working with young people was a key strength and enabler of outcomes. Both programs were also found to be well integrated into the broader youth mental health landscape however, partners reported the demand for these services exceeded the capacity of YETTI and YFlex, indicating the need for more services for this cohort.

The Psychosocial Support service evaluation reported a positive consumer experience where they valued the flexibility and support made available through the program, the coaching approach utilised and appreciated the service being delivered in a safe and inclusive way. Areas of improvement included extending the length of support packages available to consumers as 20% reported feeling rushed or under pressure to resolve their issues. This was reinforced by support workers who agreed that overall the support packages were not long enough for consumers. Another area for improvement was the need for psychosocial capacity building. Feedback highlighted expectations of offering emotional support and practical support as part of capacity building as being important to consumers, however only 14% of consumers felt they didn't receive enough emotional support.

The Mental Health Stepped Care evaluation reported positive consumer experiences who identified a number of key strengths of the model that can be built upon in the future. The small percentage (11.6%) of outcome measures available for this evaluation is also an area to focus on in the future to facilitate improvements in data collection. Practitioners delivering stepped care supported the model, but reported more support was needed from general practice and tertiary services. Another important finding were the challenges identified in information management systems, consumer demand, collaborative care and workforce shortages. In addition to the response to the Mental Health Stepped Care evaluation, EMPHN is working with providers to consider how to improve integration and outcomes of all the Mental Health services it commissions in the Eastern Melbourne catchment.

A number of improvements have been put into motion and next steps planned for all these evaluations that will be undertaken in collaboration with partners, key stakeholders and consumers. These evaluations were conducted during COVID-19 which resulted in a period of service restriction which may have had an impact on these programs.

Australian Government

The Australian Government is the principal funding body for Primary Health Networks.

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