Beacon Strategies

# Evaluation report

## Integrated Mental Health Service Hubs

Prepared for Brisbane North PHN
December 2021

## Acknowledgements

Beacon Strategies acknowledges the Traditional Owners of the lands on which we live and work, and pay our respects to Elders past and present. We acknowledge Aboriginal and Torres Strait Islander people who contributed their knowledge and expertise as part of this evaluation of the *Integrated Mental Health Service Hubs* program.

Beacon Strategies acknowledges those who contributed their experience and insights to this evaluation through the completion of surveys and participation in focus groups and interviews — particularly those with a lived experience of mental health recovery.

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The approach to developing the monitoring and evaluation framework within this document is based on the work of Anne Markiewicz and Ian Patrick. For more information, refer to Markiewicz A. and Patrick I. (2016). Developing monitoring and evaluation frameworks, SAGE: Los Angeles.

## About Brisbane North PHN

Brisbane North PHN is one of 31 Primary Health Networks across Australia and funded by the Australian Government Department of Health. Brisbane North PHN supports clinicians and communities in Brisbane's northern suburbs, Moreton Bay Regional Council and parts of Somerset Regional Council with a vision for a community where good health is available for everyone.

## About Beacon Strategies

Beacon Strategies is a mission-based health and social services consultancy.

Established in 2015 and based in Brisbane, Queensland, Beacon Strategies partners with organisations across the health and social services sectors to plan, design, implement and evaluate their programs and services.

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# Executive Summary

## About the program

Primary Health Networks (PHN) receive several streams of funding from the Commonwealth Department of Health to commission mental health services to meet the needs of people with severe mental illness in the community.

Following a review of its commissioned services to better meet the needs of people with severe mental illness, Brisbane North PHN established three *Integrated Mental Health Service Hubs* ('hubs') in 2019. These Hubs use a pooled funding approach to deliver clinical and non-clinical services in one location and facilitate access to tailored packages of care for people with severe mental illness.

Three separate providers are contracted by Brisbane North PHN to deliver the hub model across three catchment areas across the Brisbane North and Moreton Bay North region. In 2021, Brisbane North PHN engaged Beacon Strategies to undertake an external evaluation of the hub model across Brisbane North to explore whether this integrated approach improves outcomes for consumers.

## Approach to the evaluation

The evaluation approach considered the program from several perspectives or domains — appropriateness, effectiveness, implementation and sustainability. Aligned to a set of guiding evaluation questions, data was analysed sourced from program documentation, client/program data collected according to the Primary Mental Health Care Minimum Data Set (PMHC-MDS), and semi-structured interviews and focus groups with key stakeholders (e.g. Hub staff and management, Brisbane North PHN, peer PHNs). The findings were then considered in the context of the evidence base and strategic environment relating to severe and complex mental health services.

## What was found

### Appropriateness

Stakeholders shared positive perceptions of the value and impact of the hub model to support people with severe mental illness to live well in the community and achieve their recovery goals. While all perspectives were positive, sector stakeholders generally reported less positive perceptions of value and impact of the hub model than service users and hub staff.

Service users reported an overall positive experience with the services they received, particularly in relation to accessibility and feeling welcome, valued and respected. An area that service users reported less agreement was having opportunities for family or friends to be involved.

For trends of non-engagement or disengagement from the service, referral data shows that around 17% of all inward referrals were recorded as 'declined' on intake, while 14% of referrals had an unplanned disengagement from the service. This is partly attributable to data quality issues, particularly in the initial stages of the program's establishment, where multiple episodes of service were recorded for an individual. There was reasonable

timeliness in the response to a new referral, with half of all referrals who engaged with the service being supported within two weeks of being referred.

Stakeholders, including hub staff, Brisbane North PHN and local sector stakeholders identified strengths of the hub model as relating to workforce, service environment, integrated approach, and the nature of support provided through the Hubs. Limitations or gaps identified in the design of the hub model included barriers to accessibility, availability/capacity, resourcing, time constraints, inward referrals, local stakeholder engagement and outcome measurement.

### Effectiveness

Since being established in July 2019 the hubs have collectively commenced 1,651 episodes of service, with 1,006 of these episodes closed/ceased and 746 open/active as at end-August 2021. There was a continued net gain in episodes of services each quarter over time, indicating an increasing capacity of the program to support more service users. The average duration of an episode of service was 193 days, ranging from 1 to 728 days across all episodes.

Main sources of referrals were community non-government organisations (NGOs), self-referral, general practice and public mental health services. Over time, there was an increasing proportion of referrals coming from public hospitals and mental health services, self-referral and 'other' sources, while the rate of referrals received from community NGOs, general practice and other private practitioners decreased.

A total of 38,620 service contacts were delivered during the reporting period at a rate of 1,485 per month across all hubs. 13% of planned contacts were not completed due to clients not attending. The average number of service contacts per episode of care was 23.2, and was relatively consistent across each of the hubs. Individual clients were the participants in 61% of service contacts, followed by clients in a group setting at 31%. Over half of service contacts were completed face to face, however a temporary shift to remote service delivery was observed during quarter 2 2020 as a result of the COVID-19 pandemic.

Service users supported by the hubs tended to be aged between 25 and 54 years (but ranged between 15 to 65+ years), female (62%), born in Australia (84%). Approximately 1 in 10 service users identified as Indigensou, while 7% of service users identified as LGBTI and 13% were experiencing or at risk of homelessness.

Although there were a considerable number of clients accessing support from the hubs who reside outside of the Brisbane North PHN region, clients generally accessed services that were closest to them geographically.

The most common presenting diagnosis was post-traumatic stress disorder then major depressive disorders. 8 in 10 service users presented with an additional diagnosis. but mostly positive recovery scores recorded at baseline through the Recovery Assessment Scale - Domains and Stages (RAS-DS).

Positive group-level changes in psychological distress and recovery over time

Significant positive treatment effect for those with matched pre and post scores of 51% for distress (K10+) and 41% for recovery (RAS-DS)

Examples of goal attainment shared qualitatively, but not systematically recorded

A high proportion of clients reported very high levels of psychological distress at baseline as measured by the the Kessler Psychological Distress Scale (K10+), indicating that the majority of service users are likely to have a severe mental disorder. While baseline recovery scores measured using the RAS-DS generally showed high levels of self-reported recovery against recognised domains of mental health recovery, service users generally had lower levels of clinical recovery at episode start, which relates to management of symptoms and impact on everyday functioning.

Measurement of group-level client outcomes using the K10 demonstrated group-level improvements in mental health outcomes as a result of engagement with hub services. Matched K10 scores (episode start and end) demonstrated that 51% of episodes result in a significant positive treatment effect in psychological distress. Service users also reported an overall improvement in total recovery scores over the duration of their engagement with hub services. However, availability of RAS-DS score data at episode end was relatively low (<5%), making it difficult to generalise these findings at a hub or individual level. Examples of goal attainment were reported qualitatively but not systematically recorded.

### Implementation

The hub model was implemented as intended by each provider and has stayed true to the original co-design outputs, while allowing for local variation in how services are delivered by the three commissioned providers based on their organisational and local context.

A review of contracted data compliance requirements indicated several gaps in the systematic and consistent collection of data.

Enabling factors for effective implementation of the hub service identified by Hub staff, management and Brisbane North PHN included

- physical aspects of the hub sites, including inclusive spaces, connection to transport, and locally based
- hubs working collectively to support integration of services and shared learning
- positive, collegial relationship between the hubs and PHN
- existing infrastructure and local presence of selected commissioned providers
- integration of clinical and non-clinical workforce
- workforce diversity, including the qualifications, skills, experience and characteristics of hub staff
- consumer participation
- co-location and partnerships with the HHS

Barriers to the effective implementation of the hubs were identified as:

- accurately capturing and reporting on service delivery in an integrated model
- using two systems for record keeping
- hub eligibility criteria being difficult for stakeholders to navigate
- misinformation about the NDIS and resulting inappropriate referrals
- demand management

- systemic challenges, particularly availability of bulk billing services and lack of exit pathways

In operationalising the hub model, hub managers and Brisbane North PHN staff highlighted the importance of being adaptable and as flexible as possible within the Department of Health guidelines.

Workforce was consistently identified as an important factor for successful implementation of the hub model. Integration of clinical and non-clinical hub workforce was identified as a challenge due to staff coming from different operating models and frameworks and difficulty defining the role of mental health nursing staff. It was highlighted that the hub model can be an adjustment for people with a clinical background who have not previously worked in community based settings.

### Sustainability

The hub model broadly aligns with the scope and intent of the Department of Health guidance for commissioning primary mental health funding streams, however the pooling of funding streams is a new and innovative approach to commissioning services for people with severe and complex mental illness. Brisbane North PHN staff and hub staff identified that the hub model supports a more seamless approach to stepped care and allows people to access different types of services simultaneously. The hub model demonstrated an effective response to previously identified areas of need within the Brisbane North PHN region, although service reach within the Redcliffe part of the region was highlighted as an unmet need.

A comparison of the hub model with a sample of peer PHNs demonstrated variability in how other PHNs have commissioned services for people with severe and complex mental illness. These included separately commissioned or 'siloed' funding streams, or an integrated approach whereby providers are funded to deliver a mix of clinical and non-clinical services. Similarities between the hub model and other PHNs commissioning approaches were identified and included contracting providers to deliver services to a specific sub-region, aligning sub-regions with hospital catchments and delivery of outreach services.

A number of factors were proposed by peer PHNs in commissioning severe and complement mental health services sustainably into the future that focused on:

- importance of co-design
- sub-regional approach
- partnerships with State-funded services
- relationships with referrers, particularly GPs
- shared resourcing
- single entry points
- care planning
- outreach into communities
- external drivers (e.g. NDIS roll out and COVID-19).

## Key implications and learnings

In interpreting the findings of the evaluation, several key themes emerged with implications for future commissioning and delivery of the Hubs model:

- ***People with severe and complex mental illness accessing the hubs report positive experiences and improved recovery outcomes when they remain engaged***

  Over 1,500 individuals have been supported and over 38,000 service contacts delivered during the 2.5 year period since the hubs were established in mid-2019. These outcomes demonstrate the effectiveness of the hub model to improve the mental health recovery of those service users who access and remain engaged in support. Opportunities exist to strengthen these outcomes by better understanding and managing the factors that drive rates of non-engagement and disengagement.

***While the pooling of resources enables integration of clinical and non-clinical supports in one place, the hubs are not fully integrated as part of the local service system***

When compared with traditional commissioning approaches, the hubs contribute to improved coordination across services and less duplication of services. However, better integration was generally limited to services available within the hubs rather than a broader definition of integration that considers the hubs as part of the wider service system. Local sector stakeholders identified a need for improved communication and engagement between the hubs and external providers, particularly regarding eligibility and referral processes. Pathways for service users to 'step up and down' to in order to manage demand for services and respond to individuals with more acute needs were identified as a challenge due to availability and capacity of external services.

***Strengthening the use of outcome measurement tools by practitioners would enable greater demonstration of recovery outcomes being achieved***

Where data was available for the K10 and RAS-DS assessment tools, it showed a positive treatment effect for service users completing an episode of service. However, the ability to demonstrate positive recovery outcomes across the program is limited by the availability of data collected upon commencement of, during and at completion of an episode of service. Qualitative issues were identified relating to their implementation by Hub staff, indicating a need to focus on improving their uptake and use. In addition to these prescribed measures of recovery outcomes, an updated monitoring and evaluation framework could include a focus on more intermediate outcomes (e.g. goal attainment, skill building, meeting needs) to demonstrate progress towards recovery outcomes.

***There are opportunities to strengthen the implementation of the hubs model***

Hub providers have effectively implemented the hub model and generated positive outcomes for service users, however there remain opportunities to further strengthen its delivery. Areas for improvement included expanding the reach, accessibility and capacity of the hubs to meet demand, improving responsiveness of referrals, involving family, friends and other natural supports, improving data quality, and continuously improving the service through evaluation and reporting.

***A hub-based model of integrated commissioning of mental health supports is becoming more common, with opportunities for replication into new areas and for learning from other regions***

Brisbane North PHN's Hubs model represents a commissioning approach that aligns with the current guidelines for commissioning services under these funding streams and responds to the regional priorities identified in the PHN's planning work. Similar commissioning approaches are being considered by peer PHNs as the policy and program landscape evolves, creating opportunities to learn from innovative approaches and share with other PHNs. This includes progressing system improvement priorities identified in the *Planning for Wellbeing* joint regional plan to further improve outcomes for people with severe and complex mental illness.

## Future recommendations

This report includes a set of recommendations for consideration by Brisbane North PHN (see full list on page 101) to improve future service commissioning and delivery to meet the needs of people with severe and complex mental illness, which span the following areas:

- communicating the outcomes of the evaluation through targeted reporting products
- better understanding and responding to the factors driving levels of non-engagement and disengagement
- building awareness and strengthening relationships with referring organisations
- increasing referrals to the hubs from the primary care setting (GPs) to identify and connect people with support earlier in their journey
- engaging with Metro North HHS to better integrate the hubs as part of a local service system
- strengthening the impact of the program through additional program capacity and reach, supported program exit and involvement of natural supports
- updating the monitoring and evaluation framework to reflect meaningful outcomes, develop data quality and collection protocols, and establish regular performance reporting mechanisms
- undertaking forward planning to guide the future delivery of the hubs model
- connecting with other PHNs to share with and learn from integrated approaches to commissioning services for people with severe mental illness
- exploring opportunities for Brisbane North PHN to deliver on other strategic priorities (e.g. single multi-agency care planning; integrated assessment and referral) as part of the hubs model.

# Introduction

## Purpose of this report

This report describes the outcomes of an evaluation of the Integrated Mental Health Service Hubs commissioned by Brisbane North PHN and delivered by Neami National, Stride and Communify Queensland.

In mid 2021, Brisbane North PHN engaged Beacon Strategies to undertake an external evaluation of the hub model across Brisbane North to explore whether this integrated approach improves outcomes for consumers. Specifically, the evaluation is focused on the value of pooling resources and commissioning an integrated service in comparison to other non-integrated models uniquely delivered in Brisbane North and Moreton Bay Regions. The external evaluation aimed to:

- collect, collate and analyse data and information outlined in an agreed evaluation framework, including surveys, interview and other qualitative data collection
- review and evaluate the novel aspects associated with Brisbane North PHN's model of implementation
- produce detailed reporting and communicate the evaluation framework outcomes, data and analysis
- provide recommendations for sustainability of ongoing evaluation activities and the broader framework to support the integrated mental health hubs is supporting people with a severe mental illness.

This evaluation report aims to comprehensively present the findings drawn from the evaluation of the program completed during June to October 2021 and is structured around the following sections:

1. Introduction
2. Background
3. Methodology
4. Findings
5. Discussion
6. Recommendations

# Background

## Program and policy context

### The program and policy environment calls for more integrated and coordinated services for people with severe mental illness

An estimated 3 per cent of the Australian adult population has a severe mental illness with symptoms that can be persistent or episodic in nature.[1] Reducing the severity of mental illness requires a range of services and supports that alleviate the impairment associated with a mental health condition on a person's social and occupational functioning. These services and supports are often provided by the primary healthcare sector, non-government organisation (NGOs), state-funded health system and National Disability Insurance Scheme (NDIS). The importance of coordinating and integrating these services and supports to meet the needs of individuals across the areas of medication management, physical health, alcohol and drug services, psychosocial support and broader community services such as housing, education and employment is increasingly recognised in policy and program guidance.[2]

The Fifth National Mental Health and Suicide Prevention Plan highlights *coordinating treatment and supports for people with severe and complex mental illness* as a key priority area.[1] The Fifth Plan recognises the role of Primary Health Networks (PHNs) and Local Hospital Networks (LHNs) in meeting the needs of people who are severely impacted by mental illness and may have other complex needs for services from a range of agencies. This includes:

- promoting integrated approaches to mental health services for people with severe and complex mental illness
- coordinating supports to address the problems of fragmentation this group often experiences
- meeting the psychosocial support needs of people with severe mental illness who are not more appropriately supported through the NDIS.

The COVID-19 National Mental Health and Wellbeing Pandemic Response Plan also outlined priority areas to address complex needs of those with severe, chronic or acute mental illness in ways that promote best practice care, assertively reach out to those who are ill, decrease reliance on inpatient services and increase services within the home and community:[3]

Similarly, the recently published Inquiry Report on Mental Health by the Productivity Commission identifies care coordination for people with a severe mental illness,

[1] Australian Government Department of Health. The Fifth National Mental Health and Suicide Prevention Plan. Canberra: Commonwealth of Australia; 2017

[2] Department of Health. PHN Primary Mental Health Care Flexible Funding Pool Programme Guidance: Primary mental health care services for people with severe mental illness. Australia Government: 2019.

[3] National Mental Health Commission. National Health and Wellbeing Pandemic Response Plan. Sydney: National Mental Health Commission; 2020.

described as having both a single care plan developed with and for them and a care coordinator provided to oversee the implementation of the plan, as a priority reform. It recognises that some government-funded programs currently offer care coordination services, it highlights several factors that limit the effectiveness — including focusing on individuals rather than networks, limited workforce capability, short-term arrangements promoting premature closure of cases, and instances of multiple care coordinators with overlapping responsibilities.[4]

At a state level, Queensland shares a similar aspiration of improving the integration of services as part of the Shifting Minds Queensland Mental Health, Alcohol and Other Drugs Strategic Plan 2018-2023. It outlines a commitment to providing personalised and integrated care with a focus on placing community-based services at the centre of integrated care.[5] Queensland Health also invests in services to meet the needs of people experiencing severe mental illness across the continuum of care. This includes the Mental Health Community Support Services (MH CSS) which are non-clinical recovery-focussed psychosocial wraparound support services delivered one-to-one, peer-to-peer or group-based depending on the person's recovery needs. MH CSS are delivered through NGOs.

The Commonwealth Department of Health provides PHNs across Australia with several streams of funding to commission mental health services to meet the needs of people with severe mental illness in the community. PHNs are required to commission effective and locally relevant services aligned to these funding streams:[1,6,7]

- Primary Mental Health Care Services for People with Severe Mental Illness — includes:
    - commissioning clinical coordination and peer support services for this group, including through the use of mental health nurses
    - establishing links between clinical services and psychosocial support commissioned by PHNs for this group
    - promoting the use of single multiagency care plans
    - developing clear assessment and referral pathways with state/territory acute and community based mental health services
- National Psychosocial Support Measure — includes psychosocial support services focused on building capacity and skills of people to manage their mental illness, improve their relationships with family and others, and increase their social connectedness and economic participation. It supports people who have a mental health condition that affects their day-to-day functional capacity, or ability to manage the social and emotional aspects of their lives, who are not accessing psychosocial supports through the NDIS.

[4] Productivity Commission. Inquiry into Mental Health - Volume 1. Canberra: Australian Government; Jun 2020.

[5] Queensland Mental Health Commission. Shifting minds Queensland mental health, alcohol and other drugs strategic plan 2018-2023. Brisbane: Queensland Mental Health Commission; 2018.

[6] Department of Health. National psychosocial support programs for people with severe mental illness [web page]. Australian Government: 2021.

[7] Department of Health. PHN Primary Mental Health Care Flexible Funding Pool Programme Guidance: Psychological therapies provided by mental health professionals for underserviced groups. Australian Government: 2019.

- Continuity of Support — provides psychosocial support to people who are not eligible for the NDIS and have previously accessed services under one of several PHN-funded programs (e..g Partners in Recovery, Personal Helpers and Mentors)
- Psychological therapies provided by mental health professionals for underserviced groups — provides short term, focused psychological intervention to people with a diagnosable mental illness, including severe mental illness where clinically appropriate. These services complement fee-for-service treatment funded under the Medical Benefits Schedule (MBS) Better Access Initiative.

## The hubs model was designed to improve integration of mental health services to better meet the needs of people in Brisbane North.

As part of the *Planning for Wellbeing* joint regional plan for mental health and alcohol and other drug (AOD) services, Brisbane North PHN and Metro North HHS have committed to delivering integrated services through new and different approaches to service delivery, creating better alignment and integration between services across the stepped care continuum, and support for the mental health workforce.[8] Severe and complex mental illness is identified as a focus area with shared objectives to:

- improve the physical health of people experiencing severe and complex mental illness
- assist people to access and sustain safe, secure and affordable housing
- support successful transition to the NDIS
- foster community connections by people experiencing severe and complex mental illness
- establish alternatives to hospital Emergency Departments (EDs)
- improve the experience of people transitioning between hospital and community
- improve services for people experiencing borderline personality disorder.

In 2018, Brisbane North PHN undertook a targeted review of its commissioned services and undertook a co-design process to inform potential commissioning approaches to better meet the needs of people with severe mental illness.[9] Consumers, carers and service providers were involved in the review. Service gaps within existing programs were identified, including the Mental Health Nursing Incentives Program (MHNIP).

The recommendation from this process was the establishment of three Integrated Mental Health Service Hubs ('hubs') that combine clinical and non-clinical services in the one location and facilitate access to tailored packages of care for people with severe mental illness. Several initiatives were combined, including Mental Health Nursing in Brisbane (MHNiB), National Psychosocial Supports (NPS) and Continuity of Supports (CoS) measures, and aspects of the Brisbane MIND Program.

[8] Brisbane North PHN and Metro North HHS. Planning for wellbeing. Brisbane: Brisbane North PHN and Metro North HHS; 2018.

[9] Brisbane North PHN. What's next: PHN commissioned primary mental health services 2018-2020. Brisbane: Brisbane North PHN; 2018.

Brisbane North PHN's pooled funding model is a relatively new approach to commissioning severe and complex mental health services compared to a more siloed approach preferred by peer PHNs.

## About the Integrated Mental Health Service Hubs

Informed by the strategic environment described above, Brisbane North PHN revised their commissioning approach and leveraged a pooled funding strategy to develop a new model of service delivery for people with severe mental illness. This involved combining several funding streams to establish three *Integrated Mental Health Service Hubs* from July 2019. Through a tender process, three providers were contracted to deliver the hub model across three catchment areas aligned with the Metro North Hospital Health Service (MNHHS), which are outlined in Table 1 below.

***Table 1: Integrated mental health service hubs in Brisbane North PHN region***

| Provider | Hub catchment area | Hub name |
|---|---|---|
| Stride | Redcliffe/Caboolture Hospital catchments | Stride Hub Caboolture |
| Communify Queensland | Royal Brisbane and Women's Hospital (RBWH) catchment | Recovery & Discovery Centre (Bardon) |
| Neami National | The Prince Charles Hospital (TPCH) catchment | Living & Learning Centre (Strathpine) |

A regional program model was developed that outlined required components to be developed and delivered by each provider which included:

- assessment, triage and intake
- service navigation
- care coordination (including mental health nursing)
- psychological therapy (groups)
- physical health care
- psychosocial support
- assistance to access the National Disability Insurance Scheme (NDIS)
- a range of in-reach services by external providers (for example alcohol and other drugs treatment, employment, housing and finance).

The amount of funding provided to each hub per financial year for each of the Department of Health Funding streams is outlined Table 2 below.

***Table 2: Funding provided to each hub***

| Program | 2019-20 | 2020-21 |
|---|---|---|
| Mental Health Nursing | $561,284 | $597,577 |
| Continuity of Support (COS) | $447,732 | $469,471 |
| National Psychosocial Support Measure (NPSM) | $218,787 | $454,080 |

| | | |
|---|---|---|
| Psychological therapies | $120,750 | $122,682 |
| NDIS Readiness | $0 | $130,000 |
| **Total funding per Hub** | **$1,348,553** | **$1,773,810** |

Each hub provider is responsible for operationalising the hub model and its core elements as specified by the PHN, while allowing for variation based on the provider's approach and local context. Core elements of the hub model include:

- all services are provided through a hub or hub-and-spoke model
- the hub leverages off and strengthens existing infrastructure and facilitates access to a wider range of services and supports
- the hub is accessible to and welcoming of people with severe mental illness including those from diverse populations
- clinical and non-clinical services are integrated with services both within and external to the hub, and provided as part of a stepped care approach
- GPs remain central to the care team
- psychological therapies, mental health nursing and psychosocial supports are physically co-located in the hub and outreach is provided to ensure maximum geographical reach in the catchment area
- formalised agreements with external providers ensures provision of in-reach services (e.g. AOD treatment, financial counselling), strong referral pathways and smooth transitions
- a diverse workforce, including people with a lived experience of mental illness, provide services and support ensuring the ability to accommodate varying types of presentations, needs and supports.

Workforce to deliver hub services varies by hub provider. Workforce composition at the time of the evaluation is outlined in Table 3 below:

***Table 3: Hub workforce composition***

| Provider | Hub Name | Workforce (FTE) |
|---|---|---|
| Stride | Stride Hub Caboolture | 1.2 Reception<br>3 Mental health clinicians<br>4 Social/support workers<br>2.5FTE Mental Health Nurses |
| Communify Queensland | Recovery & Discovery Centre (Bardon) | 3 Care coordination<br>7.1 Psychological support<br>0.4 Psychological group therapies |
| Neami National | Living & Learning Centre (Strathpine) | 1.0 Liaison Officer<br>1.0 Operations Support Officer<br>1.0 Senior Practice Leader<br>2 Mental Health Nurses<br>4.0 Wellbeing Coach<br>1.0 Peer Practice Leader<br>2.0 Peer Coach |

An *Evaluation Framework* was previously developed in 2019 by Brisbane North PHN representatives to prospectively guide evaluation activities across each of the commissioned hubs.[10] Upon engagement by Brisbane North PHN in mid-2021 to undertake an external evaluation of the hubs model, Beacon Strategies refined this framework to develop an evaluation plan that outlined the intent, scope and approach to evaluating the hubs model across the region on behalf of Brisbane North PHN.

[10] Taylor T. Brisbane North Integrated Mental Health Service Hubs: Evaluation Framework. Report prepared for Brisbane North PHN: 2019.

# Methodology

## Evaluation planning

A detailed evaluation plan was developed by the evaluation team to outline the evaluation approach in July 2021. The evaluation plan refined the original evaluation framework and set the evaluation parameters. The updated evaluation plan was presented to Brisbane North PHN staff and representatives from the three commissioned providers to invite feedback, suggest refinements, and seek endorsement prior to the commencement of evaluation activities.

The agreed evaluation plan documents key aspects of the evaluation approach:

- principles of evaluation approach
- program theory (refer to Appendix A)
- program logic model (see Table 4 on next page)
- evaluation questions (refer to Table 5 on page 19)
- data collection plan (refer to Appendix B)
- evaluation reporting.

In the development of this evaluation report, the evaluation team collated, analysed and reported on all relevant data sources supplied or otherwise made available, which were aligned to this data collection plan. Minor amendments to the evaluation questions outlined in the original plan have been made to aid readability. Each of the data collections methods is described in more detail in the pages below.

*Table 4: Program logic model for the Integrated Mental Health Hubs program*

**Program goal:** Support people with severe mental illness to live well in the community; access clinical and non-clinical services, matched to their level of need; and achieve their recovery goals.

| Inputs | Activities | Outputs | Short term outcomes | Long term outcomes |
|---|---|---|---|---|
| PHN pooled funding:<br>• Primary mental health care services for people with severe mental illness<br>• Psychological therapies provided by mental health professionals for underserviced groups<br>• National Psychosocial Support Measure<br>• Continuity of Support<br><br>Contract management and service development by PHN<br><br>Department of Health guidelines<br><br>Provider systems and processes<br><br>Skilled and qualified hub workforce<br><br>Co-located, in-kind services<br><br>Assessment and outcome tools (PMHC-MDS and RAS-DS)<br><br>Representation from hubs senior and operational management | Provide clinical and non-clinical support to people with severe mental illness comprising:<br>• Welcome/reception<br>• Intake and initial assessment<br>• Individualised care plan including care coordination, service navigation, mental health nursing/physical support, psychosocial support, psychological therapies<br>• Ongoing review<br>• Planned exit<br>• Follow up<br><br>Governance and quality management<br><br>Workforce development<br><br>Partnership and networking<br><br>Monitoring and evaluation | Inward referrals<br><br>Episodes of service<br><br>Individualised care plans<br><br>Service contacts<br><br>Onward referrals completed<br><br>Outcomes assessment collection<br><br>Service level program documentation<br><br>Formal and informal inter-agency partnership activities<br><br>Evaluation report | Positive experience of hub services reported by clients through integration<br><br>Improved access to integrated clinical and non-clinical supports for people living in the community with severe mental illness<br><br>Achievement of client goals identified in individualised care plan<br><br>Connection to relevant services and supports to meet clients' needs<br><br>Awareness and confidence of hubs model amongst hub providers and other local service providers | Improved mental health literacy of participants<br><br>Positive recovery outcomes for people with severe and complex mental illness<br><br>Reduced levels of psychological distress reported by participants<br><br>Efficient use of available resourcing for commissioning primary mental health services |

**Assumptions**:
- Service users choose to engage with Hubs service
- Suitably capable workforce available to deliver specified activities
- Adequate mix of clinical and non-clinical services and supports can be delivered within physical hub model, including external agencies
- Each provider to operationalise the model in line with Hub core elements / components
- Data collected by individual hubs is consistent and comprehensive.

**External factors:**
- Impacts of COVID-19 on service continuity
- Funding specifications of Department of Health
- BNPHN and MNHHS strategic direction outlined in 'Planning for Wellbeing'
- Future system reforms in response to Productivity Commission's Inquiry Report on Mental Health

## Evaluation questions

Several high-level evaluation questions were drafted against key domains aimed at gauging the extent to which the program met its objectives from different perspectives. These include:

- **Appropriateness** — the extent to which a program's design and approach was suitable in terms of achieving its desired effect, in its given context and meeting the needs of all relevant stakeholders.
- **Effectiveness** — the extent to which the program and its stated objectives were achieved
- **Implementation** — the extent to which outputs were delivered efficiently using the available inputs (e.g. time, funds, expertise). This includes process factors such as governance and management.
- **Sustainability** — the extent that benefits associated with a program are continued.

Table 5 below outlines the evaluation questions that guided the evaluation approach. Evaluation questions were considered for inclusion based on their perceived usefulness, practicality and alignment.

***Table 5: Evaluation questions***

| Domain | Evaluation questions |
|---|---|
| **Appropriateness** | Did the hub model meet the needs of service users?<br>Did the hub model meet the needs of local system stakeholders?<br>Was an integrated hub model suitable to achieve the intended outcomes?<br>What were the strengths and weaknesses in the design of the hub model? |
| **Effectiveness** | Did the hub model improve access to clinical and non-clinical support for people with severe and complex mental illness?<br>Did service users achieve their support goals?<br>Did service users report lower levels of psychological distress?<br>Did service users experience a positive change in recovery outcomes? |
| **Implementation** | Was the hub model implemented as intended?<br>What were the barriers and enablers to implementing the hub model?<br>What were the direct and indirect resources required to implement the hub model? |
| **Sustainability** | Did the hub model contribute to building the evidence base for effective commissioning approaches for severe and complex mental illness? |

# Data collection and analysis

## Client and program data

Client and program data was routinely collected by hub staff aligned to the Primary Mental Health Care Minimum Data Set (PMHC-MDS) (refer to https://pmhc-mds.com/) prescribed by Brisbane North PHN using the information management system rediCASE.

The data was systematically collected throughout the course of the delivery of services and supplied to the evaluation team in a de-identified manner for use in the final evaluation. The data supplied included the following elements:

- incoming referrals
- client characteristics
- episodes of service
- service contacts
- client outcomes.

As prescribed by the PMHC-MDS, the Kessler Psychological Distress Scale (K10+) was used as a standardised measure of severity of mental health symptoms at multiple timepoints during an episode of service. More information about the K10+ tool is available at https://www.blackdoginstitute.org.au/wp-content/uploads/2020/04/k10.pdf.

The hub providers collected and provided additional data through other systems or processes around components not captured by rediCASE, such as the Recovery Assessment Scale - Domain and Stages (RAS-DS) tool from their internal client information management system around client assessment and outcomes. More information about the RAS-DS tool is available at https://ras-ds.net.au/.

The evaluation team undertook limited cleaning of the data to remove illogical records then performed descriptive analysis and visualisation of the data supplied using Microsoft Excel.

## Qualitative data

Additional program data was collected through semi-structured interviews and/or focus groups with key stakeholders of the program, including hub staff, hub managers, representatives from peer PHNs and representatives of the program's funder Brisbane North PHN.

Interviews were conducted from September to October 2021, through semi-structured interviews and focus groups held either in-person or virtually via Zoom. Each interview was conducted by two members of the evaluation team, with comprehensive notes taken and later thematically analysed. A total of 14 focus groups were completed with stakeholders, including consisting of:

- 7 focus groups with internal stakeholders (including hub staff and management)
- 2 focus groups with representatives from Brisbane North PHN
- 5 semi-structured interviews with other peer PHNs

Participants were nominated by the Brisbane North PHN program team and contacted initially with an information sheet and consent form. Once completed, Brisbane North

PHN staff then provided their names and contact details to the evaluation team, who then contacted them directly. Informed consent was obtained from all participants who took part in the qualitative interviews. Audio recordings of the qualitative sessions were taken only once informed consent was provided by participants and were used to amend the recorded written notes and was subsequently destroyed after the completion of this process. Additionally, participants' details were de-identified for use in the final evaluation.

All interviews/focus groups were conducted in accordance with a documented conversation guide, with questions aligned to the below areas of inquiry:

- experience and perceptions of the program
- strengths and limitations of the program's design
- integration of clinical and non-clinical support
- outcomes experienced by hub staff and managers, and case examples
- implementation-related enablers, barriers and process learnings
- sustainability considerations.

An outline of the interview questions is contained in Appendix C.

## Survey data

Additional quantitative and qualitative data was captured through three hub experience surveys for respondents from key perspectives, including:

- 105 responses to Hub experience survey (service users)
- 27 responses to Hub experience survey (hub staff)
- 51 responses to Hub experience survey (sector stakeholders).

Survey items included in the survey were composed of a mix of quantitative and qualitative (free-text) items that were purpose-designed for this evaluation to augment other routinely collected data, covering aspects of the hub model, including:

- effectiveness of hub services
- appropriateness of hub services
- quality of hub services
- efficiency of hub services.

The survey tools were designed by Brisbane North PHN as part of the original evaluation framework for the Hubs. Brisbane North PHN administered the survey links for the hub staff and sector stakeholder surveys via an email link with the service user survey distributed by the hub providers. An outline of the survey questions for each hub experience survey is contained in Appendix D.

## Desktop review

Desktop review aimed to generate an understanding of the delivery of the program through analysis of key documentation and information supplied to the evaluation team. It also aimed to position the findings of the evaluation within the broader context of the program to inform implications and recommendations. Desktop review covered the following source materials:

- key national, state or regional strategy or policy documents to identify alignment with relevant strategic priorities
- available evidence base relating to services meeting the needs of people with severe mental illness
- program information describing commissioning approaches undertaken by other PHNs
- documented priorities of the program's funder Brisbane North PHN and the Department of Health (Cth).

# Findings

## Overview

The findings presented in this section of the report are structured around the four evaluation domains outlined in the evaluation plan, and further organised around each evaluation question. The sub-sections below explore the findings relating to the appropriateness, effectiveness, implementation and sustainability of the program.

## Appropriateness

Appropriateness refers to how well the program's design was suitable in achieving its desired effect in the given context and in meeting the needs of relevant stakeholders. Three aspects of the program's appropriateness were considered:

- extent to which experiences with the service met the needs and expectations of service users, staff and sector stakeholders
- whether an integrated hub model was most suitable
- strengths and limitations of the program's design.

### Does the hub model meet the needs of service users?

#### Service user experience

The service user experience refers to the extent that the hub model was suitable in meeting the needs and expectations of service users. Service experience is associated with factors such as safety and inclusiveness as perceived by service users, accessibility to the service, staffing and responsiveness.

Several of these items relating to service user experience were captured through the PHN version of the Your Experience of Service (YES) survey, which requires respondents to self-rate their experience of service using a five-point rating scale from *1: never* to *5: always*. For the item, *overall, how would you rate your experience with the service?*,this is based on a different five-point rating scale, which ranges from *1: poor* to *5: excellent*.

Figure 1 below shows the mean scores over the 5-point scale for 10 items of the YES survey relating to the experience of service users. This draws from a sample of over 100 surveys completed by service users, with slight variation in responses received to individual items due to items being non-mandatory.

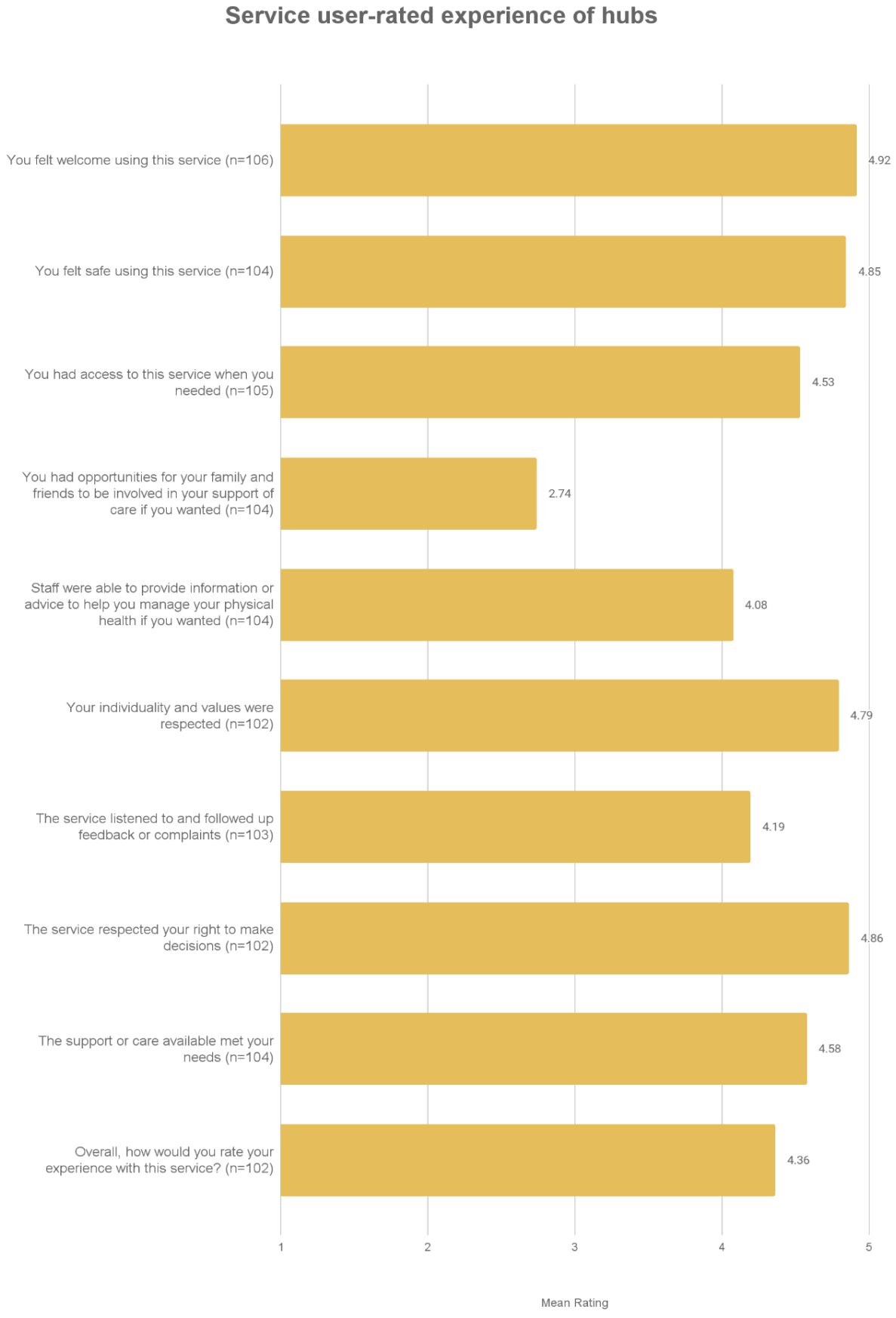


***Figure 1: Service user perceptions of their experiences with the hubs***

Service users reported having an overall positive experience with the services they received through the hubs (mean=4.36). Service users also felt that the hub model made them feel welcome (mean=4.92), safe (mean=4.85), and their individuality and values were respected (mean=4.79). In relation to accessibility, service users reported having access to the hub model when they needed it (mean=4.53).

Regarding interactions between service users and staff, service users reported positively on the staff's ability to meet their care needs (mean=4.58) and providing information or advice in managing their physical health when they wanted it (mean=4.08). Staff were also able to actively listen, to follow-up any feedback or complaints (mean=4.19), and respected their right to make their own decisions (mean=4.86).

While most items were rated positively, one item was rated relatively more negatively, with service users reporting less agreement with having opportunities for people in their supporting network, such as family or friends, to be involved with their wishes (mean=2.74).

In the original evaluation framework, a performance target of 85% positive responses (i.e. responses either *usually* or *always*) was agreed between the PHN and hub providers. This target was exceeded for all items except for the family/friends involvement item at 79% positive responses.

Qualitative insights shared by service users highlighted the staff, style of the service and community-based setting as factors driving a positive service user experience:

> ***"I'm lost for words… as busy as they are, they assisted me with absolutely everything! Gave me a second chance at life."*** *(Service user)*
>
> ***"I feel the service was adequate together with my psychiatrist and psychologist"*** *(Service user)*
>
> ***"I've only been engaged for a short period of time but am really enjoying the comfortability when walking into the hub… in this environment I feel I will move forward and enjoy my time learning and forming new connections and learning so many new exciting things."*** *(Service user)*
>
> ***"Feels like a safe place to share with people with similar struggles, led by caring, kind, patient and knowledgeable psychologists, therapists, social workers and counsellors."*** *(Service user)*
>
> ***"There's a warmth in this program and a genuine care for each other, which participants can feel. And there's no judgment either. It's right from when you come through the door, all the way up to [the hub manager]. It's reflected in all of us."*** *(Hub staff member)*
>
> ***"[The hub] is the most fantastic concept for those struggling in the community with mental health issues. There should be more hubs available and more peer support workers employed!"*** *(Service user)*
>
> ***"The hubs are life changing for many people. They often give people a second chance at life. The professionalism is outstanding."*** *(Service user)*
>
> ***"I feel I have a place to heal and people that care."*** *(Service user)*

> ***"I can rely on the hub and not doubt myself… I feel like I can talk about life and how I'm feeling without being judged or labeled."*** *(Service user)*

> ***"Having access to affordable and reachable mental health treatment which would otherwise be unattainable has been great; I do find it hard making sessions around my personal life but the opportunity has been amazing. And the facilitators are always very friendly."*** *(Service user)*

Examples of when the hub model was not able to meet needs of service users were described by hub staff around suitability criteria, which determine whether a person could or could not access hub supports. This included people who were accessing psychosocial support through the National Disability Insurance Scheme (NDIS), or engaged in case management with other services where duplication would occur.

A small number of service users highlighted instances of dissatisfaction with the experience of accessing support through the hubs:

> ***"Any sort of help getting the referrals the hub requires me to attain to be able to offer me any help…. Help getting diagnosed instead of just assuming my conditions are just minor and temporary… literally anything would be more help than a home visit and then nothing other than phone calls demanding I get referrals for them to do anything further."*** *(Service user)*

> ***"Things have only deteriorated… how am I even supposed to answer this?"*** *(Service user)*

> ***"There was no integrated clinical, or non clinical care offered. This was very disappointing."*** *(Service user)*

## Service non-engagement and disengagement

The status and outcome of inward referrals provides an indicator of the ability of the hubs to meet the needs of service users based on the levels of non-engagement and disengagement from the service. Figure 2 below shows the breakdown of the 2,265 referrals that were made to the hubs from their establishment in July 2019 onwards by status/outcome of the referral. A further 150 referrals that were received prior to the July 2019 establishment of the hubs are not included in this analysis, which represented a cohort of clients who were transitioned into the hubs from a previous PHN-commissioned program.

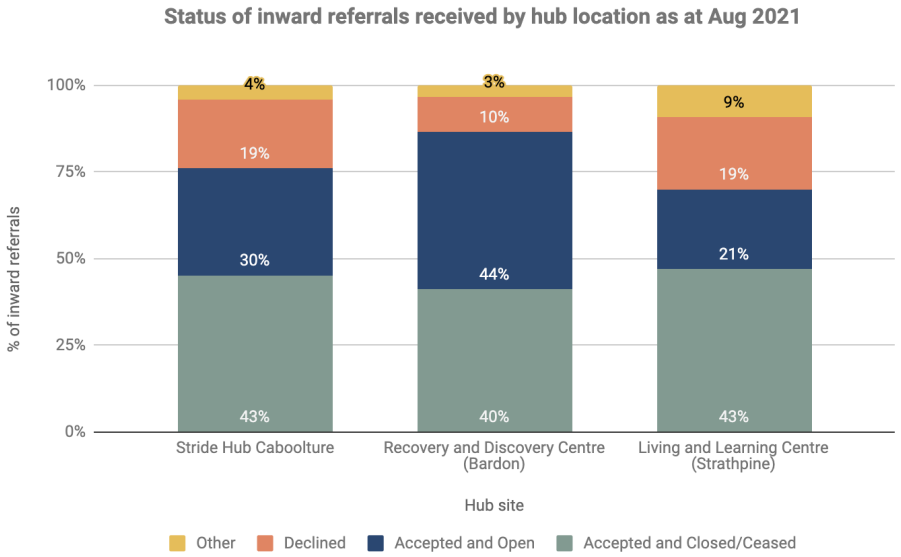


***Figure 2: Status/outcome of inward referrals per hub location***

Across all hubs, most referrals are Accepted and Closed/Ceased (n=1,006; 44%), followed by Accepted and Open (n=746; 33%) or Declined (n=385; 17%). A further breakdown of the Declined and Closed/Ceased categories is provided below. The breakdown is relatively consistent across each hub, with the Recovery and Discovery Centre (Bardon) reporting a lower proportion (10%) of referrals that were declined on intake compared to the other hubs (20% and 21%).

A small number of referrals categorised as Other included referrals 'viewed' or 'not viewed' in the system, reflecting a temporary administrative workflow where a referral is being processed by a provider. Most of these were recent referrals (84%) but there were some referrals that were historical (i.e. more than 3 months old) that had not been accepted or declined. This is most likely a data quality issue rather than these referrals not having been responded to — these referrals are likely duplicates or have been actioned without being recorded in the dataset.

A total of 746 referrals had a status of accepted which comprised those referrals that had an open and ongoing episode of service.

Further breakdown of the status of referrals that were declined or closed/ceased provides an indication of the proportion of people who were referred to the service that did not engage at all or who disengaged for a reason other than a planned exit from the service. This data can indicate instances where the service was perceived as or genuinely unable to meet a person's needs.

Referrals that were declined refers to those referrals that did not result in an episode of service commencing and no service contacts being completed. A breakdown of the reason provided for those referrals that were declined across all hubs is provided in Figure 3 below.

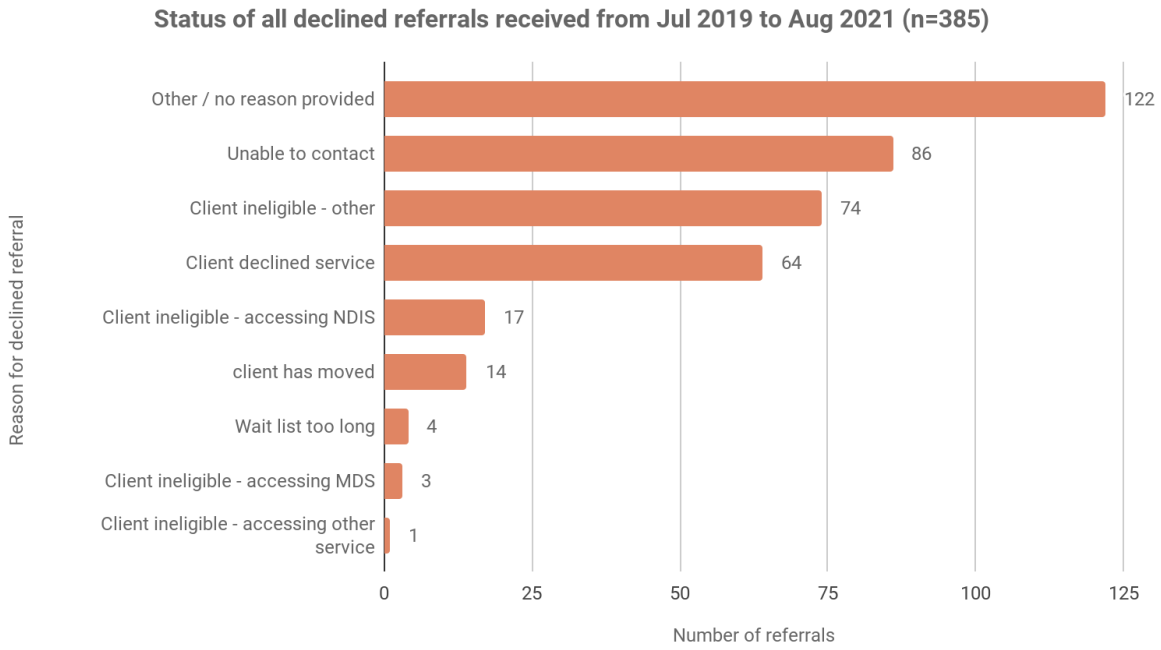


***Figure 3: Number of declined inward referrals who did not engaged with the service***

The data shows that no reason is recorded for almost 1 in 3 declined referrals, with the next highest reasons being *unable to contact* (22%), *client ineligible - other* (19%) and *client declined service* (17%).

It should be noted that this does not necessarily mean that these individuals didn't receive services. There were 87 episodes of service accepted or completed that were related to individuals who had a declined referral. This could reflect multiple referrals for one person being received for different types of services (e.g. clinical support, psychosocial), administrative workflows, appropriateness of referrals, readiness or engagement of clients or data quality issues.

Referrals that were closed/ceased includes those referrals that had been accepted, commenced and then concluded an episode of service. A further breakdown of those referrals that were closed/ceased is provided in Figure 4 below.

While planned exit is the most common reason for a closed episode of service, several other reasons may indicate unplanned disengagement from the service. These include *client could not be contacted* (n=127), *client declined further contact* (n=74), *client declined service* (n=44) or *no service contact for 90 days or more* (n=35). *Ineligible* may indicate the level of inappropriate referrals (n=28). Collectively, these referrals comprise around 31% of all closed/ceased referrals, and 14% of all referrals received into the hubs from July 2019 onwards.

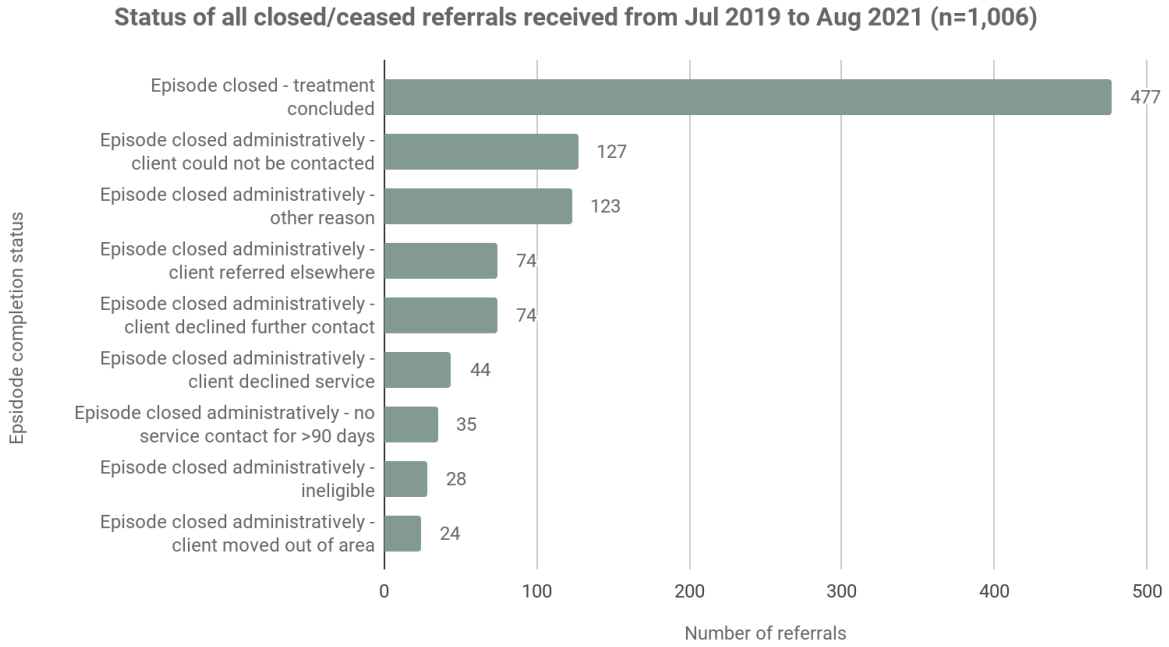


***Figure 4: Number of closed referrals who engaged with the service by episode completion status***

Further, according to the data specification, any episode of service that is closed/completed requires at least one service contact to be completed with the client. Analysis of service episode data shows that 144 (14%) of closed/completed episodes did not have any service contacts recorded, indicating some inconsistency in how data is captured and categorised by 'status'.

## Timeliness of response

An indicator of service experience for clients is the timeliness of the service response, shown through the length of time waiting between key steps of the 'journey' through the service.

Figure 5 below shows the breakdown of time (in days) between the date a referral was made to a hub and the date that the first contact was completed or attempted (i.e. scheduled but client did not attend). This excludes data from 553 referrals where no service contact was recorded (e.g. declined).

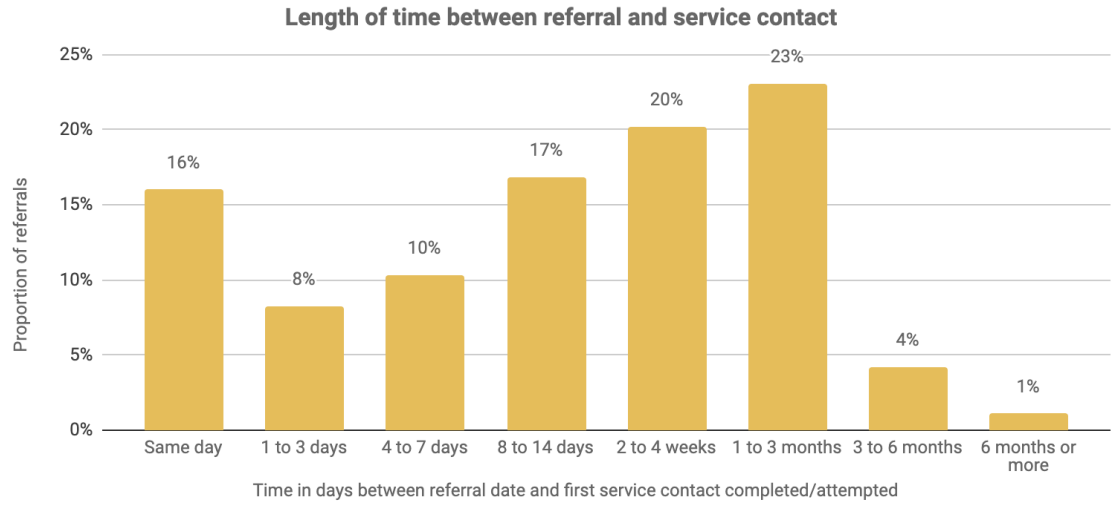


***Figure 5: Breakdown of time between inward referral and date of first contact***

The median is 14 days, meaning half of all referrals are engaged within 2 weeks from a referral being made. The timeframe ranged from 0 days (contact was same day) to a maximum of 492 days.

Further breakdown of the data by referrals flagged with a risk of suicide on the referral, tended to have a lower level of responsiveness than those without — that is, a longer period between referral and first service contact.

# Does the hub model meet the needs of local system stakeholders?

## Staff-rated perceptions of hub services

Survey data demonstrated that hub staff generally have positive experiences providing hub services. In Figure 6 below, hub staff rated highly that their role makes a difference to the people they serve (mean=4.65), they are satisfied with the quality of care they provide to service users (mean=4.30), and staff work well together in providing care to people (mean=4.33).

Hub staff also believe that the hub model represents an improvement in the care provided to people with severe mental illness (mean=4.26), that *integrated services* (mean=4.23) is a good descriptor of what type of care people receive at the hubs. Hub staff were generally pleased with their performance when meeting the standard of their role (mean=4.42).

Where hub staff responded that aspects of the hub were more neutral than positive were the perception of *seamless services* being provided within the hubs (mean=3.89) and that there was good communication with other organisations that provided care to service users (mean=3.74).

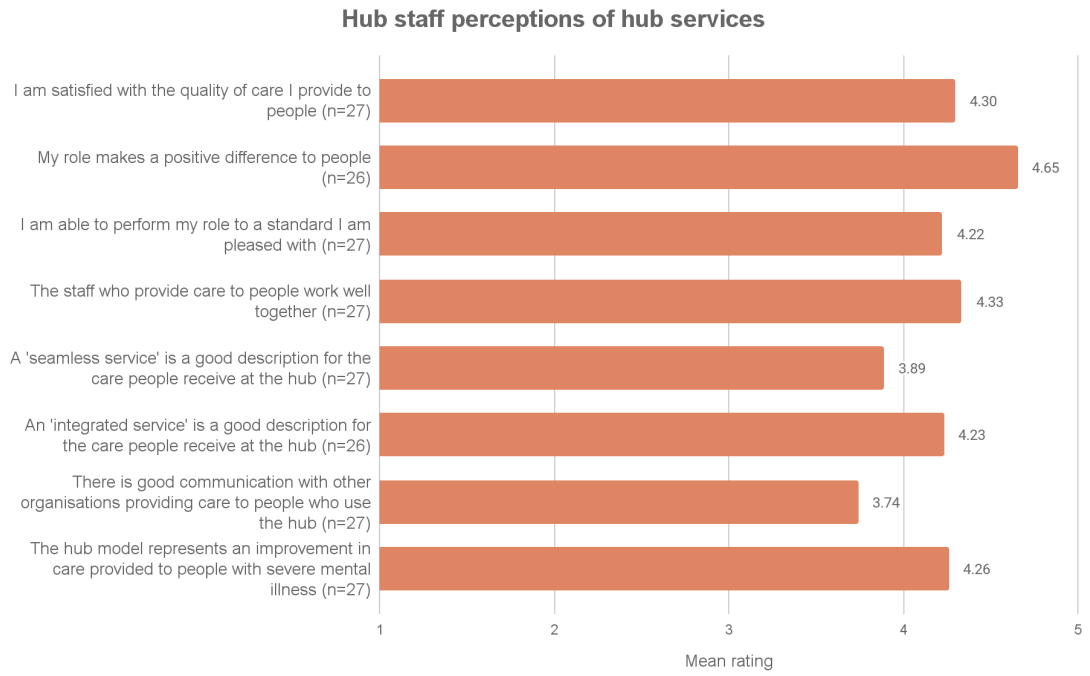


***Figure 6: Hub staff perceptions of hub services***

In the original evaluation framework, a performance target of 65% positive responses (i.e. responses either *agree* or *strongly agree*) was agreed between the PHN and hub providers. This target was exceeded for all items.

Hub staff noted that service users are not isolated to one worker and the team works around the person. It was observed that service users respond well to the team approach and are more likely to come back if they need to or to seek help, even if their usual worker is not there. Rather than only offering 1:1 support, staff reported that a usual episode of service includes group work.

The hubs were described by staff as providing a safe and welcoming environment. Factors contributing to this environment included shared, open and interactive spaces; and the hub workforce. It was highlighted that a welcoming environment begins with 'front of house' staff who, once a referral is accepted, build trust with the service user and provide an orientation to the hub.The ability for hub staff to provide outreach services and tailor their approach to 'meet people where they are at' was also raised as contributing to a positive service user experience.

Hub staff reported that a streamlined referral process and services being under the one umbrella also supports a positive experience for service users by providing timely connection to relevant supports. Where referred clients were determined as ineligible or where the hub was not able to meet their needs, the 'no wrong door' approach of the hubs helped to connect these individuals with relevant support options. Hub staff noted their role in facilitating warm referrals to external services or helping people know where to call.

> ***"There's no wrong door here so if someone wants help we will help them find it."*** *(Hub staff)*
>
> ***"The Hub is very driven to meet the needs of its clients, while supporting the team. It has a great culture of support"*** *(Hub staff)*
>
> ***"Participants enjoy the vibe of the hub and a lot of people who did not like groups now attend. Not only that, the participants are socialising with each other outside the service building friendships [and] improved integration with community"*** *(Hub staff)*
>
> ***"Countless people have been traumatised from the hospital system and that purist clinical model… when you're in and out of the system, the serious damage that has occurred along the way to their world view and sense of self. So it's like they come here and rediscover their sense of self as they have been so disconnected from themselves for so many years."*** *(Hub staff)*

## Sector stakeholder perceptions of hub services

A survey of local sector stakeholders captured their experiences of interacting with the hubs. A total of 51 sector stakeholders responded to the survey. The majority of sector stakeholders were from non-governmental mental health services (39%), Hospital and Health Services (HHS) mental health services (18%) and general practice (10%). The majority of sector stakeholders that completed the survey defined their role as mental health professionals (45%), followed by other professions (22%), and then equally by support workers (10%) and other allied health professionals (10%).

As seen in Figure 7 below, sector stakeholders reported generally neutral-to-positive experiences with the hubs across several items (green bars) relating to likelihood of referring someone, strength of relationships, partnering with hubs, perception of service quality and outcomes achieved. These items are rated as level of agreement with statements ranging from *1: strongly disagree* to *5: strongly agree.*

For the items (yellow bars), *overall, how would you rate your experience with the hub?* ,this is based on a different five-point rating scale, which ranges from *1: poor* to *5: excellent*. Respondents were asked to rate the experience with hubs they had experience with, and were removed from analysis if they didn't have experience with a particular hub.

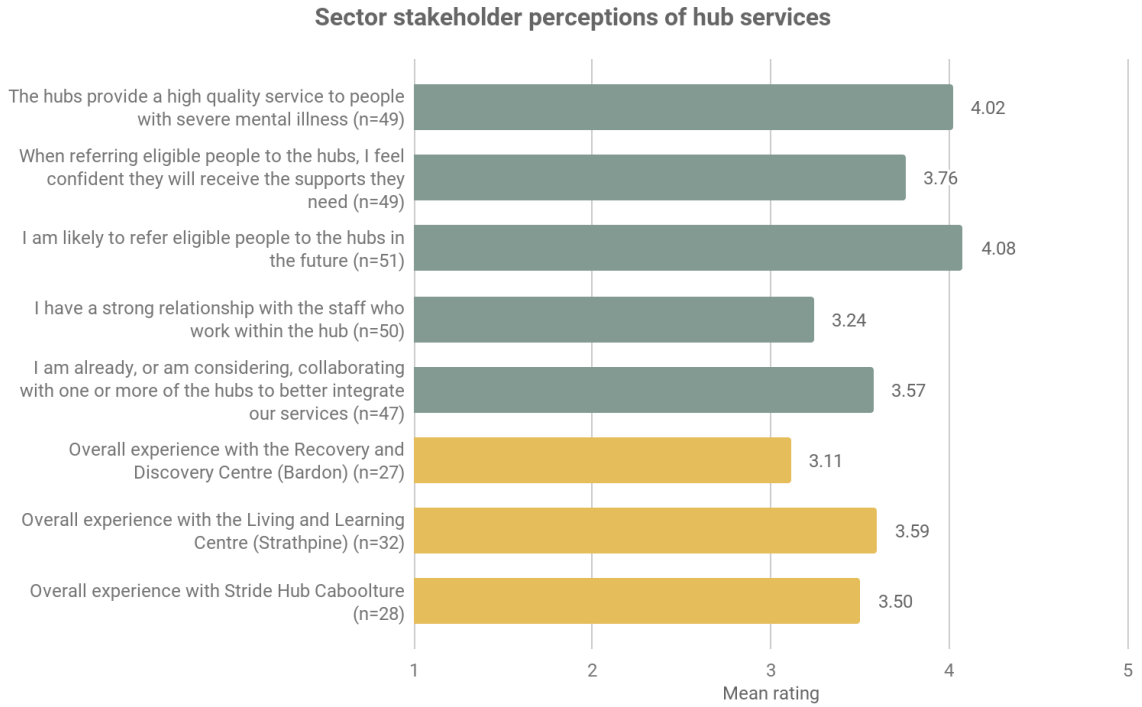


***Figure 7: Sector stakeholder perceptions of their experience with the hubs***

Stakeholders generally agreed that the hubs provided high-quality services to people with severe mental illness (mean=4.02) and were likely to refer eligible people to the hubs in future (mean=4.08). Responses that were more neutral overall were stakeholders reporting they have strong relationships with hub staff (mean=3.24), and are (or would consider) collaborating with one or more hubs to better integrate their services (mean=3.57), and people referred receiving the support they need (mean=3.76). In the original evaluation framework, a performance target of 85% positive responses (i.e. responses either *agree* or *strongly agree*) was agreed between the PHN and hub providers for the green shaded items. This target was only met for the *likely to refer in future* item, with all other items not meeting this target.

Overall experience with a hub rated between *3: good* and *4: very good* for all three hubs. The agreed performance target for these items was 85% positive responses (either *good*, *very good* or *excellent*) which was not met by any of the three hubs.

Local stakeholders reported that clients they had referred had provided positive feedback regarding their experience of the hubs and described the services as being responsive, flexible and friendly. Stakeholders also noted positive experience working

with hub staff. Several stakeholders highlighted factors that contribute to their positive perception of the hubs:

> ***"The level of respect they give to each and every person, the patience, ensuring everyone feels supported, safe and normalising their emotions and current state."*** *(Sector stakeholder)*
>
> ***"I believe the hubs are an excellent resource run by people dedicated and passionate about supporting people with complex mental health issues."*** *(Sector stakeholder)*
>
> ***"My experience with [the hub] has been fantastic — they are responsive, engaging and collaborative regarding referrals and work actively to engage these clients in their recovery goals."*** *(Sector stakeholder)*

Some stakeholders reported that referring to or working together with the hubs could be improved based on previous experiences. Several instances noted referrals had not been accepted because the person was not determined to be appropriate for the hub model, resulting in poor experiences for clients during the referral and intake process.

> ***"Referrals not being accepted because the client was determined as being "too severe" or "too complex" despite this being what they are designed to treat. If there is any suicide risk, they would not accept or even provide suggestions or solutions of other services to support the consumer's recovery goals."*** *(Sector stakeholder)*
>
> ***"If they could [be] more approachable and contactable it would be good."*** *(Sector stakeholder)*
>
> ***"Unclear what clinical services are provided by mental health nursing staff, how does this differ from the other services provided?"*** *(Sector stakeholder)*
>
> ***"There's a delay in both having an assessment, and then also in commencing support."*** *(Sector stakeholder)*

## Was an integrated hub model suitable to achieve the intended outcomes?

A key component of the design of the hub model was the integration of clinical and non-clinical services and supports within a physical location.

As seen in Figure 8 below, the service experience surveys administered to service users, hub staff and sector stakeholders included several items relating to the perceived value and impact of an integrated hub model in achieving the intended outcomes. Response statements are scored on a five-point Likert scale ranging from *1: strongly disagree* to *5: strongly agree*.

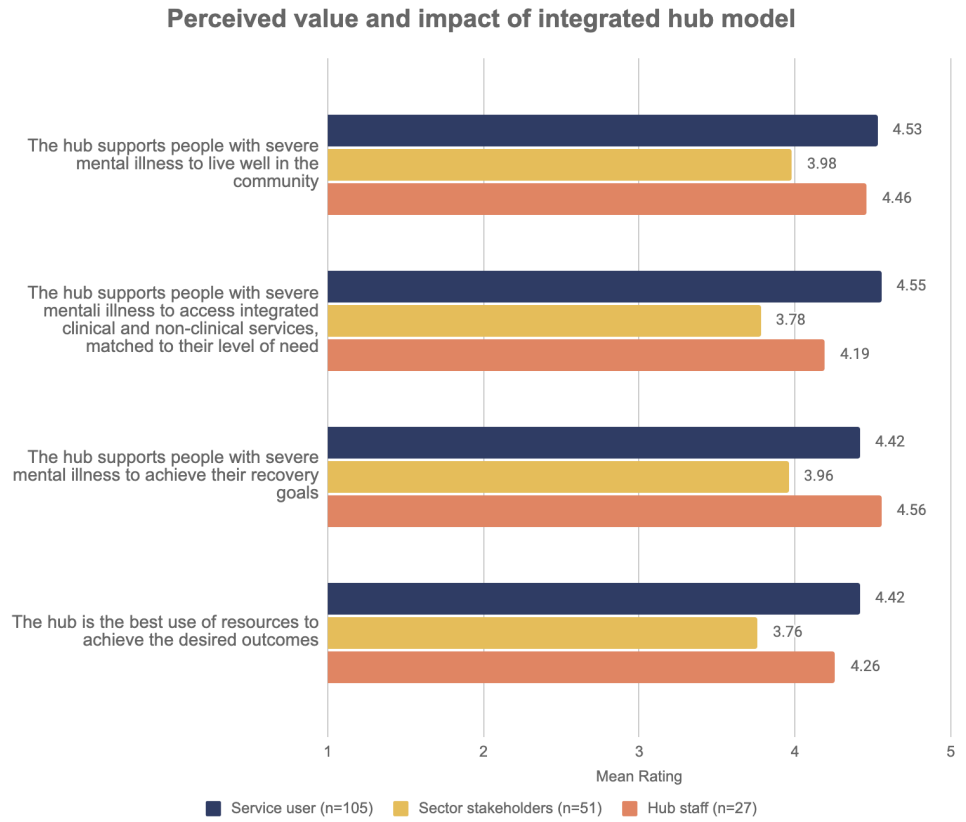


***Figure 8: Perceived value and impact of integrated hub model by respondent type***

Service users reported positive perceptions of the value and impact of the hub model, represented by the high mean scores recorded for perceptions of integration of clinical and non-clinical services (mean=4.55), living well in the community (mean=4.53), achievement of recovery goals (mean=4.42), and best use of resources (mean=4.42).

Hub staff also reported strongly positive perceptions across all items similar to that reported by service users. An observable difference is shown with sector stakeholders reporting lower perceptions across all items than service users and hub staff.

In the original evaluation framework, a performance target of 85% positive responses (i.e. responses either *agree* or *strongly*) was agreed between the PHN and Hub providers, with the following results:

- Service user survey outcome targets were met or exceeded for all items
- Sector stakeholder survey outcome targets were not met for all items, with particularly lower levels of *service integration* (67% positive) and *best use of resources* (68% positive)
- Hub staff survey outcome targets were met or exceeded for all items.

Service users were also asked several items that relate to specific aspects of integration based on their experience which was based on an existing measure (integRATE tool). It aims to measure integration in health care delivery on a five-point Likert scale ranging from *1: never* to *5: always*. As items are negatively phrased, lower scores on these items indicate more positive perceptions.

As seen in Figure 9 below, service users reported generally positive perceptions of specific aspects of integrated care through their experience with the hub model. Service

users reported that they did not feel uncomfortable due to different providers not getting along (mean=1.21), and were not unclear on the roles of hub staff, including whose role it is to deal with a specific question or concern (mean=1.48). Service users also felt that the information or advice provided by different service providers was not conflicting (mean=1.58), and didn't feel as though they had to explain something because service providers were not sharing information with each other (mean=1.74).

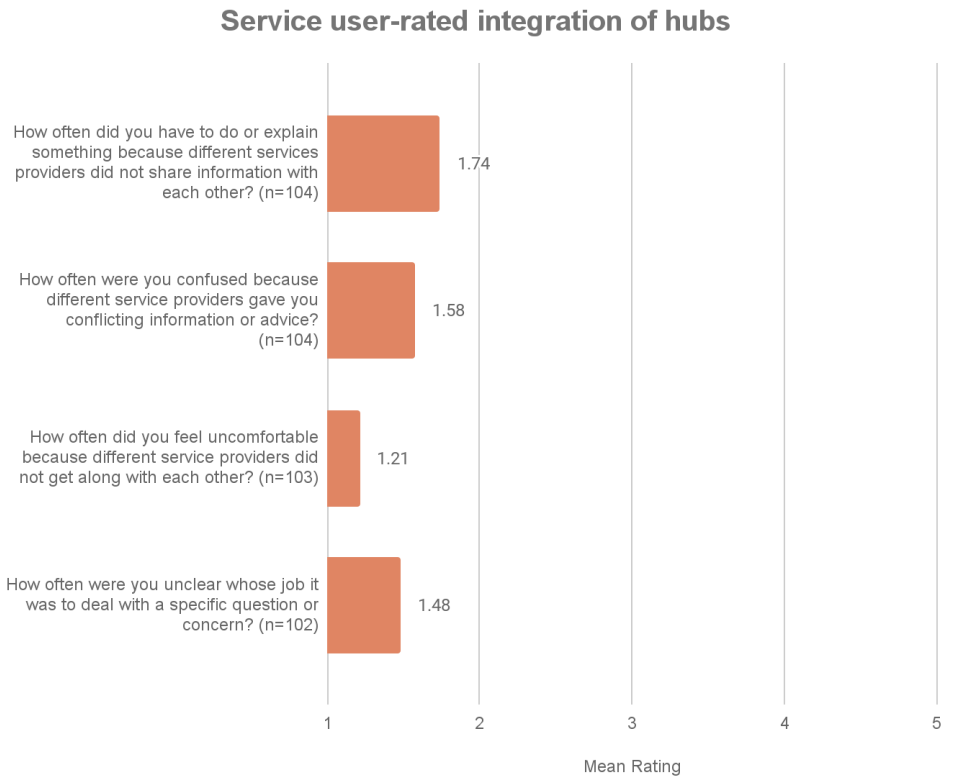


***Figure 9: Service user perceptions of the hubs' integration***

The agreed performance target for these items is a 65% positive response rate, where response is *never*. This target was exceeded for one item (different services not getting along), met for one item (unclear roles) but was not met for the other two items (explaining something because providers didn't share information) and (confused because of conflicting information).

Through open-ended responses, service users reported that the hubs supported access to affordable mental health treatment and easy to access programs and improved access to other (external) services.

> ***"I have better access to the services I need and opportunities to engage in social activities."*** *(Service user)*

> ***"The variety of what is on offer is wide, appealing to the masses."*** *(Service user)*

Hub staff reported that having clinical and non-clinical staff in one space supported the integration of services. The ability to take a stepped care approach that reportedly responds to the needs of the person through a single service intake process was also highlighted as positive. The integration of clinical and non-clinical services also reportedly supports a seamless service user experience and enables a smooth transition

to step up and step down the level of care provided based on individual need and readiness.

> ***"The way I describe it, we can help people get connected, so there's lots of supports out there for mental health but it's an extremely disjointed system."*** *(Hub staff member)*

> ***"In the past, you have to go through different organisations or programs to get that support and doing that you are re-telling your story over and over again and it can be traumatic in itself. It can be draining, it can be exhausting. So being able to just come here and do an intake with ourselves or the nurse, we can capture that information and provide those warm handovers"*** *(Hub staff)*

> ***"[the client] knowing they don't have to keep telling the same story over and over again"*** *(Hub manager)*

It was suggested that having both clinical and non-clinical workforce within an integrated service model enabled better collaboration leading to better outcomes for service users. Information sharing through case reviews both internally and with service partners were identified as key to supporting service integration.

> ***"Everyone gets to contribute to ensure the direction of care is the same... That is unusual because that can't happen when you use different service models. Its nice that everyone is together"*** *(Hub staff)*

> ***"Clinical and non-clinical staff sitting in the one space … helps to break down those barriers of communication and interaction. Helps people to work better as a workforce which leads to better client care"*** *(Hub staff)*

Being able to access holistic, wrap-around support in one place was also perceived to improve integration. Compared with traditional care, where a person may access multiple providers operating from different service models, the hub model was reported to better streamline integration by offering a wider range of services without the formalities and avoiding multiple stakeholders working on the same thing.

> ***"The key difference is that people can access a suite of service through that one referral pathway and through that one intake process they can then be linked in with a wide variety of health professionals to meet their needs"*** *(Hub manager)*

> ***"I think there's a greater risk of duplication of services in a non-integrated environment if you have people accessing multiple services"*** *(Hub manager)*

> ***"if I'm talking about my program, when a referral comes through I explain to the person what my scope of practice is and what my program has to offer and if they need support outside of that I can refer on as well."*** *(Hub staff)*

Instances where the integrated hub model was identified as not able to achieve the desired outcomes for individuals was attributed to the complexity of a person's presenting issues.

> ***"[limited integration for] probably the highly highly complex, the revolving door that we can't provide for as we aren't a crisis service."*** *(Hub staff)*

# What are the strengths and weaknesses in the design of the hub model?

## Strengths of the model

Service users identified several factors that represented the strengths of the hub model, including:

- access to peer workers with a lived experience
- welcoming environment
- integration of services
- individualised support
- holistic service offering
- regular connection and continuity
- focus on skill-building.

A selection of open-ended responses provided by service users illustrated the strengths of the model that had the greatest impact on their recovery:

> ***"The consideration and effort put into my circumstances and wellbeing."*** *(Service user)*
>
> ***"Being able to speak to lived experience support workers who understand what I've experienced."*** *(Service user)*
>
> ***"The personal care displayed by all the members of staff and the courses that teach so many strategies. Also the personal one-on-one focus on my needs, situations, goals and mental welfare."*** *(Service user)*
>
> ***"Please keep doing what you're doing to the standard you do it... funding for projects that have actual humanity at their core is fleeting and the complexity of social, socioeconomic and community need for people with serious conditions makes them less popular."*** *(Service user)*
>
> ***"Ongoing support from my worker, who was very empathetic and was a good listener. She always helped me and saw I was trying really hard to move forward and always encouraged me to contact her when I needed and was genuine in her need to support me."*** *(Service user)*
>
> ***"Meeting people with similar issues who have become friends."*** *(Service user)*
>
> ***"The transport services allow me to attend many medical appointments and community activities. As I don't drive and [with] my anxiety, I would not be attending the majority of these appointments without this invaluable service."*** *(Service user)*

Several components were commonly identified as strengths of the design of the hub model by hub staff and management including:

- integration and coordination of both clinical and non-clinical supports, enabled through a pooled funding approach
- a 'no wrong door' approach
- a place-based approach within a physical hub

- single point of access
- team-based approach
- capacity for outreach
- individualised planning and support
- external partnerships, particularly with HHS services and co-located opportunities

Hub staff and managers reflected that the design of the model aims to be flexible and allows for adaptations to provide the best consumer experience. They described the ability to work with individuals over a period of time and monitor changes in their needs, using assessment and review to periodically inform changes to care planning, offer additional supports (e.g. group therapies) and identify professional development opportunities for hub staff.

> ***"We listen to what people want. If there are people who really need something and they talk about that, then we will source it."*** *(Hub manager)*
>
> ***"It's that flexibility that participants have to access a wide variety of different services throughout their time and that can be very flexible and changing. [The Hub] can adapt based on [a] person's needs, preferences and circumstances."*** *(Hub manager)*
>
> ***"extremely flexible without losing its integrity."*** *(Hub staff)*
>
> ***"Feedback that I've had is that people find it a very welcoming place… shared spaces helps this … coffee and lunch with consumers [in an] open interactive space."*** *(Hub staff)*
>
> ***"We have a lot more flexibility with the time you can have with clients. It's not set by that hourly structure. And I think that's really important … to allow that person the time to talk and not to cut them off."*** *(Hub staff)*

Survey data aligned with this feedback, with hub staff reporting that the hub model is flexible, integrated and responsive, and offers a wrap-around approach that is more effective than other models staff had previously worked within.

> ***"Having the mental health nurses is great, and the DBT, Wise Choice etc make a huge difference"*** *(Hub staff)*
>
> ***"Community participation groups are a very good means of connecting people to different support… participants talk and promote other support streams to each other".*** *(Hub staff)*

Outreach was described as integral to the hub model's success, and a requirement for people with severe and complex mental illness. The ability to meet people where they are at and where they are most comfortable was described as important for engagement and individual recovery. Outreach was reported to occur in community-based settings (park, neighbourhood centre, local cafe), the clients' home, or utilised to upskill the client (e.g. transport training).

Based on their experience with the hubs, local stakeholders reported the following key strengths:

- physical hub environment, including location, facilities and nature of setting
- variety of supports offered

- flexible levels of service offered
- multidisciplinary team approach
- integration of clinical and non-clinical supports
- community-based and has less stigma than mental health services
- responsive and capable workforce.

While mixed perspectives overall were shared with regard to referral and communication, some local stakeholders highlighted the ease of the referral process and responsiveness of hubs in following up referrals as a strength.

> ***"Variety of support offered, well-qualified staff, provides an essential service for people not accessing/eligible for NDIS"*** *(Sector stakeholder)*

> ***"Care coordination to fill the gap of PiR. Mental Health Nursing. 1:1 support where capacity allows."*** *(Sector stakeholder)*

Brisbane North PHN staff identified the psychosocial funding stream as a strength of the hub model because of its ability to 'fill the gaps' and support integrated care. This was in comparison to other funding streams which fund specific services (i.e. clinical care coordination and psychological therapies). Psychosocial funding was reported as being a key component of the model, which has been reflected by the demand for this type of support.

## Limitations

Some service users highlighted instances where the hub model was not able to meet their needs or expectations, which were often associated with factors that reflected limitations of or gaps in the program's design. These included:

- barriers to accessibility ranging from proximity to where someone lives, transport, parenting and caring responsibilities and business hours availability
- more programs and resources to meet demand, particularly DBT therapy, housing and employment support
- larger hub facilities with mix of private and group spaces
- more social connection and peer support opportunities
- greater involvement of friends and families
- time-limited support
- being referred and connected earlier to support.

A selection of experiences shared by service users to illustrate these identified limitations of the model include:

> ***"I experience extreme difficulties establishing a new professional relationship, it often results in repeated cancelled and rescheduled appointments. Knowing there is a 6 month time allotment for my case adds to the pressure and guilt, which ultimately leads to anxiety and migraines and thus more cancellation/reschedule."*** *(Service user)*

> ***"The service needs desperately to have an on-hand psychiatrist who can help reinforce the service's ability to keep people out of the ward. If there was access to a doctor who could help stabilise medications or provide acute support when other options are limited."*** *(Service user)*

> ***"Unfortunately COVID put a dampener on excursions, getting out would have been good."*** *(Service user)*

Service users also noted instances where self-identified readiness of people to engage and apply skills in their life was a limitation of the model:

> ***"Me making more consistent application of strategies learnt [would have assisted further]."*** *(Service user)*

Service users reported that access to transport support, availability of after-hours supports and more hubs closer to home would assist them further.

Sector stakeholders identified a broad range of suggested areas of improvement to respond to perceived gaps or limitations in the design of the hub model, including:

- robust clinical support
- longer term non-clinical transition groups
- contact between providers and HHS services to improve relationships
- communication regarding outcome of referrals and support being provided
- improving referral pathways, particularly acceptance
- availability of after hours support
- administrative burden for service users
- specificity around hub branding, naming and information
- sector engagement.

Sector stakeholders reported that there is not enough capacity within the hubs to meet community needs, with suggestions to address this including more staff and bigger spaces. In particular, increasing access and/or existing capacity to Dialectical Behavioural Therapy (DBT) programs, clinical supports, 1:1 therapy and NDIS readiness/connection was identified. Sector stakeholders also noted a need for more consistency across service delivery in each region.

Some sector stakeholders reported limited understanding of what was available for people and how the hubs actually work with service users. Suggestions to improve the sector's awareness of the hubs included networking with referrers, targeted marketing, in-services with local mental health services and regular updates about hub services.

> ***"More staff… they are overwhelmed with numbers needing help. Better trained and experienced mental health team members"*** *(Sector stakeholder)*

> ***"It appears the staff dictate who they will/will not see with limited understanding of risk profiles."*** *(Sector stakeholder)*

> ***"It would be beneficial if staff from the hub could provide an in-service to [my organisation] in efforts to better understand the service and collaborate."*** *(Sector stakeholder)*

> ***"Inform GPs of their existence. The names of the Hubs are non-specific and do not reflect their function."*** *(Sector stakeholder)*

> ***"I don't think there are any strengths. I no longer refer to [hub] and nor do my colleagues because the referral itself takes significant time to complete and they are never accepted for care anyway."*** *(Sector stakeholder)*

> ***"I don't think anyone knows about the hubs, there is not enough advertising around them"*** *(Sector stakeholder)*

Hub staff and managers reported several limitations or challenges in the program model, noting that some of these are not absolute in nature and in some instances can also be identified as a strength of the model:

- resistance to integration of clinical and non-clinical supports and workers
- finding mutual understanding with HHS
- prioritising collaboration over competition between hubs
- time-limited nature of support
- lack of flexible funding / brokerage to meet clients' immediate needs
- limited involvement of medical staff (e.g. GPs) in hub model.

Hub managers reported that an episode of care being time-limited (up to 12 months) was a limitation of the hub model design. Both hub and Brisbane North PHN staff raised the challenges posed by this when supporting people with severe and complex mental illness due to the research indicating that mental health recovery takes a lot longer than 12 months. Synonymous with this feedback, service users reported that increasing the service delivery period from 12 months to 24 months would assist them further. Hub managers did note that when a service user needs more than 6-12 months of support, then extended support is generally provided.

> ***"...mental health isn't linear, they aren't going to engage every week, on the week and progress all the actions that they want to complete by the end of the 12 months."*** *(BNPHN staff)*

> ***"Knowing there is a 6 month time allotment for my case adds to the pressure and guilt, which ultimately leads to anxiety and migraines and thus more cancellation/reschedule."*** *(Service user)*

It was emphasised by one hub manager that this limitation has also been one of the model's strengths, resulting in a focus on recovery, supporting resilience and building independence.

The inability to step up support to HHS services was highlighted as another limitation in the hub model design. It was noted that 'theoretically' the HHS can step down to the hubs and hubs can step up to acute care. However, in practice, this reportedly does not occur. Despite HHS acute care clinicians co-locating in each of the hubs, hub staff noted they are unable to step people up to an acute care team when an individual has acute care needs, noting that the hubs are not an acute or crisis service. Co-investment in the hub model by the HHS and/or shared and defined pathways were suggested.

The inability to effectively measure meaningful recovery outcomes was identified as a limitation of the program's design by hub managers and staff. At a practical level, hub staff reported challenges obtaining pre and post outcome measures despite acknowledging these requirements. This was attributed to prioritising rapport-building with clients and respecting the decision of clients who don't wish to complete outcomes assessments. Staff reported that this means services are unable to demonstrate the impactful work they do to their funding provider.

From a design standpoint, hub staff also reported that the prescribed outcome assessment tools, particularly K10, is not useful for understanding a person's level of distress and does not provide a valid representation of recovery outcomes. It was raised that the K10 also doesn't capture the great strides a service user makes during their engagement with the hub. As a point in time measure, instances were raised around K10 being overly sensitive to changes in feelings and emotions of an individual that day and not representative of longer-term change in outcomes between the start and end of an episode of service.

To overcome these reported shortfalls, hub representatives suggested designing evaluation measures in collaboration with consumers. This could reflect the 'measurement' that hub staff are already engaged in each service contact to understand a person's motivation, mood and mental health, and gains over time. Other alternatives identified include the Camberwell Assessment of Need Short Appraisal Schedule (CANSAS) tool, which is already utilised by the Recovery and Discovery Centre, or capturing clients goals and whether these have been achieved on exiting the service.

# Effectiveness

Effectiveness refers to the extent to which the program achieved the desired outcomes. Three aspects of the program's effectiveness were considered:

- access to both clinical and non-clinical support based on referrals, episodes of service, client characteristics and presenting as well as psychosocial needs
- achievement of service users support goals
- change in service user outcomes such as lower levels of psychological distress and recovery outcomes

## Does the hub model improve access to clinical and non-clinical support for people with severe and complex mental illness?

### Referrals

Table 6 below shows the top 5 sources of referral by referring organisation type across each of the three hubs for episodes of service that involved at least one service contact with a client. The data shows some differences in the referral trends of each hub, with the Living and Learning Centre (Strathpine) more likely to generate self-referrals, while the Recovery and Discovery Centre (Bardon) is more likely to generate referrals from community support organisations. Stride Hub Caboolture is more mixed across a few sources, but has about double the proportion of referrals from general practice than the other two hubs.

**Table 6: Proportion of inward referrals received by referring organisation and hub**

| *Stride Hub Caboolture* | | *Recovery and Discovery Centre (Bardon)* | | *Living and Learning Centre (Strathpine)* | |
|---|---|---|---|---|---|
| *Top 5 referral sources* | *% of referrals* | *Top 5 referral sources* | *% of referrals* | *Top 5 referral sources* | *% of referrals* |
| Community Support Organisation (non-profit) | 17.8% | Community Support Organisation (non-profit) | 43.7% | Self-referral | 36.8% |
| General Practice | 15.7% | Self-referral | 12.0% | Community Support Organisation (non-profit) | 15.2% |
| Public mental health service | 16.3% | General practice | 7.6% | Public mental health service | 11.0% |
| N/A - Self referral | 13.2% | Private practice | 7.0% | Other | 8.0% |
| Other | 10.9% | Not recorded | 5.2% | General practice | 7.2% |

Analysing referral trends over time, it is evident that at a regional level the distribution of referral sources has changed. About half the proportion of referrals came from community support organisations in 2021 than in 2019 and similarly lower rates of referrals from general practice and private practice, while referrals have increased from public hospitals and public mental health services, self-referral and referrals categorised as 'other'.

## Episodes of service

Since July 2019, the hubs have commenced a total of 1,651 episodes of service where at least one service contact has been completed. A further 101 episodes were transitioned over to the hubs at the establishment of the program in July 2019 from the previous PHN-funded programs but have been excluded from the analysis due to data quality issues.

Across all episodes commenced during the period, a total of 1,006 episodes of services have been closed/ceased, with 477 episodes of service (or about 29% of all episodes) being closed due to *treatment concluded*, which represents planned or successful exits from the service. There were 746 open or active episodes of service as at the end of the reporting period (August 2021), however 97 of these open episodes had not recorded a service contact in the last 90 days, indicating they potentially should be closed administratively according to data collection protocols.

The breakdown of episodes commenced since July 2019 is reasonably consistent across each hub:

- 569 episodes of service at the Recovery and Discovery Centre (Bardon)
- 556 episodes of service at Stride Hub Caboolture
- 526 episodes of service at the Living and Learning Centre (Strathpine).

Acknowledging that the number of episodes does not necessarily reflect the number of unique clients who have obtained support through the hubs due to some clients receiving multiple episodes of service for various reasons, the breakdown of unique clients receiving support through the hubs is mostly similar with:

- 545 episodes of service at the Recovery and Discovery Centre (Bardon)
- 515 episodes of service at Stride Hub Caboolture
- 502 unique clients at the Living and Learning Centre (Strathpine).

Figure 10 below shows the time-trend of episodes of service that commenced and were completed from the establishment of the hubs in Quarter 3 2019 for all episodes where at least one service contact was completed. The dashed line represents the net gain/loss of episodes over time, which provides an indication of the 'caseload' of the hubs overall. Given that only one quarter showed a net loss of -1 episode at the end of that quarter, this shows that the hubs have consistently delivered an increasing number of episodes of services in almost every quarter.

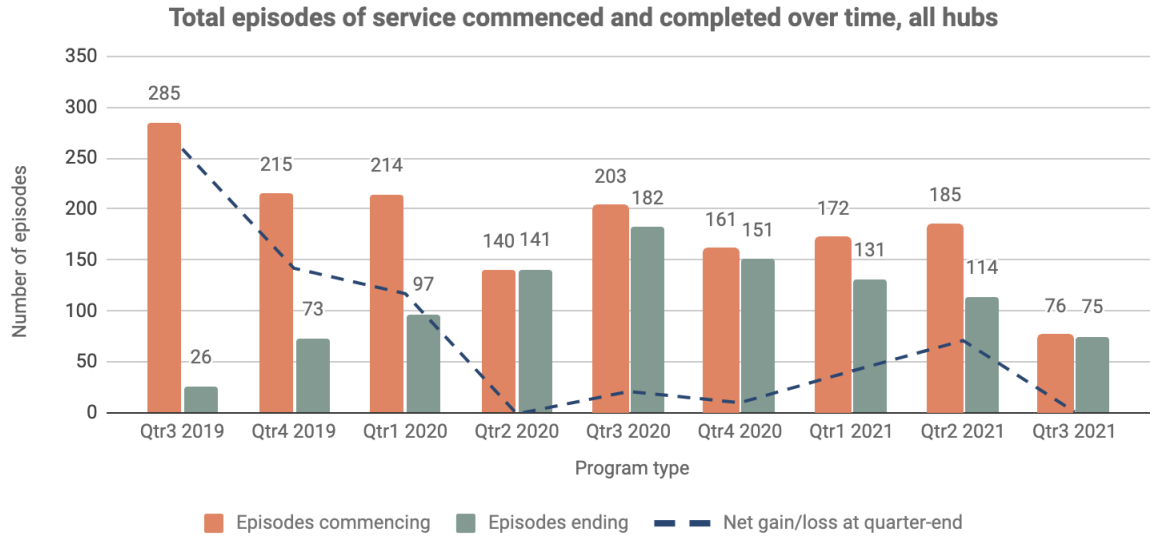


***Figure 10: Number of commenced and completed episodes by all hubs, per quarter***

These figures do not include 137 episodes of service that were *accepted* and 144 that were *closed/ceased* but do not have a commencement date due to no service contacts recorded — the first service contact recorded represents the date an episode of service commences in the dataset.

For the total 1,006 episodes of service that were closed/ceased and had an episode start and end date recorded, the average duration of an episode of service was 193 days, which ranged from a minimum of 1 day to a maximum of 728 days. There was slight variation across each hub, with the average duration ranging from 181 days at Recovery and Discovery Centre (Bardon) to 192 days at Stride Hub Caboolture and 202 days at Living and Learning Centre (Strathpine).

## Service contacts

A total of 38,620 service contacts were completed over an almost 26-month period from start-July 2019 to end-August 2019. This is a rate of 1,485 service contacts completed across all hubs per month. A further 5,684 service contacts were planned but not completed due to the participant not attending their scheduled appointment, comprising about 13% of all planned service contacts.

The average number of service contacts completed per episode of service was relatively consistent across each hub at 23.2 sessions per episode of service. However, the maximum number of sessions completed within any single episode of service varied considerably from 166 sessions at Recovery and Discovery Centre (Bardon) to 292 at the Living and Learning Centre (Strathpine) and 315 at Stride Hub Caboolture.

The average duration of a service contact was 80 minutes, ranging from 72 mins per session at the Living and Learning Centre (Strathpine), to 78 mins per session at the Recovery and Discovery Centre (Bardon) and 88 mins per session at Stride Hub Caboolture. An interpreter was used for approximately 1% of service contacts that were completed. Almost all service contacts were completed during weekday business hours (98%).

Figure 11 below shows the number of service contacts completed quarterly by each hub. It shows a reasonably consistent trend across hubs, with service contacts increasing over

the first few quarters upon establishment of the service, followed by a relatively steady level of activity until the last quarter (which was not a full period).

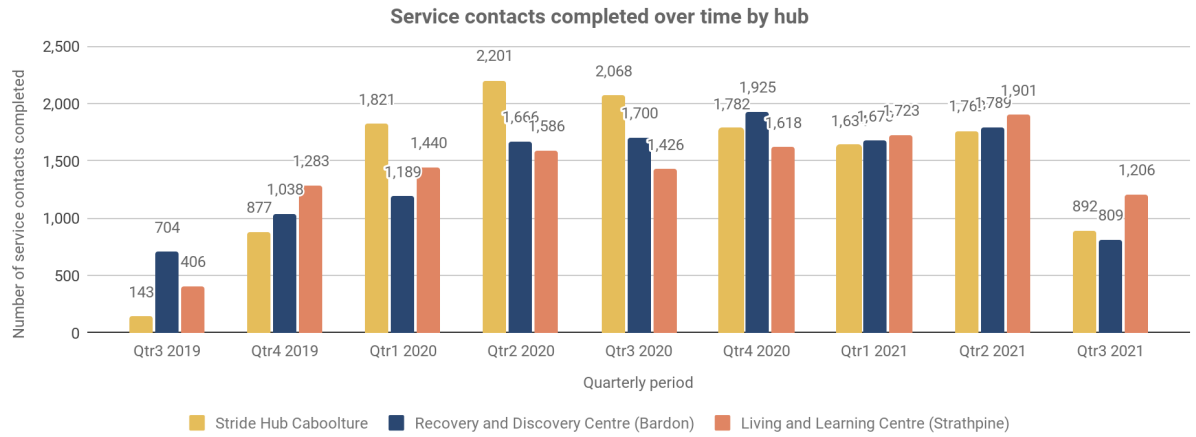


***Figure 11: Number of quarterly service contacts completed by each hub***

Figure 12 below provides a breakdown of the type of service contacts completed over the period for all hubs. It shows that over half of service contacts were for psychosocial support (52%), followed by clinical care coordination (23%) and psychological interventions (18%). These breakdowns varied between each hub, with the Living and Learning Centre (Strathpine) completing a significantly higher proportion of psychosocial support (66%) and less psychological interventions (7%), the Recovery and Discovery Centre delivered a higher proportion of clinical care coordination (31%) than the other hubs, and Stride Hub Caboolture delivered a higher proportion of psychological interventions (29%).

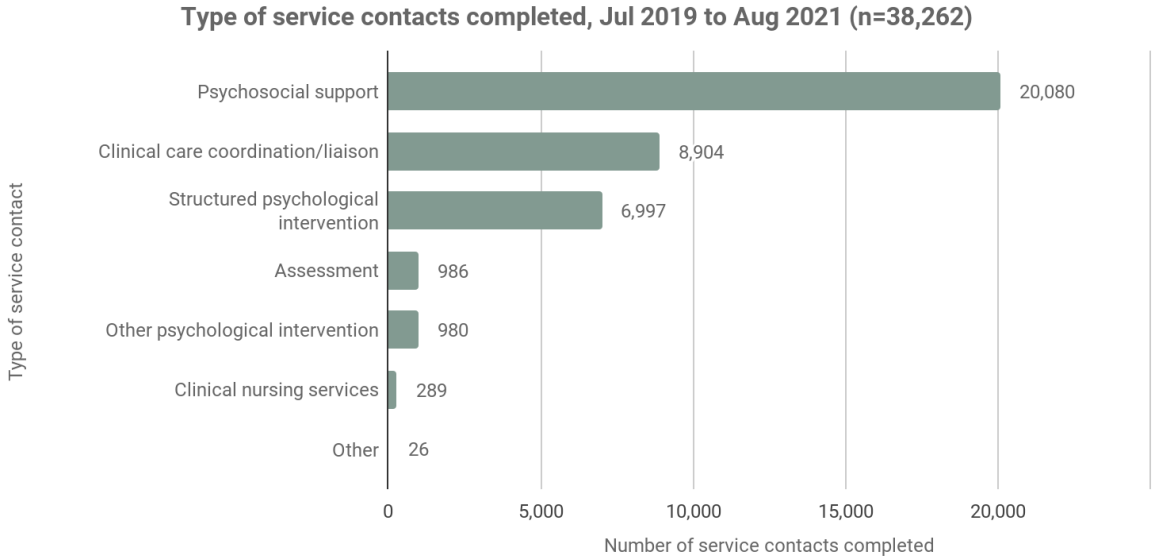


***Figure 12: Number of completed service contacts by type of service contact***

Figure 13 below provides a breakdown of the participant of service contacts completed across all hubs. It shows individual clients were the participant in 61% of service contacts completed, followed by clients in a group setting for about 31%. Other health professionals or natural support networks comprised less than 1 in 10 service contacts. This breakdown also varied across hubs as seen by:

- Living and Learning Centre (Strathpine) recording a relatively higher proportion of individual client contacts (70%) than other hubs
- Stride Hub Caboolture recording a relatively high rate of client group contacts (43%)
- Recovery and Discovery Centre (Bardon) recording a relatively high rate of contacts with other health professionals and service providers at 10.3%

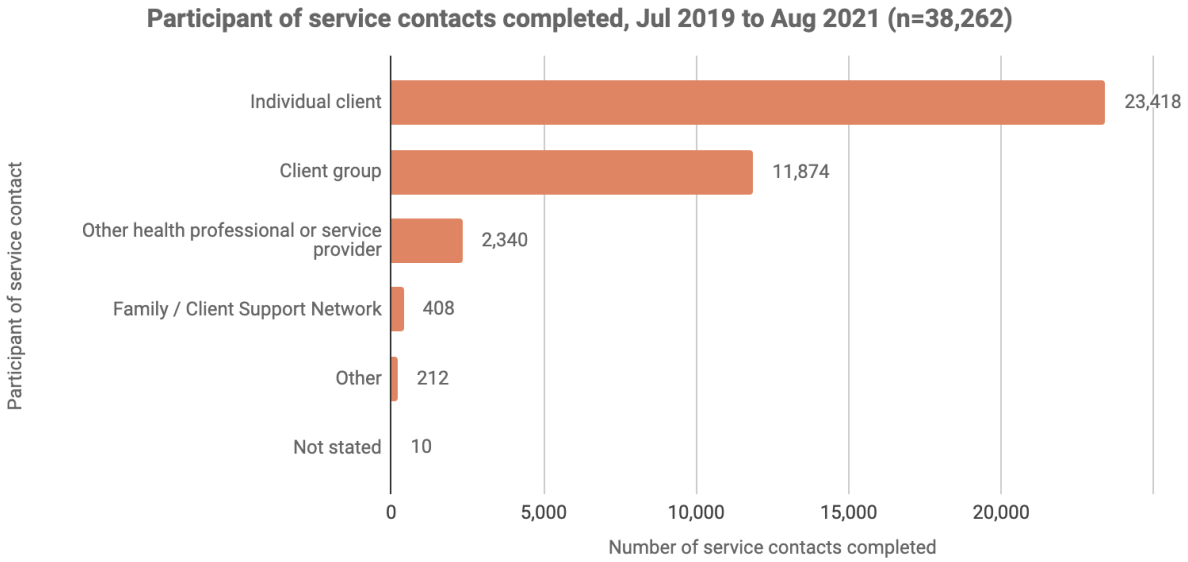


***Figure 13: Breakdown of participant service contacts by number of service contacts completed***

Figure 14 below shows the breakdown of the modality of service contacts completed across all hubs. Just over half (51%) of service contacts are delivered face-to-face, with the other considerable contribution being telephone service contacts (38%). Variation between hubs showed that Stride Hub Caboolture completed a relatively higher proportion of service contacts face-to-face at 61%, while the Recovery and Discovery Centre (Bardon) and Living and Learning Centre (Strathpine) completed relatively more service contacts remotely via telehealth modalities.

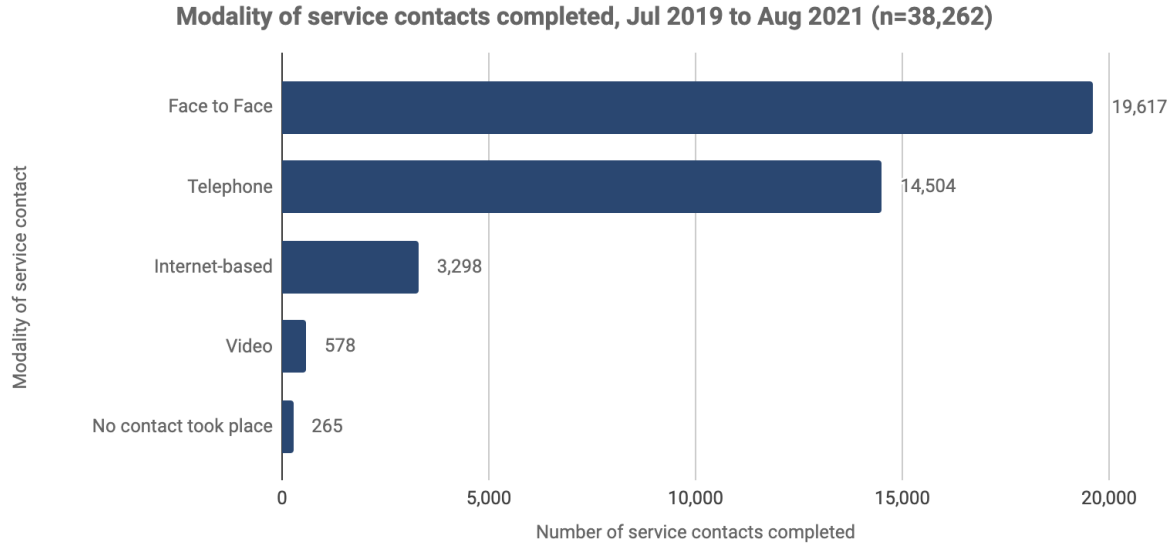


***Figure 14: Breakdown of service contact modality by number of service contact completed***

Further breakdown of the 19,617 service contacts that were completed face-to-face shows that not all service contacts were completed within the hub location. While most (57%) were completed within the *service provider's office* (presumably the hub site), about 20% were categorised as *other* and 18% were completed within the client's own home. Once again, there are differences observed between hubs, with the Living and Learning Centre (Strathpine) completing over 3 out of 4 contacts within the hub location, compared to less than half (44%) for the Recovery and Discovery Centre (Bardon).

A marked change in the modality of service contacts completed was observed as a result of the COVID-19 pandemic. Figure 15 below shows the impact of COVID-19 from when disruption from the pandemic started around Q2 2020, with face-to-face contacts dropping and remotely delivered service contacts increasing to the overwhelming majority. However, this reverted to the usual trend quickly following the initial impact of the pandemic. In the most recent quarter, the data shows another noticeable shift towards greater levels of remote delivery which coincides with COVID-19 related lockdowns and restrictions, however this is not a full quarter of data so these smaller numbers should be considered with some caution.

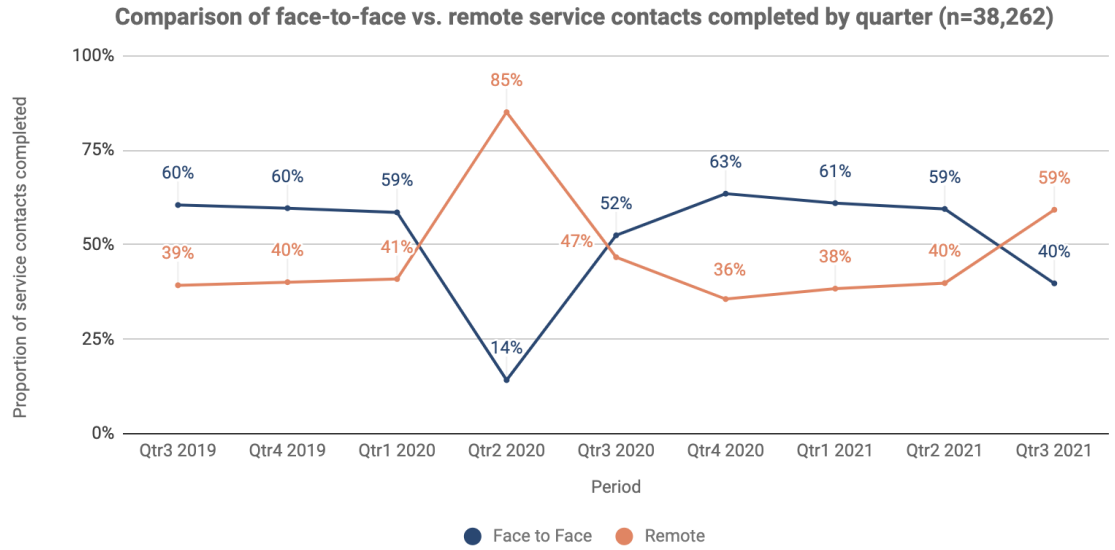


***Figure 15: Comparison of hub service delivery modality, per quarter***

In addition to service contacts completed, a total of 7,627 non-clinical activities were recorded over the period across all hubs. Non-clinical activities are an additional field collected in Redicase but not uploaded to the PMHC-MDS that provide an indication of administrative work completed by the hubs. These mostly related to phone calls (55%) or computer work (16%). While the Learning and Learning Centre (Strathpine) and Stride Hub Caboolture both recorded around 3,500 non-clinical activities over the period, the Recovery and Discovery Centre (Bardon) only recorded about 560 non-clinical activities.

## Client characteristics

Table 7 below describes the demographic characteristics of the clients who commenced an episode of service with at least one service contact completed across each of the hubs.

***Table 7: Demographic characteristics of service users who engaged at a hub***

| Indicator | | Stride Hub Caboolture | Living and Learning Centre (Strathpine) | Recovery and Discovery Centre (Bardon) | Total / all hubs |
|---|---|---|---|---|---|
| Age range (%) | 15-24 years | 13% | 19% | 24% | 19% |
| | 25-34 years | 20% | 24% | 23% | 22% |
| | 35-44 years | 22% | 20% | 15% | 19% |
| | 45-54 years | 21% | 22% | 21% | 21% |
| | 55-64 years | 18% | 12% | 13% | 14% |
| | 65+ years | 7% | 3% | 4% | 5% |
| Gender (%) | Female | 63% | 65% | 58% | 62% |
| | Male | 34% | 33% | 34% | 33% |
| | Non-Binary | 1% | 1% | 3% | 2% |
| | Not stated / provided | 1% | 1% | 4% | 2% |
| | Trans Male | 1% | 0.2% | 1% | 1% |
| | Trans Female | 0.4% | 0% | 0.4% | 0.2% |
| | Intersex | 0% | 0.2% | 0.4% | 0.2% |
| Country of Birth (%) | Born in Australia | 81% | 90% | 82% | 84% |
| | Born outside of Australia | 8% | 9% | 12% | 10% |
| | Unknown or not stated | 12% | 0% | 5% | 6% |
| Indigenous status (%) | Aboriginal and / or Torres Strait Islander | 12% | 11% | 6% | 10% |
| | Non-Indigenous | 64% | 77% | 77% | 73% |
| | Not stated | 24% | 11% | 17% | 18% |
| LGBTI status (%) | LGBTI | 4% | 11% | 7% | 7% |
| | Non-LGBTI | 39% | 58% | 32% | 43% |
| | Not stated / recorded | 58% | 30% | 62% | 50% |
| NDIS participant (%) | Yes | 5% | 1% | 3% | 3% |

| | | | | | |
|---|---|---|---|---|---|
| Homeless-ness status (%) | At risk | 4% | 8% | 7% | 6% |
| | Short-term / emergency accommodation | 2% | 3% | 6% | 4% |
| | Sleeping rough / non-conventional accommodation | 3% | 3% | 1% | 3% |

Figure 16 below shows the geographic distribution of clients for all commenced episodes of service based on the postcode recorded for their residence. Lighter shading represents relatively fewer clients from that postcode, with darker shading representing higher numbers of clients from that postcode. The data shows that clients generally accessed services from the hub that was closest to them geographically. However, the distribution of clients between Stride Hub Caboolture and the Living and Learning Centre (Strathpine) was generally split for the area stretching East from Narangba and North Lakes over to Redcliffe.

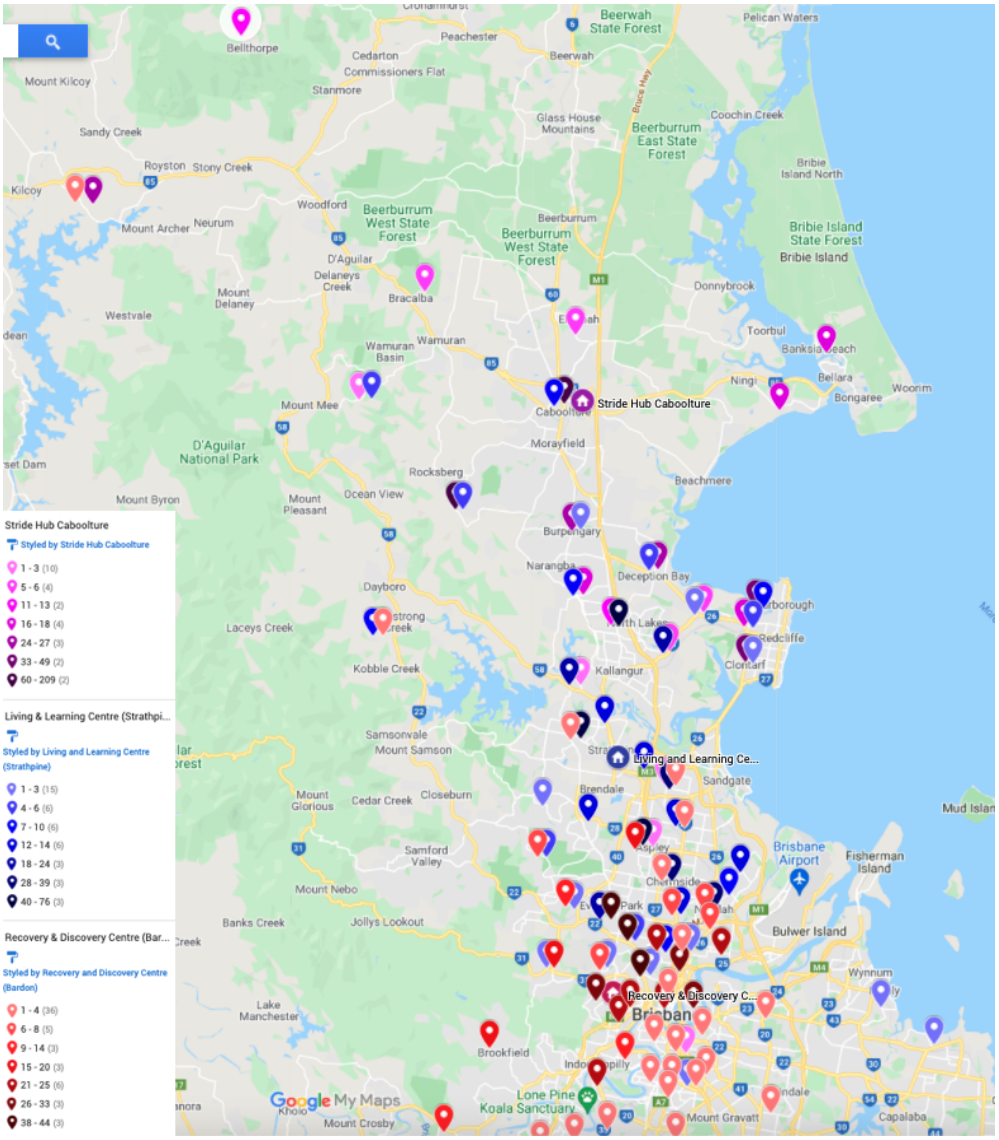


***Figure 16: Geographical distribution of service users by each hub***

The data also shows a considerable number of clients accessing support from the hubs who reside outside the Brisbane North PHN region, particularly those residing in the Brisbane South PHN region who accessed support through the Recovery and Discovery Centre (Bardon). Not visible on the map above are several clients who are recorded as residing in locations well beyond the Brisbane North PHN boundaries, such as the Gold Coast, Sunshine Coast, Mackay, Darling Downs and Melbourne.

## Presenting needs of clients

The presenting needs of clients can be identified through the information provided on inward referrals received and obtained through the intake and assessment process relating to mental health diagnosis, identified life stressors and baseline levels of self-reported psychological distress and recovery.

Figure 17 below shows the principal diagnosis identified for commenced episodes of service across all hubs. The most common diagnosis identified was post-traumatic stress disorder at about 1 in 5 episodes of service (18%), followed by major depressive disorders (13%), personality disorders (9%) and bipolar disorder (9%). An additional diagnosis was identified in over 80% of clients, with the most common additional diagnosis being a generalised anxiety disorder.

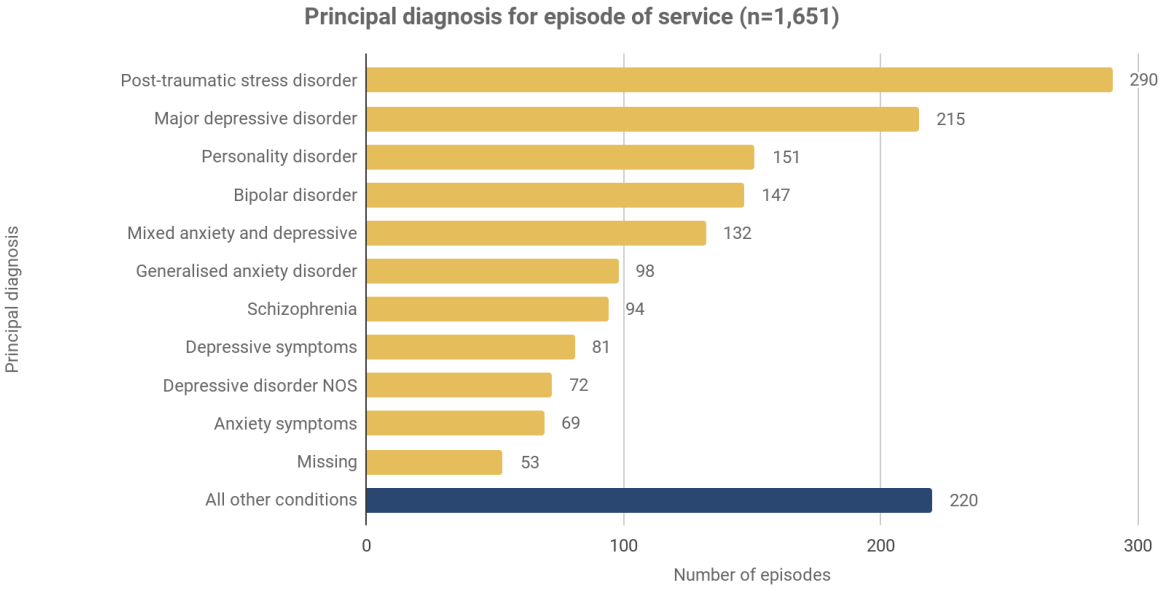


***Figure 17: Breakdown of service user principal diagnosis by number of episodes***

About 1 in 5 episodes were associated with a co-occurring alcohol and other drug (AOD) issue, which could be a diagnosed substance use disorder, dependence and/or harmful use. This figure was slightly higher at the Recovery and Discovery Centre (Bardon) at 26.7% compared to the Living and Learning Centre (Strathpine) at 20.3% and Stride Hub Caboolture at 11.7%.

Figure 18 below shows the most frequently reported life stressors associated with an episode of service, noting that an episode may be associated with several life stressors. The data highlights *mental illness* as a source of stress in about 53% of all episodes of service, followed by past experience of abuse or violence (14%), AOD-related problems (12%) and unemployment (10%).

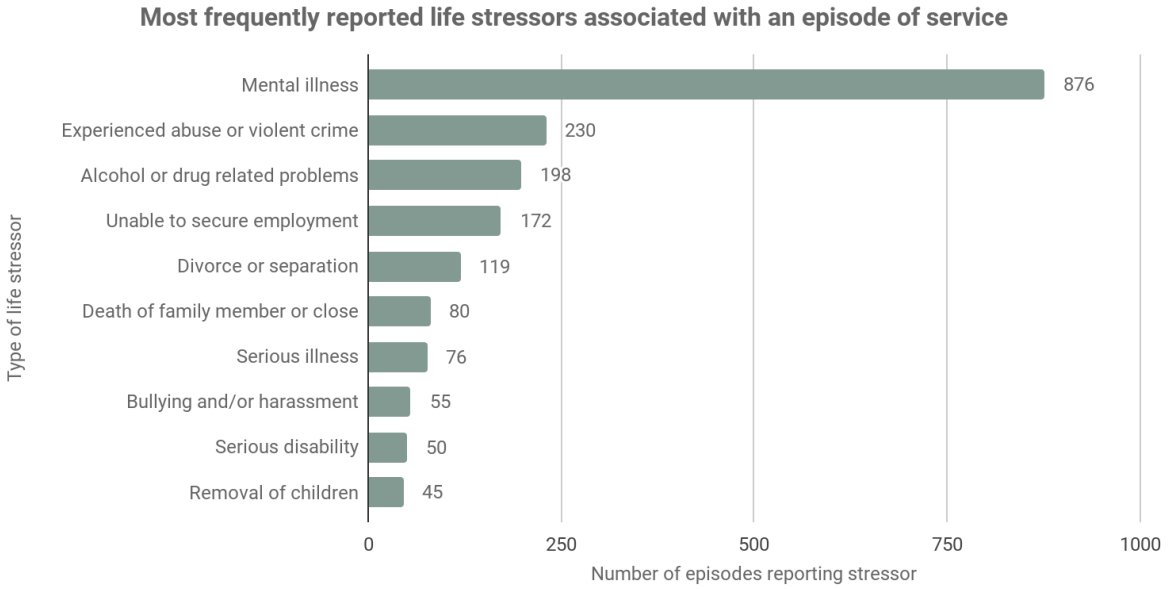


***Figure 18: Breakdown of life stressors by number of episode***

The levels of psychological distress reported by service users upon commencement of an episode of service provides an indication of the severity of mental health concerns they present with at baseline. Figure 19 below shows the breakdown of psychological distress by category of severity at baseline across each hub for the 1,184 episodes of service where a K10 score was recorded upon commencement. The data shows that most service users have levels of psychological distress and are likely to have a severe mental disorder according to a recognised scoring protocol.[11] These rates are slightly higher for service users of the Living and Learning Centre (Strathpine) (73%) than Stride Hub Caboolture (69%) and the Recovery and Discovery Centre (Bardon) (65%).

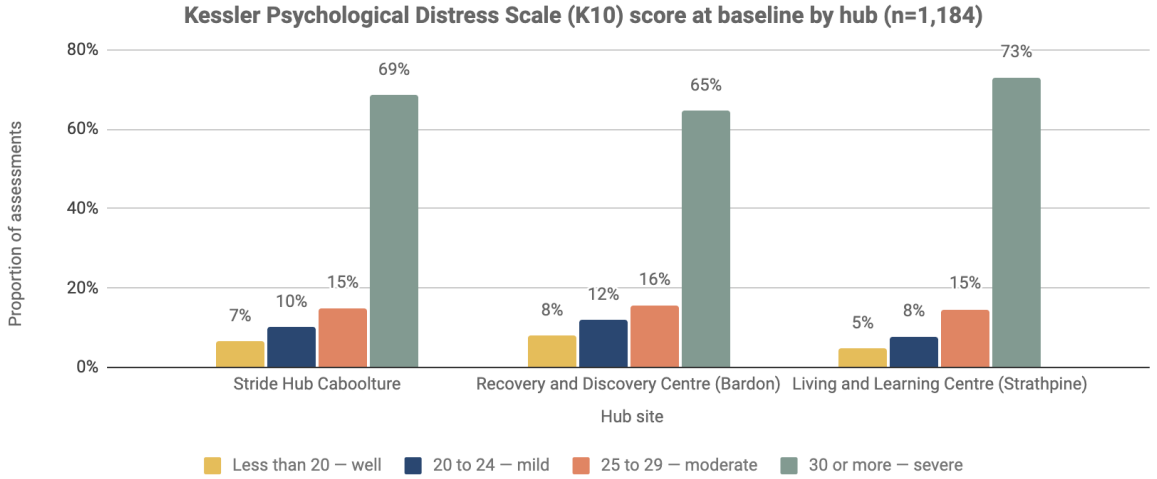


***Figure 19: Breakdown of Kessler Psychological Distress Scale (K10) severity by hub***

The K5, a modified version of the K10 that is considered to be potentially more culturally appropriate for Aboriginal and/or Torres Strait Islander people than the K10, was administered in an additional 4 episodes of service. All 4 of these baseline K5

[11]Andrews, G Slade, T. Interpreting score on the Kessler Psychological Distress Scale (K10). Australia and New Zealand Journal of Public Health: 2001; 25:6: 494-497.

assessments scored over 15, which indicates a very high level of psychological distress according to the standardised scoring protocol.

The RAS-DS tool was completed at baseline for a total of 524 episodes of service, which is about 32% of all episodes of service that commenced during the evaluation period. The RAS-DS provides a total 'recovery' score across all sub-scales, where higher values indicate more positive self-assessed levels of recovery. Figure 20 below shows the breakdown of total RAS-DS scores by quartile for each hub.

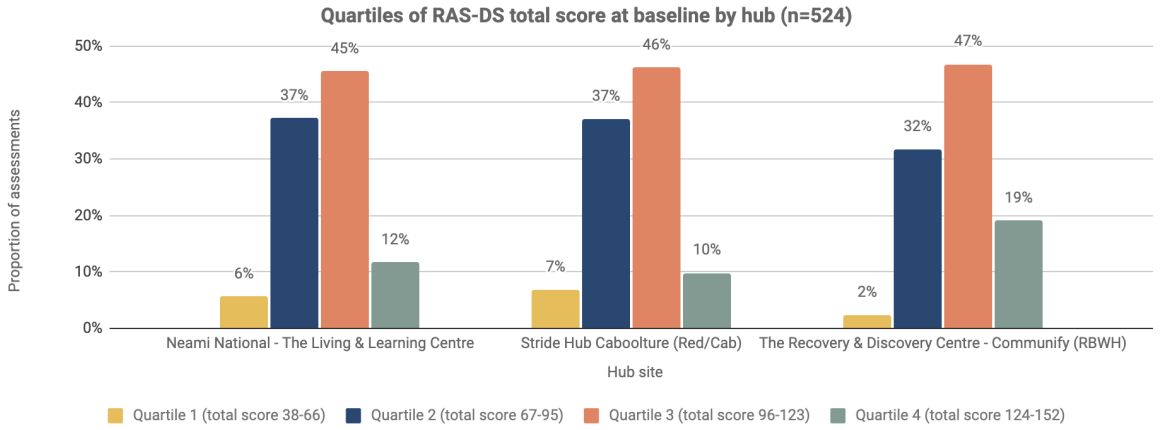


***Figure 20: Breakdown of quartile of RAS-DS total recovery score at baseline by hub***

The average score out of 152 for service users at the Recovery and Discovery Centre (Bardon) was slightly higher at 103.6 than at Stride Hub Caboolture (96.9) and at the Living and Learning Centre (Strathpine) (98.1). When analysing the data at the level of each domain as shown in Figure 21, it can be seen that service users generally present with higher self-reported levels of functional recovery based on the *Doing Things I Value* domain, which includes items relating to engagement in meaningful activities and a sense of contributing to others. Conversely, service users across all three hubs reported lower levels of clinical recovery (*Mastering My Illness* domain), with this domain focused around management of symptoms and impact on everyday functioning.

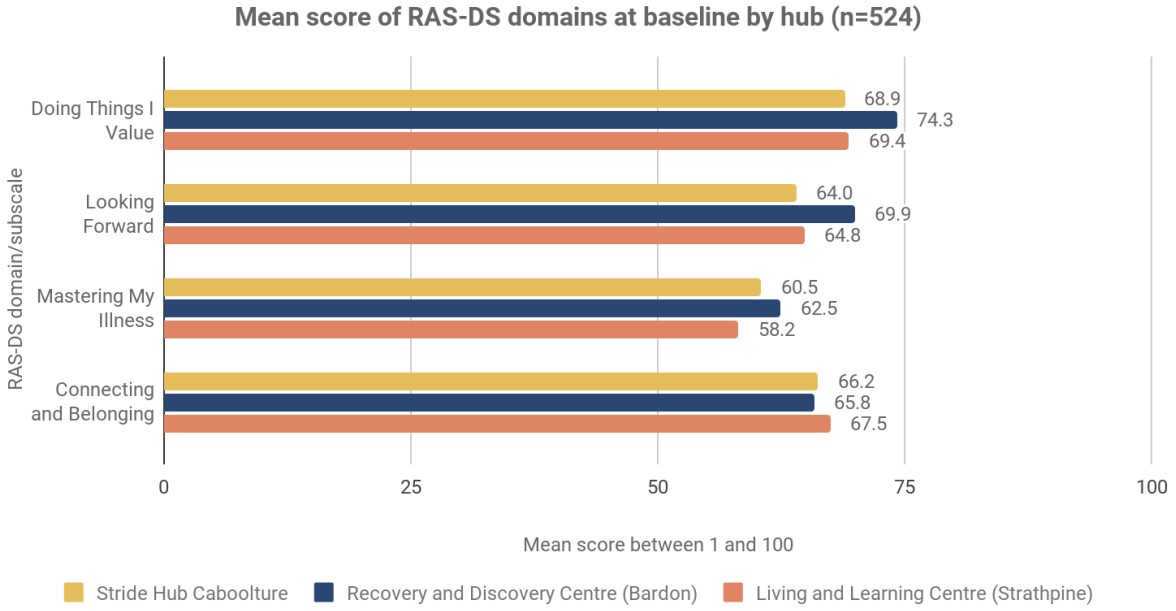


***Figure 21: Baseline mean score of RAS-DS domains by hub***

A more detailed analysis of the individual needs identified by service users during intake and assessment was not possible due to differences in how the psychosocial needs of service users were collected and recorded between each hub. A desktop review of relevant program documentation supplied to the evaluation team for a sample of client intake and planning documentation was reviewed for each hub. All hubs use a written intake and assessment form that covers a range of psychosocial factors (e.g. socioeconomic, relationships, existing supports, protective factors) and physical health domains. The Recovery and Discovery Centre also uses the Camberwell Assessment of Need (CANSAS) tool as part of their practice to assess the met and unmet psychosocial needs of service users.

## Do service users achieve their support goals?

### Achievement of self-identified goals

It was not possible to determine the proportion of clients who had achieved self-identified goals upon completing their episode of service. This is due to variation in how service user goals are approached and documented by each of the hub providers.

To understand how self-identified goals are captured and maintained, a sample of de-identified documentation was obtained from each of the hubs and formed part of the desktop review. The sample demonstrated variability in the tools and templates used by each of the hubs to document and monitor goals. Self-identified goals were generally documented in the client's individual plan, however progress towards goal achievement is not systematically captured or prompted in templated documents.

The exception to this was the Recovery and Discovery Centre (Bardon), which uses a template prompting staff to record the date that a service user's goal is achieved. A person's self-identified goals are captured by all hubs periodically, including at commencement and review. It was observed in one sample that a service user's goals may change throughout an episode of service and closing off of previous goals may not be well documented.

Through the survey, service users reported on some of the changes in their life aligned to their goals since engaging with the hub. Common themes were social connectedness and feeling less isolated.

> ***"I have a support network of people who I can count on and I feel less alone in this world"*** *(Service user)*
>
> ***"Meeting new people and learning new ways to deal with mental illness"*** *(Service user)*
>
> ***"Every aspect of my day to day life has changed for the better since I have been attending the hub"*** *(Service user)*
>
> ***"I am no longer living an isolated life. I can converse with strangers. I am coping with life. I am smiling"*** *(Service user)*

## Case examples of ability of hub to meet psychosocial needs of service users as reported by hub staff

Social interaction as a component of the hub model was also identified by hub staff as addressing a common theme of social isolation. Staff reported that the hubs support service users to feel connected and accepted without question or judgement and have hope for the future. The hubs were described as a gentle entry to building and maintaining relationships and establishing a sense of connection and belonging. Group work was identified as a great way to address social isolation.

> ***"What I find interesting and what I can see [is] some of our participants, on the odd occasion, that they will come and they are really not in a good place. I get so worried about them when they get like that. But yet, they still get out of bed, and because they know me so well they come here and it's such a good environment for them. They still make the effort. It doesn't matter how they feel, they still make the effort to come here."*** *(Hub worker)*
>
> ***"I do pretty much all her communication because when she does it, it doesn't go very well. But she's coming to two groups a week and starting to have conversations with people and reducing her social anxiety and is improving her confidence."*** *(Hub worker)*
>
> ***"People feel they are part of a community, they make friends, their lives are expanded, they no longer feel isolated. They are given the resources they need to achieve their goals."*** *(Hub worker)*
>
> ***"I feel less isolated because I am connected with people who truly understand the struggle of living with severe mental health issues."*** *(Service user)*
>
> ***"every aspect of my day to day life has changed for the better since I have been attending the hub."*** *(Service user)*

Hub staff also reported that the hubs support clients to build their confidence, skills and experience to work towards their individual goals. Identified changes in support outcomes for service users were identified and included (re)engaging in work or study and achieving independent living.

> ***"It's about working with one goal. I've had lots of people who are living paycheck to paycheck because they can't get a job. They can't get a job because they don't have a license and they can't catch public transport because of their anxieties. So it could be something as simple as working to catch public transport together and building up their confidence doing that over a few weeks. And then they can catch public transport and then they have money and then they move out of home. It's just one small thing like to access the service, it could be something so small being a catalyst for something so big."*** *(Hub staff)*

NDIS support was also described as an element of the model that supported people with their needs. Although it is not the role of the hubs to get people on to the NDIS, it was reported that psychosocial needs may need to be actioned before providing

NDIS support or it can be difficult to work with the person because they may, for example, be homeless or experiencing financial hardship.

Case examples of how the hub model has supported service users to achieve their psychosocial goals were provided by hub staff:

> ***"There was a woman who I was on the tail-end of supporting with receiving her NDIS plan. This woman has some very severe physical limitations that are very linked to her mental health. Lots of trauma in her past and her mental health was impacting her in accessing anything.***
>
> ***So the person in the role before me supported her to get NDIS largely on her assessment so that she can get the physical supports needed... Based on my short interactions with her, she would never have gotten the NDIS without it. It's a wonderful example of recovery because prior to getting the NDIS plan, her son was providing all of the support. So he's in the 12th grade, and was going to school 2 days a week, but providing that social, emotional and physical care to his mum. So they have been able to do that with the nurses and the OT to get this NDIS plan over the line and her son to actually go back to school. And his own mental health was in decline, but it's drastically improving because she's going to have that ongoing care as a result of being able to access those things. That's an amazing outcome."*** *(Hub staff)*
>
> ***"I had a referral that came through to me 2 months ago. This young person was extremely socially isolated and lived on her own and her only connection was with her mum who lived close by. She lives in an apartment that is way too expensive and receives Centrelink income which is nothing... her entire income for her rent. She didn't know anyone and had one online friend. So she came to groups.. We have a clay group that we are starting and they're coming to a drama group and that drama group is something they really connected with and the growth in 2 months, they made friends in real life. They have a housing support worker and are in more affordable housing. They are attending adventure therapy groups. Her feedback is, "I definitely would recommend that to someone else." We also ask "How empowered do you feel and accepted in the community do you feel after?" and it's always gone up at least two marks before and after attending the group each week."*** *(Hub staff)*
>
> ***"I had another [client] that was banned from almost every service, doctors, Centrelink, pharmacies, shopping centres and everything just because of behaviour. I guess huge anxiety and depression and all these things. We worked on a lot of things and that was mainly getting access to the community again. And also empowering, how to start becoming independent and questioning and coming from that curious spot. "What do you think is going on? How do you think we can improve the situation?" He's actually come so far now that he just got his [driver's] license two weeks ago which was something he never thought he would ever do. But he's got that and he's living independently now and he's got access to the doctors again, Centrelink, and got good rapport with housing because he rings up every now and then to see how his application is going. He's doing all the right things. He's speaking appropriately now instead of yelling at people and being really aggressive. I'm just really amazed by that huge turn around of this***

***person. But he's only one of many that have been through this space. It's incredible to watch the journey of some people, which have been significant."*** *(Hub staff)*

## Do service users report lower levels of psychological distress?

Figure 22 below presents the breakdown of severity of psychological distress measured by K10 score for all assessments completed at the respective timepoints of episode start, midpoint review and episode end. This comprises over 1,800 total K10 assessments completed across all hubs.

The data shows a lower proportion of service users reporting very high levels of psychological distress at both review and episode end, which are indicative of a severe mental illness. The data also shows a considerably higher proportion of service users reporting K10 scores that are indicative of no mental illness.

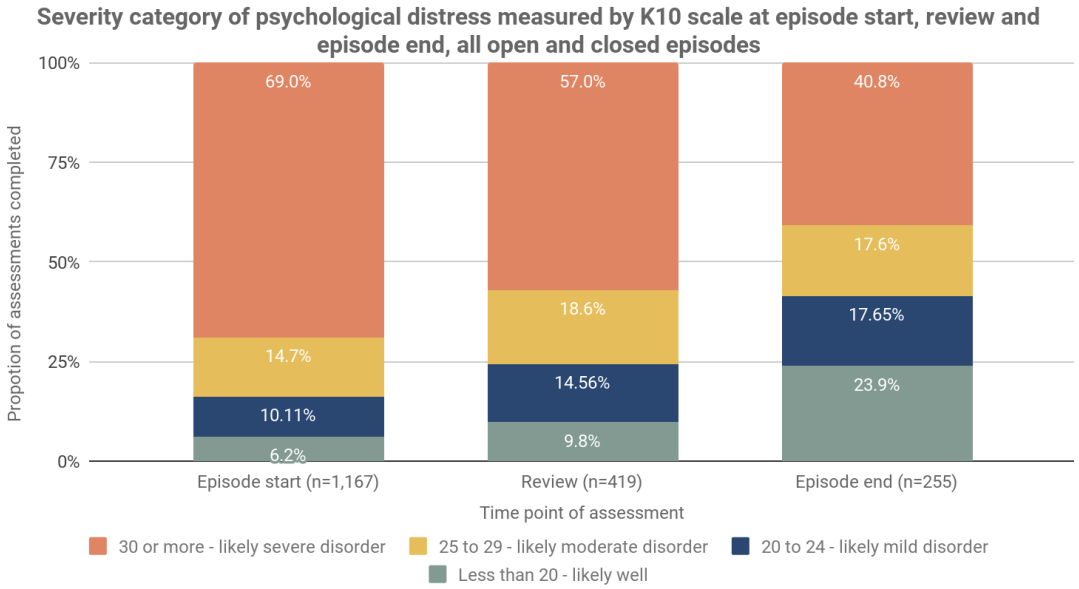


***Figure 22: Change in severity of psychological distress as measured by K10+***

This positive change in K10 scores observed at a group level was consistent across all three hubs. The mean K10 score at the end of an episode decreased by just over 8 points for the Living and Learning Centre (Strathpine) and Stride Hub Caboolture, and decreased by around 4 points for the Recovery and Discovery Centre (Bardon).

Figure 23 below shows the change in K10 score at an individual level for the 214 episodes of service that were closed/ceased where both a pre and post K10 score had been recorded.

The data is ordered by the K10 score at baseline for the individual, with green bars showing a decreasing K10 score pre and post (i.e. a positive change where the service user is reporting less distress), while the orange bars represent an increase in K10 score pre and post (i.e. a negative outcome where the service user is more distressed).


***Figure 23: Individual-level change in pre and post K10+ measures***

The PMHC-MDS specification prescribes an effect size statistic to measure significant changes in K10 scores between episode start and episode end for those episodes with a matched pair of K10 scores. The effect size (based on *Cohen's d* statistic) calculates a value where +0.5 or more is categorised as *Significant improvement*, -0.5 or less constitute *Significant deterioration* and between -0.5 and +0.5 indicates *No significant change*. Applying this statistic to the 214 matched pairs above shows that 51% of episodes (n=109) showed a *significant improvement*, 38% (n=81) had *no significant change*, and 11% (n=24) had a *significant deterioration*.

## Do service users experience a positive change in recovery outcomes?

The RAS-DS tool was administered by hubs to service users to measure changes in pre- and post- measures of recovery across four domains aligned to key components of recovery-oriented practice — *Connecting and belonging; Looking forward; Doing things I value;* and *Mastering my illness*.

The availability of RAS-DS score data at episode end was relatively low, with only 58 episode end scores recorded across all hubs. Only 43 completed episodes of service had both a matched pair of RAS-DS scores recorded at episode start and episode end available for analysis, which was less than 5% of all completed episodes of service. This makes analysis of changes at a hub-level or at an individual-level challenging, and caution should be applied to generalising these findings.

Figure 24 below shows the group-level change in total recovery scores measured by RAS-DS and categorised into quartiles for all hubs. The data shows an overall improvement in the total recovery score of service users over the duration of engagement in an episode of service, represented through an increase in proportion of service users within quartiles 3 and 4 at review and episode end. At a hub-level, this trend of more positive self-reported recovery scores was consistently observed. The trend was also consistent across each domain of the RAS-DS, with the largest

improvement observed in the personal recovery *(Looking Forward)*, clinical recovery *(Mastering My illness)* and social recovery *(Connecting and Belonging)* domains.

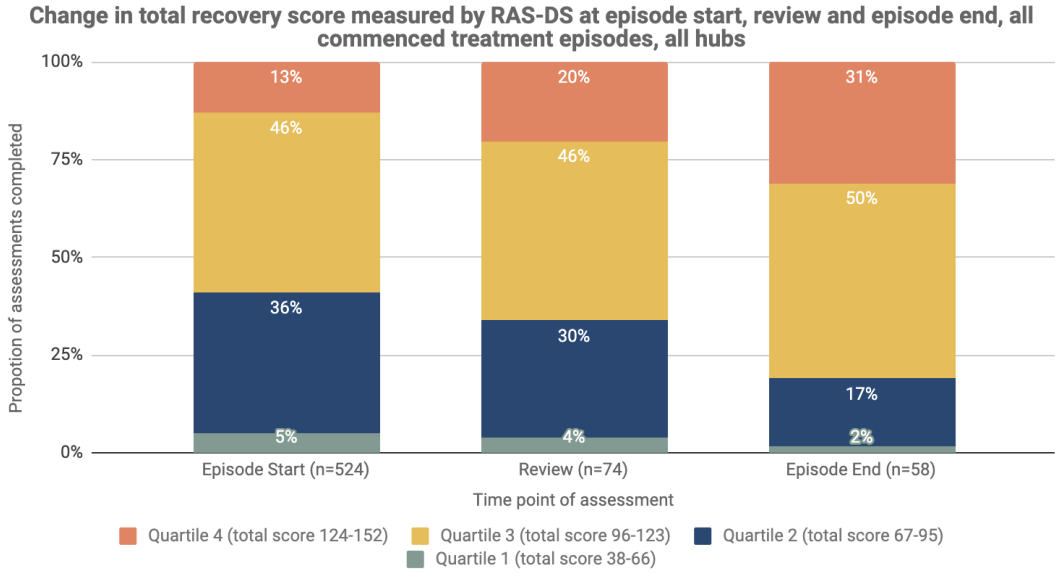


***Figure 24: Change in total recovery score measured by RAS-DS***

Figure 25 below shows the individual-level change in total recovery score using the RAS-DS for the 42 completed episodes with paired data available across all hubs.

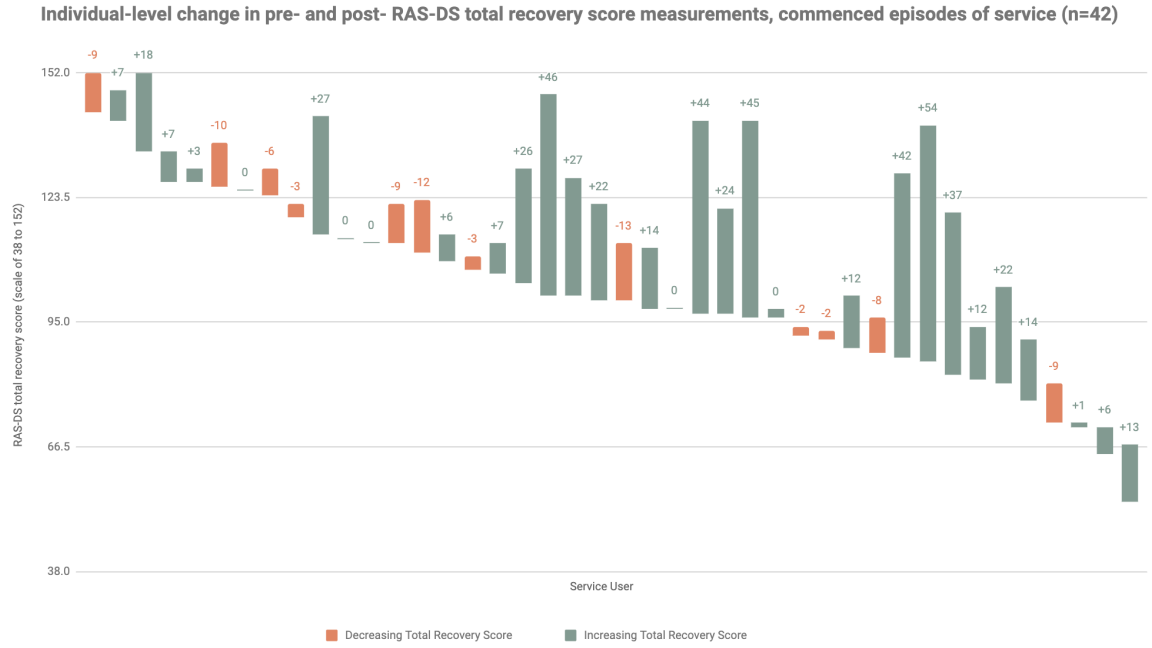


***Figure 25: Individual-level change in total recovery score measured by RAS-DS***

Applying the same effect size statistic described earlier to measure significant changes in total recovery score between episode start and episode end for the 43 matched pairs above shows that 41% of episodes (n=17) showed a *significant improvement*, 51% (n=22) had *no significant change*, and 5% (n=2) had a *significant deterioration*. Both the small sample size and relatively high scores recorded at baseline should be considered when interpreting this outcome.

Another key indicator for assessing the effectiveness of the hub model was service users self-reporting a change in recovery outcomes once they have engaged with the hubs.

From the service user survey, respondents were asked to compare their current outcomes to their outcomes before engaging with the hub on a five-point Likert scale from *1: much worse* to *5: much better*.

In Figure 26 below, service users overall reported positive feedback on their outcomes after engaging with the hubs. Service users generally agreed that, since engaging with the hubs, the following relevant outcomes had positively changed (ordered by mean score):

- hope for the future (mean=4.13)
- reduced need to access HHS (e.g. hospital-based) services (mean=4.11)
- overall wellbeing (mean=4.05)
- ability to access services needed (mean=4.00)
- self-efficacy or belief in own ability to manage illness (mean=3.90)
- day-to-day living skills (mean=3.89).

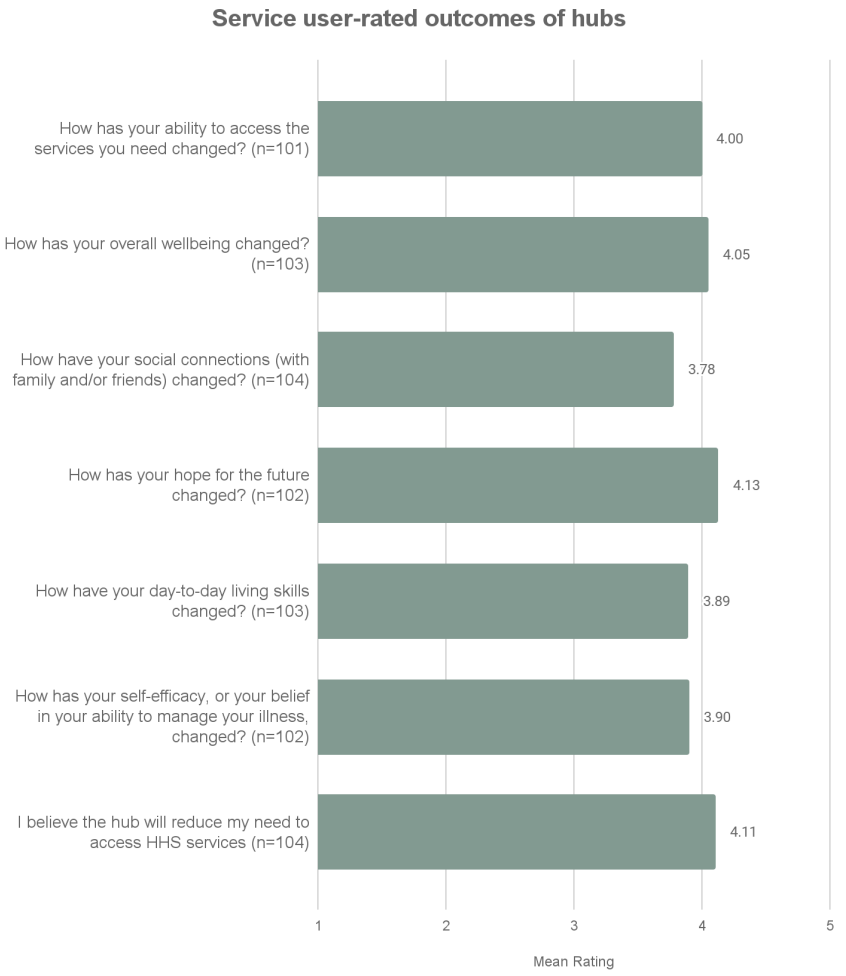


***Figure 26: Service user perceptions of changed outcomes after engaging in the hubs***

Qualitative findings supported the survey data, with service users reporting changes in self-efficacy and self-management skills since engaging with the hubs. This included developing coping skills and putting these into practice, confidence in and knowledge of where to seek help, managing day-to-day life, and increasing self-awareness and

independence. Other changes reported included improvements in physical health, stabilisation of mental health and reduced hospital admissions.

> ***"I'm not so angry anymore, not as confused. Mental health is stabilised (no more hospital admission) I am off [illicit] drugs (wise choices). Also my physical health is improving."*** *(Service user)*
>
> ***"I feel more independent and capable with dealing with difficult emotions."*** *(Service user)*
>
> ***"I am learning skills to cope with my illness and putting them into practice as well."*** *(Service user)*
>
> ***"Different life skills are helping me to interact better in my relationships so both needs/wishes are met and valued/respected."*** *(Service user)*
>
> ***"I think the biggest feedback I keep getting is 'I haven't been back to the hospital'... There's a lot of people going in and out of hospital like a revolving door and now a lot of them have the support and haven't been back there. There are some that do end up back in hospital because of some situations. But that's one thing we've been doing is helping people to manage their own wellbeing and giving them some strategies around coping."*** *(Hub staff)*
>
> ***"One of the people said to me the other day, "You know what, I haven't self-harmed since working with [hub provider]." That's significant because he said he was either suicidal or self-harming and that's pretty amazing really."*** *(Hub staff)*

It should be noted that several survey respondents reported no change or a deterioration in their mental health since engaging with the hubs.

> ***"Things only get worse now with added frustrations of being obligated to fulfill requirements for "the hub" with no further support."*** *(Service user)*
>
> ***"My life has no change!! Ongoing issues mentally and physically."*** *(Service user)*

## Case examples demonstrating a change in recovery outcomes for people with a severe mental illness

Through qualitative findings, hub staff reported that the development of an individualised care plan supported service users to achieve their recovery goals. The role of hub staff in breaking down a person's goals into more manageable goals and facilitating linkages with other services such as housing, child safety, court services, alcohol and other drug services, financial support and food security, was highlighted.

Peer workers and their lived experience were identified as a powerful and important component of the model to break down the stigma around mental illness.

Case example of demonstrating a change in service user recovery outcomes were reported by hub staff:

> ***"[the service user] was defensive, aggressive and showed all sorts of deficits whether that would be their interpersonal skills, their mood was low and depressive and their anxiety scores were high. They were unable to parent, they***

***had child protection in their lives and the children were moved and had financial struggles. It's a whole lot. Fast forward to now after completing the DBT group, the changes have been massive in terms of the parenting capacity. No more [child protection]involvement and very much has improved in terms of connection, relationships and the warmth of the relationships with the children. In terms of the interpersonal skills there were massive gains where they were nowhere near as defensive because before they would fight with school staff or with Centrelink staff and always on the defense and quite aggressive. There is none of that now and that is zero. The mood sits in the middle as opposed to zero out of ten and the motivation is a nine out of ten now. The home is now being kept clean and attending with availability for the children and improved relationships externally and repaired relationships with parents."*** *(Hub staff)*

***"What I observed was when I first met with him, he was very withdrawn, found it very difficult to engage and had no self-confidence that he was able to achieve anything. He's moved leaps and bounds. He has volunteer work and studying. He's got this ambition of what he wants to do in his life. And I just think, "Wow! It's all done here, but it was done by the team, and everyone stepped in certain areas and we're involved in it. I think that's a beautiful example. He's also facilitated a group as well. He did interviews for people to work here. He's gone from someone who really didn't have any confidence whatsoever and was really struggling with his mental health and he really stepped up above. He's up there with us."*** *(Hub staff)*

# Implementation

Implementation refers to the extent to which the service was implemented in accordance with the way that it was intended (i.e. fidelity), along with the management and governance of the service. Several aspects of the program's implementation were considered:

- completion status of program objectives and outputs
- level of compliance with data collection requirements
- planned variations to the regional model to meet the local context
- implementation-related enablers, barriers and process learnings
- direct and indirect resources to implement the hub model, including:
    - average cost per episode of care, and per service contact
    - directly funded and in-reaching service provided in each hub
    - in-kind non-service contributed provided by hub providers

## Has the hub model been implemented as intended?

### Identification of planned variations to regional model to meet local context

Brisbane North PHN staff reported that the hub model has stayed true to its design and this has become clearer over the course of implementation. The model was described as becoming 'bigger and bigger' as a result of the partnerships established and the co-location arrangement initiated by the HHS. Documented outputs of the program review and co-design process, as well as documentation developed as part of the PHN's commissioning process, were reported to support PHN program staff in ensuring that what was intended and what is being operationalised are consonant.

> ***"I think just because we had done that review and we had done such a good job of recording what the feedback was from the review and therefore what the outcome [was]. So the invitation to tender, the tender specs for the hubs... I've referred back many times to what we were meant to be doing and to see if we are doing that. That doesn't exist for other programs just because we haven't taken the time to do that review."*** *(Brisbane North PHN staff)*

> ***"It's like a set of principles that we can come back to all the time. Like these are the characteristics of the service that we want."*** *(Brisbane North PHN staff)*

Although core elements of the hub model have remained consistent, variance in how the hub model has been implemented across the three catchments was noted, with each hub provider making the model their own based on their organisational context and needs of the local community.

> ***"So thinking beyond the model as we have alluded to, they have all each taken the model and slightly made it their own. I'm comfortable with that."*** *(Brisbane North PHN staff)*

***"...yes there are definitely preferences on how [hub providers] work and what they do organisationally that has impacted on how the model has been then implemented."*** *(Brisbane North PHN staff)*

## Level of compliance with data collection requirements

As outlined in table 6 below, a review of PMHC-MDS data against contracted indicators demonstrates that compliance for the following data collection requirements have not been met:

- 90% of episodes have a K10+ pre and post score recorded. (33% achievement)
- 90% of episodes have an initial K10+ completed to identify severity of mental illness upon referral. (71% achievement)
- 100% of service contacts have relevant service location recorded. (85% achievement)
- 100% of PMHC MDS service contact information is entered within 10 days of it occurring. (86% achievement)

## Completion status of contracted service outputs

The status of contracted service outputs were assessed by reviewing hub service agreements and aligning the key performance indicators with PMHC-MDS data. This is outlined in Table 8, noting that only quantitative data indicators are included — qualitative reporting in meeting minutes and periodic reporting have not been included for analysis..

***Table 8: Completion status of contracted key performance indicators***

Note: Table legend for status column — = not completed; = partially completed; = completed

| Indicator | Source | Contracted target | Status | Notes on completion status |
|---|---|---|---|---|
| 1. The proportion of episodes where there are pre and post K10+ scores recorded | MDS Quarterly progress report | 90% of episodes have a K10+ pre and post score recorded | | 33% of closed/ceased episodes of service where reason for closure is 'treatment concluded' across all hubs have both a K10+ pre and post score recorded |
| 2. The proportion of episodes where there is a RAS-DS pre and post score recorded | MDS Quarterly progress report | | | |
| The proportion of care coordination episodes where there is an improvement in wellbeing at treatment completion, as measured by the K10+ | MDS Quarterly progress report | Establish a baseline for change in psychological distress as measured by the K10+ for an episode of care | | For the 226 episodes of service with a pre and post K10+ score for comparison, 69% recorded an improvement in wellbeing (indicated by decreased K10 score), 10% recorded no change, and 21% recorded more negative wellbeing (indicated by higher K10 score) |
| The number of referrals accepted where the severity of mental illness is minimal/low, mild, moderate or high/severe as measured by the K10+, or where the data is missing | MDS Quarterly progress report | 90% of episodes have an initial K10+ completed to identify severity of mental illness upon referral | | 71% of commenced episodes across all hubs have a K10+ pre score recorded |
| The average unit cost of service contacts | MDS Quarterly progress report | Establish a baseline for the average unit cost of service contacts | | Primary Mental Health Care services for people with severe mental illness: $350.72 per service contact completed |

| | | | | |
|---|---|---|---|---|
| | | | | Continuity of supports / NPSM: $51.50 per service contact completed<br><br>Psychological therapies provided by mental health professionals for underserviced groups: $85.26 per service contact completed<br><br>*Note: figures based on 2020-21 financial year. Does not include DNAs* |
| The number of service contacts conducted face to face within and external to the hub and spoke(s), via the internet, telephone, vidoe and after hours (outside of 8am and 5pm) for each of the service types | MDS<br>Service documentation (e.g. SLA)<br>Quarterly progress report | 100% of service contacts have relevant service modality, location and time frames recorded. | | 100% of service contacts have modality recorded<br><br>85% of service contacts have venue recorded (15% recorded as 'not stated' or 'other')<br><br>100% of service contacts have duration recorded |
| The inreach services provided to the hub and spokes and established referral pathways | MDS<br>Service documentation (e.g. SLA)<br>Quarterly progress report | Quarterly reporting includes details of in reach services provided during the quarter | | In-reach services are reported quarterly through hub reports. In-reach services as at October 2021 are outlined in Appendix E. |
| The number of participants referred, accepted, closed and currently active. Details of any challenges experiences with increasing or managing these numbers and plans to manage these challenges | MDS<br>Service documentation e.g. business plan | 100% of PMHC MDS service contact information is entered within 10 days of it occurring. | | 86% of service contacts had a 'service contact creation date' that was within 10 days of the date recorded that the service contact was completed |

## What are the barriers and enablers to implementing the hub model?

### Enablers

Hub staff described the hub's physical aspects as enablers to implementation, including:

- inclusive spaces
- connected to transport
- locally based and easy to find

Brisbane North PHN and hub managers reported that working as a 'hub collective' has been an enabler to implementation and supported integration of hub services across the entire Brisbane North region. The benefits of working as a collective included:

- sharing implementation learnings and successes
- collaboratively identifying implementation issues and developing solutions
- sharing training opportunities for hub staff
- co-facilitation of groups
- identifying trends (e.g. more or different presentations)

> ***"When all three hubs identify the same things, we can put things in place to address it. So, for example, the intake was difficult so we each put a little bit of money to adapt our model slightly. We decided to employ a liaison officer to coordinate those referrals which has been really useful for us and has saved a lot of time."*** *(Hub manager)*

Hub managers consistently reported that the hubs have been commissioned in a way that supports collaboration and noted that Brisbane North PHN has facilitated bringing the hubs together through regular meetings (Operational Managers Meeting) and biannual hub development days.

> ***"Here we are in a space where we are not competing so all we can do is collaborate. How wonderful that that is the option we have!"*** *(Hub manager)*
>
> ***"...the services are commissioned in a way that genuinely supports collaboration and we are not working in the same patch trying to do the same thing. We are all doing something different. I think that provides such a ripe landscape to work together. There's nothing getting in the way for us to do that"*** *(Hub manager)*
>
> ***"We are also able to discuss trends like "Are we seeing more and more with these sorts of presentations?" and we can feed that back to the PHN, which in turn, the PHN has staff development days throughout the year. So training is provided to all hub staff in the three hubs where they come together. It's an opportunity for networking but it's also an opportunity for professional development..."****(Hub manager)*

Hub managers consistently reported the ability to have robust and honest conversations with PHN staff and feeling valued and respected as experts in this space. Hub managers reported that Brisbane North PHN were on board with being as flexible as they could be within the (DOH) guidelines, which gave hub providers more freedom and ability to adapt

during the program's initial phase. These sentiments were reflected by Brisbane North PHN staff who highlighted the importance of the PHNs relationship with hub providers, and ensuring that providers feel comfortable in alerting them to the challenges they are facing without repercussions.

> ***"...it's the ability to talk about how to find the solution together and let's make changes if we need to make changes."*** *(Hub manager)*
>
> ***"If there is a decision being made, we are made to understand why and the process that has been done to get to that decision."*** *(Hub manager)*
>
> ***"It's an amazing and challenging role to be the commissioner and to be beside us. It's pretty unique in doing this."*** *(Hub manager)*
>
> ***"This is a big thing we have bitten off together and we are with you."*** *(Brisbane North PHN staff)*

Engagement of providers in the co-design process and bringing them on the journey alongside the PHN was reported as an implementation enabler. Brisbane North PHN staff highlighted that building the service model from the ground up helped to establish provider buy-in and belief in the model. As part of the co-design process, Brisbane North PHN staff reported being flexible in relinquishing control of what emerged from the co-design process, but also being clear and transparent with providers about the parameters in which they must operate.

> ***"You are still working within what you need to work within. But you are pushing the boundaries because it's the right thing to do, there is a good rigorous process. If someone did ask questions, we have good evidence to say "This is why we did it. We asked a bunch of questions and this is what we learned." So we couldn't not do it after working through that process. But that does take a certain culture within an organisation to enable that to happen."*** *(Brisbane North PHN staff)*

Brisbane North PHN staff reported that the providers selected to deliver the hub model were an implementation enabler, due to their experience delivering similar services and existing local footprint. The selection of providers that were accustomed to delivering non-clinical support was purposeful and emerged from the co-design process. Brisbane North PHN reported there was a preference to top up existing non-clinical services with clinical services rather than the other way around, with previous feedback from the sector highlighting that it is easier to train non-clinical staff to operate within a clinical framework.

Hub managers also reported that their organisations existing infrastructure and local presence were enablers for implementation, with particular emphasis on their:

- clinical governance and risk management structures
- existing staff to transition to the hub
- reputation, trust and presence in their local community, and being able to leverage these to develop community partnerships
- established trust with the PHN as providers of other PHN funded services
- existing physical infrastructure (e.g. office and service delivery space)
- existing supports/programs to link clients to

> ***"Our reputation. I think it was the same again for the three hubs. Everyone knows the three providers and our allocated areas we had a presence there for a number of years. So it was really easy to get some of those community partners onboard"*** *(Hub manager)*

> ***"One was having [hub provider] as an already established organisation in the community that had trust in our local community. It was respected and trusted by health professionals and organisations in the communities.*** *(Hub manager)*

Hub managers also reported that their service agreement with the PHN was an implementation enabler as contracted targets support and justify the initiation of external partnerships.

At the service level, hub managers reported that the structure of workforce supports has facilitated integration of clinical and non-clinical staff. Key enablers for workforce integration were identified and include:

- joint team meetings, case management meetings, reflective practice and professional development
- clinical and non-clinical staff sitting in the same area
- recruitment of staff who are committed and passionate about the work the hubs do
- working together towards a shared goal

Brisbane North PHN staff highlighted that clinical and non-clinical hub staff have become more integrated over time, with the hubs attracting people who have embedded the model and believe in it. Focus group findings and results of the hub staff survey consistently acknowledged the hub's organisational culture and management style as enablers. Hub staff reported that positive team cultures were characterised by:

- staff skills highlighted and recognised
- opportunities for personal development
- inclusivity and community focused
- the manager valuing skills and being flexible in the delivery of those skills
- strengths-based
- similar values across the team
- collegiality

> ***"[The manager] understands and she is totally focused on the centre and it being really client-centred and she thinks outside of the box, is very creative and very dedicated."*** *(Hub worker)*

> ***"I am asked to work within my scope of practice and I have excellent support from my manager."*** *(Hub worker)*

Through the survey, hub staff identified ways in which clinical and non-clinical supports could be further integrated:

- improved communication and referral pathways
- providing access to other health professionals including psychiatry and allied health professionals
- nurses and psychosocial workers working better together to develop a shared understanding and for shared care planning

- improved understanding of what others do in the team

  ***Support workers very rarely collaborate with MHN's [mental health nurses].*** *(Hub staff)*

  ***"A better understanding of what others do in the team and a way of getting to know each other better."*** *(Hub staff)*

  ***"Nurses and psychosocial workers working better together - more of a shared understanding, shared care planning."*** *(Hub staff)*

Diversity in the qualifications, skills, experiences and characteristics (i.e. age and gender) of hub staff were identified as enablers and contributors to a positive service user experience.

Hub staff felt that consumer participation was an enabler, with consumers being engaged through various activities to ensure they are happy with the service including:

- consumer representation on provider interview panels for staff recruitment
- designing programs with consumers
- using client feedback to inform program development and adjust practice

  ***"The consumer participation that feeds into that and that's what's important to them. We provide that to consumers and we do ask about feedback about "What's working? What's not working?" and we review regularly"*** *(Hub staff)*

The HHS partnership and co-location of a clinician at each of the hubs was identified as an enabler. This partnership was proposed by the HHS to address the increasing number of people presenting to the emergency department who did not have an acute need and resulted in a brief intervention clinic with a co-located clinician operating out of the hubs on a full time basis.

> ***"I think as well the partnership with the hospital with that brief intervention clinic has really opened up such a shared understanding. Because now we are able to discuss back to that referrer when the referral is coming in and it's opened up a shared understanding of where they are coming from in the clinical setting and the pathway into the community setting and back again. So it's opened up so much more understanding and discussions with the Acute Care Team."*** *(Hub manager)*

## Barriers

Accurately capturing and reporting on service delivery was raised as a challenge by hub staff and Brisbane North PHN staff. At the PHN level, it was noted that the breakdown of funding was difficult to report against and, in the first two years of implementation, there hadn't been clarity on how to monitor how different funding pools were playing out in practice.

The National PMHC-MDS was reported as difficult to report against in an integrated model due to:

- not being reflective of how hub services are delivered, or the multitude of services needed to support people with severe and complex mental illness

- not demonstrating the work that occurs between referral, intake and assessment, and the time taken to do this.

This aligned with findings of the desktop review which revealed that PHN key performance indicators (KPIs) to the Department of Health (DoH) are primarily based on counting rules for episode types. The PMHC-MDS only allows one episode of care to be open for a person at one organisation, at any given time. Within a person's episode of care the "principal focus of treatment" selected by the provider broadly aligns with a PHN funding source. However, a service user may receive multiple services within their episode of care delivered by the hub, with each having a different focus of treatment (e.g. structured psychological therapy, clinical care coordination, or psychosocial support). In addressing this barrier, Brisbane North PHN proposed to DOH that one episode of care consist of multiple service types.

Other solutions put in place to improve data reporting included:

- developing new reporting templates (quarterly reporting) to monitor 'actual activity' and oversight of model implementation.
- documenting activity associated with the 'Concierge' role to address the lack of data capture related to service user engagement in the lead up to intake and assessment.

For the hubs, reporting challenges related to using two different systems for record keeping - Brisbane North PHN's Redicase system and the provider's client management system. Redicase was described by hub managers as a source of frustration, with challenges including:

- administrative burden and double handling to provide effective service delivery
- missed opportunities to gather other data insights such as 'referrals out'
- the clinical nature and rigidity of the system, and appropriateness in a multidisciplinary setting
- information sharing in a hub and spoke model
- referrals received via Redicase lacking information
- duplicative entries for group work. For example, a group facilitated by three hub staff facilitators results in three entries for each client attended
- user friendliness and inability to pull reports

Collaboration between the hubs has supported hub managers to troubleshoot Redicase issues together.

Hub managers reported that the hub's eligibility criteria was difficult for stakeholders to navigate, resulting in the need to educate (and re-educate) referrers. Across all hubs, sources of ineligible referrals most frequently reported included:

- HHS services
- general practice
- psychologists
- self-referrals

Reasons for inappropriate referral were reported and included:

- a lack of other available service options
- subjectivity of severe and complex mental health

- client does not meet the eligibility criteria (i.e. lower intensity referrals and referrals for people in crisis)
- self-referral for the NDIS

Hub staff reported that there is a lot of misinformation about the NDIS circulating in the community. This is a factor contributing to inappropriate referrals for NDIS support. The role of the Pathways Facilitator in filtering down the referrals was acknowledged as something that is working well.

Hub managers reported that it takes time (sometimes weeks) to manage inappropriate referrals, which can create a point of congestion. However, the hubs 'no wrong door' approach and working with (ineligible) people to make sure they are linked with the right services was emphasised by hub staff as a point of difference.

> ***"[I] can walk away knowing I did the best that I could."*** *(Hub worker)*
>
> ***"There's no wrong door here so if someone wants help we will help them find it."*** *(Hub staff)*
>
> ***"So if someone makes a referral, we can be like, "actually we are not the right service, but let me work with you and educate you around other potential options for you." It's a lot of work."*** *(Hub manager)*

Engagement with general practice and HHS were suggested by hub staff as avenues for providing education about the hubs, including what they do and eligibility criteria. Advertising direct to consumers was also suggested to increase visibility of the hubs, however meeting subsequent demand was raised as a concern.

> ***"I wish I had known about the Hub sooner after discharge from [an] acute episode."*** *(Service user)*
>
> ***"Maybe let Drs and in patients know more about your service so that people can access it sooner after discharge."*** *(Service user)*
>
> ***"So sometimes I feel like we are just meeting the needs of those who are known and we also know that there is so much in this community and all communities of mental health that is unseen, that is unrecognised and is unknown. I just know that there is sea of real people who are not getting the support who can benefit from the support that we offer, but for whatever reason are just not able to access it. It's not that kind of thing that we have to advertise either and sometimes I think we need to be really purposeful in not doing it because we just do not have the capacity to respond to people that could come through. So that could be a challenge sometimes in putting ourselves out there as a service."*** *(Hub manager)*
>
> ***"So that could be a challenge sometimes in putting ourselves out there as a service. We want to make sure we can provide a quality and timely response to everyone, but we know if we pop this pocket over there that really needs the service, there's not enough resources out there to support it."*** *(Hub manager)*

Demand management was reported to be a challenge by hub managers and hub staff, with varying and fluctuating wait times of up to 12 weeks for psychosocial support and 30

weeks for DBT (noting that DBT runs for a 30 week period in one of the hubs). Hub resources were reported as a *"huge barrier,"* particularly in being able to promptly respond to someone who makes the decision to work on their mental health. Survey data supported these findings, with service users identifying that more DBT (or similar skills based therapy) and one-on-one support would support them further. All hubs reported implementing a triage process and offering background support to clients on the waitlist through regular check-in calls, group work and/or brief interventions.

> ***"The demand is outstripping the supply of what we can offer. Even though we are doing our best. But we do have that 'no wrong door' policy." (Hub staff)***

High worker caseloads were identified as an implication of high demand for services, and was reported through focus groups and the hub staff survey. Increasing the workforce through additional funding or having more hubs (i.e. sister hubs) were offered as potential solutions.

> ***"Once again the need is so great in the community, you can't help but feel you are just meeting the minimal amount of people."*** *(Hub worker)*

> ***"Yeah, my caseload is huge. So I will prioritise who would need the attention. But you could be missing somebody. That means the organisation is carrying that risk. And still I can't say no."*** *(Hub staff)*

Additional funding for brokerage to actively look after the client was also proposed by several hub staff. This was supported by survey feedback, which noted that flexible funding to better support consumers would better support hub staff to undertake their role and improve service provision. For example, emergency funding with well defined guidelines.

Broader systemic challenges were identified by hub managers, hub staff and BNPHN staff, and related to:

- systems not being set up to support people with mental illness
- services not following up with clients
- availability of bulk billing services, particularly GP's, psychologists and psychiatrists.
- lack of structure and integration of the mental health system (from early intervention through to severe and complex)
- lack of exit pathways to step clients out to

> ***"My greatest frustration and what I'm finding is watching the systems letting you down. We do so much for people to try and pull that together."*** *(Hub staff)*

> ***"And you can't even get in. If you need a psychologist, you could be waiting for six months before you get one."*** *(Hub staff)*

> ***"Some of the barriers about that is what's physically out there. Bulk-billing GPs, psychology. There's not enough psychologists out there."*** *(Hub staff)*

The step down into community was discussed as being a step too big for many hub service users, presenting a challenge to opening up support for more people. A middle ground between exiting service users from the hub and moving into community supports

was reportedly needed. Stride Hub Caboolture discussed trying to increase capacity by providing training and experience in facilitating groups so that people can take peer support out into the community.

> ***"We can go about and be the most skillful and have the most amazing process in-house. But at the end of the day we are battling systematic and structural issues. So it's about, "how do we keep the hub doing what it does best?" That's beyond processes."*** *(Hub worker)*

Hub managers reported that the hubs started on 1 July 2019 and several other programs (Partners in Recovery (PIR), Personal Helpers and Mentors Service (PHaMs), and Day to Day Living (D2DL) Program) were discontinued on 30 June 2019. Programs that were being discontinued stopped taking referrals three months prior to ending, meaning that clients had to wait for the hubs to open for their referral to be actioned. This resulted in high demand for services in the establishment phase, with hubs operationalising a new service whilst also trying to meet the needs of people who had been waiting three months to receive a formal service. The need for change management with the transition of funding was highlighted, particularly for hubs operating within a 'hub and spoke' model where subcontracted providers (spokes) had previously been engaged in historic programs and therefore were transitioning to integrate their service with a new model of care.

Challenges in delivering a hub and spoke model were discussed by hub staff in focus group sessions and noted in survey responses. Challenges included:

- at times, being source of confusion for the client
- although being clear on their role, external partners may not know the hub model as well
- different organisational procedures and perspectives on how things should be approached
- confusion around who is allocated to referrals
- difficulty knowing who has made contact with clients
- not knowing people outside of their direct team

Hub staff suggested that mental health nursing staff could be directly employed by the hub provider

## Workforce

Given the identified importance of workforce to the successful implementation of the model it was considered separately as an implementation factor. Survey findings demonstrated that hub staff agreed that the way the hub model was implemented had positive outcomes in relation to their workload, responsibilities, structure, role and teamwork, which can be seen in Figure 27 below.

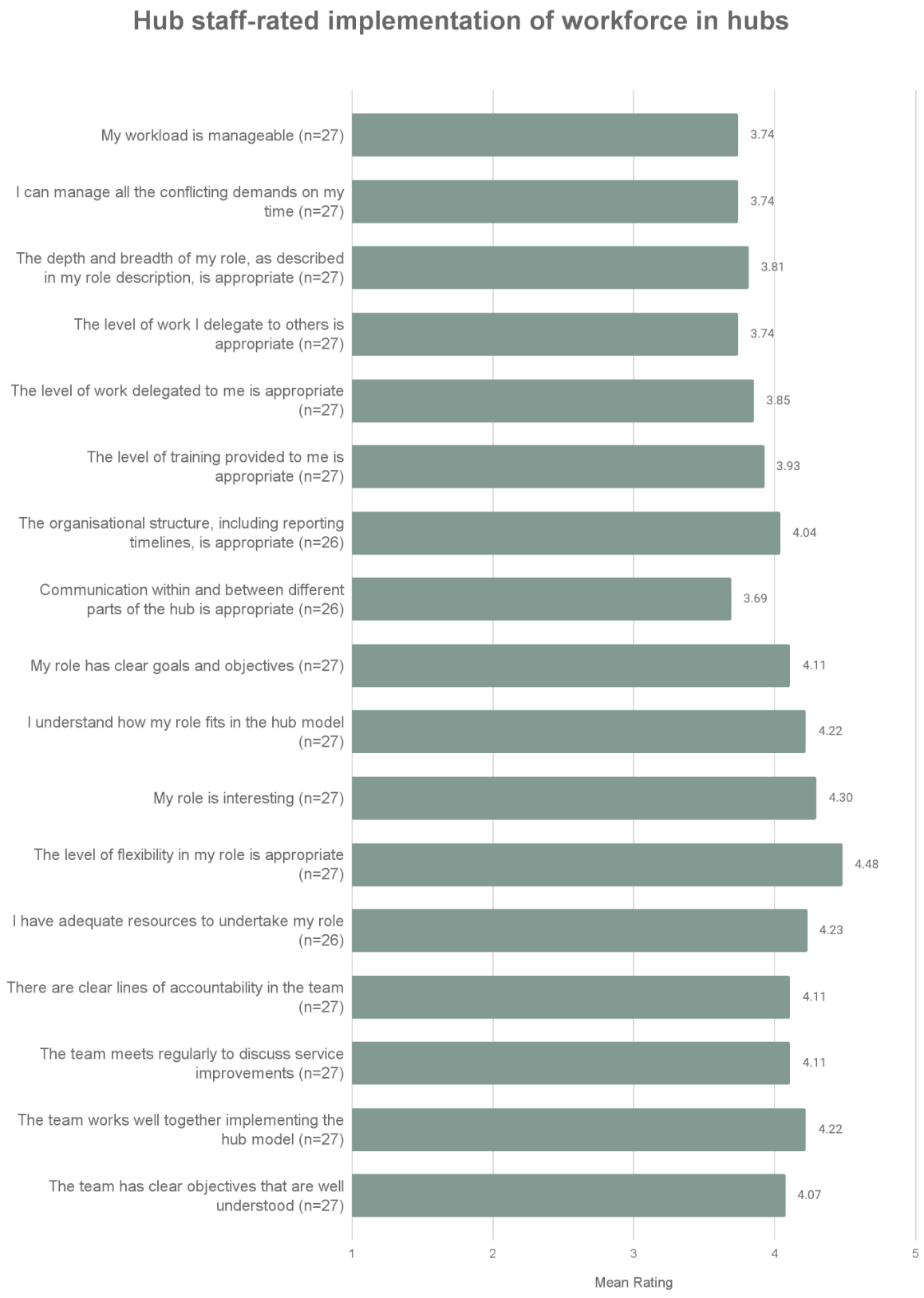


***Figure 27: Hub staff perceptions of workforce implementation in hubs***

Hub staff reported a positive rating in relation to:

- the level of flexibility in their role (mean=4.48)
- how interesting their role is (mean=4.30)
- having adequate resources to undertake their role (mean=4.23)
- their understanding of their role in the hub model (mean=4.22)
- their role having clear goals and objectives (mean=4.11).

Teamwork was also highlighted by hub staff as another positive aspect of the hub model, with hub staff reporting positively regarding:

- their team working well together in implementing the hub model ( mean=4.23)
- regular team meetings to discuss service improvements (mean=4.11)
- clear lines of accountability in the team (mean=4.11)
- clear understanding of team objectives (mean=4.07)

Responsibility of hub staff was rated as neutral to positive, with staff reporting that:

- the work they delegated to others was appropriate (mean=3.74)
- the work they were delegated by someone else was appropriate (mean=3.85)
- the depth and breadth of their role based on their role description was appropriate (mean=3.81).

The structure of the hub model was rated by hub stuff as neutral to positive. Organisational structure and reporting timelines (mean=4.04) were considered appropropriate, however training (mean=3.93) and communication within and between different parts of the hub (mean=3.69) were not viewed as positively.

Hub staff and managers noted that integrating clinical and non-clinical services within the hub model has brought challenges. Qualitative findings aligned with this survey finding, particularly with regard to defining the role of mental health nurses. It was noted that clinical and psychosocial supports come from different models which can be an adjustment for people with a clinical background.

> ***"Yeah because they [mental health nurses] are working from a different framework and different paradigm where the risk really does sit with them. And in the sector, what we deem as risk as shared responsibility. So it's just coming from a different angle in that you really need to support people who haven't worked in the community before, as a clinician."*** *(Hub manager)*

> ***"For the nurses, sometimes their role can come a bit blurry because of the demand on the other [psychosocial] side. So it's like, "Is this task they are doing with consumers clinical or psychosocial?" That is one of the things that have come up a fair bit. And defining the role of the nurses has been a bit challenging and that's been the same because of the slightly different models with the same hubs, different organisations etc. It has been a little bit difficult to define what is clinical and what is psychosocial. There is a bit of crossover."*** *(Hub manager)*

Attracting nursing staff has also presented challenges due to the hubs competing with higher remuneration rates in the sector, as well as limitations on their scope of practice in the clinical care coordination space. To maintain consistency of staff, an improvement in

remuneration was advocated for. Emphasis was also given to recruiting staff that are values driven and the 'right fit.'

> ***"For some individual practitioners this has been a challenge… [it] isn't an easy fit to have very clinical staff working in a very flexible and non-clinical environment with alternatives such as psychosocial alternatives care and an alternative view of holistic healing…. Fortunately we've got 1.5-2 years of success to show it works and the feedback form peers and participants is very positive. It's a bit easier now, because we can say this works to be in the community setting and to be clinical as well."*** *(Hub manager)*

Table 9 below highlights the different demographic characteristics of respondents from the hub staff survey.

***Table 9: Hub staff survey respondents demographic characteristics***

| Indicator | | Total (all hubs) |
|---|---|---|
| Gender (%) | Female | 66% |
| | Male | 30% |
| | Declined to answer | 4% |
| | Transgender | 0% |
| | Gender diverse | 0% |
| | Unsure / undecided | 0% |
| Sexuality (%) | Heterosexual | 56% |
| | Homosexual | 4% |
| | Bisexual | 0% |
| | Something else | 12% |
| | Declined to answer | 28% |
| | Don't know | 0% |
| Language (%) | English | 86% |
| | Other | 14% |
| Indigenous status (%) | No | 96% |
| | Yes - Aboriginal | 4% |
| | Yes - Torres Strait Islander | 0% |
| | Yes - both Aboriginal and Torres Strait Islander | 0% |
| Tenure (%) | Under 6 months | 19% |
| | 6 to 12 months | 15% |

| | | |
|---|---|---|
| | 12 to 18 months | 46% |
| | 18 to 24 months | 12% |
| | More than 2 years | 8% |
| Role (%) | Mental health nurse | 27% |
| | Support worker | 19% |
| | Administrative support | 11% |
| | Allied health worker | 8% |
| | Peer / lived experience worker | 8% |
| | Manager | 4% |
| | Other | 23% |

## What are the direct and indirect resources required to implement the hub model?

### Number and volume of directly funded and in-reaching services provided in each hub, by type of service and funding source

Hub managers provided an overview of in-reaching services as at October 2021 (refer to Appendix E), including:

- organisation delivering the service
- description of the service
- frequency of service delivery
- type of arrangement (e.g. collaboration, co-location, partnership)
- status of the arrangement (formal or informal)

The information provided demonstrates development of formal and informal partnerships with local service providers to deliver a wide range of service types.

Hub managers also provided an overview of the programs and services available at each of the hubs as at October 2021 (refer to Appendix F). This information demonstrates the availability of services aligned with requirements set out in DOH guidance..

### Type and volume of in-kind non-service contributions provided by hub providers

Through qualitative data collection, in-kind resources provided by the hubs were explored and included:

- Contribution to hub infrastructure
- Pre-contract functions to support 'opening the doors' including completing warm handovers with clients transitioning out of PHN funded services that were ending

- marketing and engagement activities e.g. development of generic hub resources, promotion of the service, attendance at discharge planning meetings with HHS services, and attendance at local community events.
- Internal functions and staff who support components of the hub e.g. senior leadership and administrative staff.

***"So while we were able to 'around the edges' do a bit of things that were called capital development such as purchase of equipment, maintenance and those types of things, that limited what the agencies were able to do with the facilities that the organisations either already had or newly leased. So ideally, we would've had a larger and more explicit capital funds budget to allow them to really fit out the centres in a way that would make sense to them."*** *(Brisbane North PHN staff)*

***"Also the pre-day one thing. So you are notified of the success and there is a whole lot of work that needs to happen to open the doors of service delivery on day one, which is the point when you technically get funded from. So it's all those functions behind the scenes that are done prior to the service commencing. So you aren't receiving any funding at that stage. All the manager's time and time at the head office to set things up to be ready to go."*** *(Hub manager)*

# Sustainability

Sustainability refers to the extent to which program outcomes and learnings can be continued beyond the life of the program. The viability of maintaining the current service offering as well as the potential for expansion and/or replication were considered in evaluating the sustainability of the service model. Three aspects of sustainability were considered:

- service alignment to identified needs and priorities
- comparison to similar commissioning approaches regarding:
    - program design
    - implementation
    - outcomes
- program's contribution to the evidence base to inform future service planning

## Does the hub model contribute to building the evidence base for effective commissioning approaches for severe and complex mental illness?

### Alignment of services against identified needs and priorities

Qualitative data indicated that the hub model aligns with Department of Health (DoH) guidance for primary mental health funding streams, which sets out service delivery parameters for Primary Health Networks. Brisbane North PHN staff reported following DOH guidance in the model development phase whilst trying to create a service that responded to the needs of consumers. Findings of the desktop review supported qualitative data findings, with documented service offerings (refer to appendix E) aligning with DOH guidance for the relevant funding streams.

> ***"So we have tried to stretch the guidelines as much as possible to enable that integrated service delivery to be provided, whilst still meeting the Department of Health's needs."*** *(Brisbane North PHN staff)*

Brisbane North PHN staff noted that the pooled funding approach did not align with DOH guidance, which notes that various funding streams should be separately funded, but closely linked.

> ***"So I guess we tried to follow the rules as much as possible in terms of guidance from the Commonwealth with the exception of then pooling together and trying to create something that then meets the needs of the service user."*** *(Brisbane North PHN staff)*

> ***"I guess the bit that jars is around the pooling of funds [which] means that the services that we deliver will look different when you look at them from a data level."*** *(Brisbane North PHN staff)*

In relation to Commonwealth Government's 'stepped care framework,' Brisbane North PHN staff reported that the hub model allows service users to step down (the level of

care) far more seamlessly and access different types of care simultaneously or one after the other.

> ***"We have just found a different way of enhancing the likelihood that people are going to receive the level of care that they need at the time that they need it, without falling through the cracks."*** *(BNPHN staff member)*

Brisbane North PHN staff reported that the hub model meets local needs identified in their regional Health Needs Assessment (HNA). Specifically, the location of the three hubs was informed by:

- demographic need
- lower socioeconomic status
- lower access to services.

Redcliffe was identified by Brisbane North PHN staff as being an area that continues to have unmet needs. This was also reported by staff of Stride Hub Caboolture, who reported that transport between Caboolture and Redcliffe is an issue.

## Comparison of program design, implementation and outcomes against similar commissioning approaches

Qualitative data from a sample (n=5) of other PHNs across Australia revealed that there is variance in the way PHNs commission services for people with severe and complex mental illness. Approaches include:

1. funding streams are siloed and commissioned separately. For example, clients are directed to one service or another depending on whether their needs are clinical or non-clinical (psychosocial); or
2. an integrated approach, with providers being funded to deliver a mix of clinical and non-clinical services.

### Design

Several PHNs reported that their commissioning approach was 'under review' and discussed their intent to integrate commissioned services at a program level and/or service delivery level.

> ***"It's still evolving and what we have been looking at is how we can have an approach that recognises the need for psychosocial support, clinical care coordination and the interface with psychiatry and general practice within a more structured model."*** *(peer PHN)*

Peer PHNs reported commissioning a range of different service delivery models for people with severe and complex mental illness including:

- A hub model underpinned by a consortium approach, with commissioned providers directly employing staff
- a hub and spoke model, whereby a lead commissioned provider sub-contracts other providers to deliver services across a dedicated region. The lead provider is the central point of contact and reports back to the PHN
- contracting individual providers
- contracting a lead organisation

Interviewed PHN's reported on differences and similarities between their commissioning approach and Brisbane North PHN's hub model. Key differences included:

- the provision of services specifically for priority populations. For example, Aboriginal and Torres Strait Islander people, culturally and linguistically diverse (CALD) populations and LGBTIQ+.
- a regional central intake/referral line to link clients to services aligned with their needs. This was in addition to the option for providers to refer (or clients to self-refer) to commissioned services directly.

Similarities included:

- contracting commissioned providers to service a specific sub-region within the PHN's catchment. This approach was consistent for NPS services across all PHN's and was mixed for clinical services.
- aligning PHN sub-regional service delivery catchments with hospital catchments
- outreach as a service model component.

Key factors informing the design of commissioned services for people with severe and complex mental illness were identified and included:

- line of sight regarding continuation of existing funding streams and how these will be structured. It was noted that the availability of future funding schedules impacts the ability of PHN's to forward plan how services will be structured (or restructured).
- external drivers, including the NDIS roll out and COVID-19
- historical funding and programs. Commissioning decisions were informed by what has or has not worked well in the past and the presence (or absence) of certain programs and services. Some PHNs reported having previously commissioned a large number of providers and subsequently transitioning to a smaller number of providers that directly employ staff
- the local context including the PHNs geographic spread, workforce availability and provider market
- outputs of previous co-design and/or consultation processes.

***"There's something about requiring a model that is so adaptive at the moment and not too fixed. Because we have different consumers even before COVID and it will be different after COVID."*** *(peer PHN)*

***"Love the idea of this kind of hub model. But when you think about how it could be applied here, it just wouldn't work."*** *(peer PHN)*

***"The major programs are doing well, so why change that? Maybe we provide improvements to the back end or the front end or improve the client experience instead of a major tendering option."*** *(peer PHN)*

***"But I don't have the funding schedules yet. So we can't commit to something. We are running out of time and time is wasting. To do a major restructure of our services is now off the cards because you need time."*** *(peer PHN)*

## Implementation

Interviewed PHNs reported on implementation learnings for effectively commissioning services for people with severe and complex mental illness. Implementation learnings included:

- importance of the consumer experience.
- developing contracted targets for sub-regional reach to support alignment between service delivery and what is expected for that region based on population size and burden of disease
- the importance of engaging with hospital services to support integration and reduce duplication.
- the importance of working with key stakeholders that refer into PHN commissioned services to facilitate partnerships and integrated care pathways. Relationships with GPs as a major referral pathway into services was consistently reported
- sharing the cost of service delivery through collaboration and co-location
- matching services with consumer needs can be restricted by having a 'one stop shop'
- overtime providers feel more confident, know more about the cohort they are servicing and their reach. Providers are well placed to identify service gaps and opportunities, and provide feedback to the PHN
- meeting the client where they are at is important. Methods to support this include outreach services into the community, co-locating services and utilising telehealth.
- in-kind services provided by commissioned providers is an enabler for connecting people to other services and supports a systems oriented approach
- there is a need for better monitoring and reporting mechanisms to meet both local and DOH reporting requirements.

  ***"The feedback that we have consistently is that participants want to be supported where they are at. They want integration. We are still seeing a lot of things for provider convenience."*** *(peer PHN)*

  ***"In changing from one model to another, we've gone from clinical led care to consumer led care."*** *(peer PHN)*

  ***"Reflecting the importance of and value that state funded services can drive by working in this type of integrated approach."*** *(peer PHN)*

  ***"In talking about the pendulum, when you get to a one stop shop, you also have a collection of all eggs in one basket. If you have 140 providers, you have a lot of providers to choose from, but if you have 3 providers you have to get creative really quickly." (peer PHN)***

Through the desktop review, similarities between Brisbane North PHN's hub model and the HeadtoHelp model were identified. HeadtoHelp is a statewide service in Victoria which was funded by the Commonwealth Government in 2020 as part of the mental health package to support Victorians during the COVID-19 pandemic. The service model for HeadtoHelp includes a state-wide phone intake that uses the Initial Assessment and

Referral (IAR) tool to determine the most appropriate support or service for a person. People identified as needing moderate to high-intensity support may be directed to a hub, with hub services being delivered by a multidisciplinary team. A key focus of HeadtoHelp is integration of clinical and non-clinical services, as well as integration with existing local services.

# Discussion

## Implications

### People with severe and complex mental illness accessing the hubs report positive experience and improved recovery outcomes when they remain engaged

Over 1,500 individuals accessed support through the hubs over the approximately 2.5 year period since their establishment in July 2019, with over 38,000 service contacts completed at a rate of 1,485 service contacts per month. Service users tended to be aged 25 to 54 years old, female and born in Australia. Around 1 in 10 people accessing support through the hubs was Aboriginal and/or Torres Strait Islander person, around 7% of service users identified as LGBTI, and 13% of people were experiencing or at risk of homelessness.

Baseline data showing the severity of mental health symptoms of service users prior to commencing an episode of service found most service users reported high or very high levels of psychological distress, which indicates that the hubs are reaching the intended target population. While baseline recovery scores captured through RAS-DS were relatively high, there was a lower level of recovery reported around the clinical domain at baseline.

Data presented in the evaluation demonstrated that the integration of clinical and non-clinical support provided through the hub model generally leads to positive experiences of service and improved outcomes for service users.

This was highlighted in predominantly positive ratings of service measured through the standardised YES survey administered to clients, although the survey response rate of around 6% of all service users commencing an episode of service is low. Service users reported positive perceptions of the services they had received, the staff who had provided support, and the value and impact of the hubs in meeting their needs. This data from service users was corroborated through the positive perceptions and experiences shared from the perspective of hub staff and managers in the ability of the program's model to meet the needs of the target audience. Common factors contributing to a positive service experience were identified as:

- safe and inclusive service environment, including the physical hub itself
- person-centred approach
- integrated clinical and non-clinical services matched with individual need
- coordination of supports through a single care plan and intake process
- capable and multidisciplinary workforce operating as a team
- group and individual activities
- timely access and connection to supports
- involvement of peer workers with lived experience.

While sector stakeholders' experiences were more neutral than positive, there was considerable support provided to the appropriateness and effectiveness of the hubs in responding to the needs of people with severe mental illness across Brisbane North.

Measurement of client outcomes using the K10+ tool at timepoints throughout an episode of service demonstrated group-level improvements in mental health outcomes as a result of engagement in the service. There was an almost 30% decrease in the proportion of people reporting very high K10 scores corresponding with a likely severe mental disorder at episode end compared to episode start. Upon analysis of individual-level change in psychological distress for those clients who had a pre and post score recorded, about 7 in 10 people who complete an episode of service experience a positive change to some extent, with another 1 in 10 reporting stable outcomes.

Change in recovery outcomes as measured by the RAS-DS also showed a positive change across timepoints, however limited availability of paired scores for individuals limits the ability to generalise these positive outcomes across the full cohort of service users.

The findings showed the ability of the hub to identify and then meet the psychosocial needs of service users. Evaluation participants consistently responded that the hub model's psychosocial support component facilitates integrated care and is highly valued by service users, with expressed need exceeding that for clinical support. These findings align with the broader evidence base which demonstrate that people with severe mental illness have a significant need for psychosocial support services.

Several examples demonstrating a change in recovery outcomes for people with a severe mental illness were highlighted through qualitative insights shared by hub staff, which focused on achieving a person's self-identified goals, meeting psychosocial needs (e.g. housing, financial, health services), improving skills and increasing social and community participation.

***Recommendation 1:*** *Brisbane North PHN to communicate the positive outcomes achieved through the establishment and implementation of the hubs through targeted reporting products to build continued confidence in the model and contribute to the evidence base.*

While these outcomes demonstrate the effectiveness of the hub model to positively impact the mental health recovery of those service users who were able to access and remain connected with support over a suitable duration, this does not reflect the ability of the hub model to improve outcomes for those who did not initially engage with support or who had an unplanned exit from the service.

Inward referral data shows that almost 17% of referrals were declined on intake, of which 1 in 3 did not have a reason recorded. In addition to these referrals that were declined upon intake, more than 500 additional referrals (47% of closed/ceased treatment episodes) were due to reasons other than a planned completion of treatment.

Recognising that there are many instances of non-engagement or disengagement from service that are beyond the control of the provider, this does represent a relatively high proportion of people being connected to the hubs who aren't completing.

Firstly, there appears a need to better understand the characteristics and/or circumstances of service users who do not engage or who disengage from services to ensure the hub model can meet diverse consumer needs. Given the evidence that positive outcomes are being achieved when service users successfully complete an episode of service, there is a need to focus more strongly on proactive strategies that secure the engagement of an individual upon intake then proactively prevent disengagement from the service over time. This includes making genuine attempts to re-engage service users who have, or are at risk of, disengaging from support.

Drivers of non-engagement or disengagement are likely to be varied and could include inappropriate referrals, requirements for service users to demonstrate a diagnosed mental illness and/or an individual experiencing real or perceived barriers to accessibility or acceptability of the service. Each of these drivers would be addressed through a different approach, so a better understanding of the drivers of non-engagement is needed.

In the short term, this should consider direct consultation with key referring partners and consumer/carer representatives to identify and overcome barriers to accessibility and acceptability in the service. These insights should be used to inform a re-design of the service user journey that understands the key 'moments' that influence engagement at various points (e.g. referral, initial connection, assessment, first month of support etc.). Strategies should be documented as part of guidelines for hub staff, with performance targets established for each hub provider.

Longer term, the continued implementation of the Initial Assessment and Referral for Mental Healthcare (IAR)[12] by Brisbane North PHN and the Hubs, as prescribed by the Department of Health, should guide how inward referrals to the Hubs are managed in the context of recording and managing service non-engagement and disengagement. This includes the need to improve the quality of insights around referral and engagement trends through consistent data capture mechanisms across both referrers and hubs.

***Recommendation 2:*** *Hubs to directly engage with key stakeholders such as referring partners and consumer/carer representatives using a consumer journey mapping approach to (re)design the journey of someone accessing support through the hubs at key touchpoints to proactively address factors driving the relatively high rate of non-engagement and disengagement from the service.*

***Recommendation 3:*** *Brisbane North PHN to develop data collection protocols to strengthen the capture of data insights around service non-engagement or disengagement as part of the broader implementation of the Initial Assessment and Referral (IAR) mechanism. .*

[12] Department of Health. National PHN Guidance: Initial assessment and referral for mental healthcare. Australian Government: 2020.

## While the pooling of resources enables integration of clinical and non-clinical supports in one place, the hubs are not fully integrated as part of the local service system

Over the last 2.5 years, each of the hubs has successfully established and delivered an integrated model of mental health support for people with severe mental illness, as demonstrated through the accessibility of a mix of clinical care coordination, psychosocial support and structured psychological therapy components within each service. When compared with traditional commissioning approaches, this approach was identified by service users, hub staff and sector stakeholders as contributing to more coordination across services, reduced burden on service users to re-tell their story and less duplication of services.

Half of all service contacts completed across the hubs were for psychosocial supports, with most of the remaining comprising clinical care coordination and psychological therapies. This can be seen as an indicator of expressed need (i.e. what support people needed), acknowledging that there were some reports that some components were not able to meet demand (e.g. provision of DBT therapy).

However, these positive outcomes relate more to conceptualising 'integration' within the hubs. Applying a broader definition of integration considers integration both within and outside the hubs themselves as part of the wider service system. There is evidence within this evaluation that considering integration of the hubs through this lens raises opportunities to strengthen these levels of integration. As an example, hub staff referred to their hubs working in streams. Amongst many instances cited of working collaboratively across these streams, there were some instances identified where clinical staff were not working closely with non-clinical staff once an individual was referred to a particular stream. A continuing priority for the PHN and hub providers is to ensure the traditional silos between organisations that an integrated model aims to address are not re-created between streams within the hub providers.

When breaking down the findings of the experience and outcome surveys administered to service users, hub staff and stakeholders, the items that relate to aspects of integration rated more negatively than other aspects. For example:

- About 1 in 5 sector stakeholders disagreed (i.e. negative response) with statements around feeling confident in referring to the hubs, having a strong relationship with hub staff, and collaborating with the hubs to integrate services.
- Between 15-20% of hub staff disagreed with statements around communication within and between the hubs, meeting regularly as a team to collaborate, and having good communication with other organisations providing care to people using the hub
- Between 12-14% of service users report being confused as a result of conflicting advice from different providers, and reporting having to take action *always* or *a lot* because providers didn't share information between them.

Referral trends also indicate some level of non-integration between the hubs and external services. The high proportion of referrals cited above that are declined upon intake (17%) without receiving any support suggests a need to strengthen inward referral

pathways. Despite the hubs applying a 'no wrong door' approach and being committed to supporting individuals to navigate the system and link with other more appropriate supports, this experience is less ideal than ensuring effective referrals the first time.

Sector stakeholders identified a need for better communication and engagement by the hubs with external providers. In particular, this relates to understanding the hub's eligibility/suitability criteria. Several sector stakeholders noted concerns with referrals not being accepted by the hub, often due to being 'too complex', and/or limited communication and follow up with the referring organisation on the outcome of a referral and progress of a shared client.

The broader neutral sentiment of sector stakeholders of the hubs reported through survey findings not just related to referrals may potentially be influenced by a lack of awareness, understanding and confidence in the impact that the hubs are having.

With local variations in how each hub has been operationalised to meet the needs of their community, including the services and supports they provide within their model, each hub should be expected to develop a more formalised engagement strategy with current and prospective referrers. This should include developing documented service-level expectations for referrers covering response times, regular updates and protocols for sharing of information to enable integration.

***Recommendation 4:*** *Hubs to engage with referring organisations to better understand their information needs and develop a targeted communications plan to increase sector awareness of the hubs.*

***Recommendation 5:*** *Brisbane North PHN and hubs to collaboratively develop service-level expectations for referring organisations covering response times and communication.*

A considerable number of referrals were received from Metro North HHS hospitals and mental health services, despite there being an existing State-funded individual recovery support program offering psychosocial support within the region. Self-referrals were the second highest source of referrals, which may indicate people having to navigate the mental health system and locate support themselves, presumably after having received a mental health diagnosis. Self-referrals were also a primary source of inappropriate referrals, with many reportedly seeking assistance to apply for and navigate the NDIS.

Despite the source of the funding coming from the Commonwealth Government and the role of the PHN, the proportion of referrals that were generated from primary health care, particularly general practice, was considerably low — less than 1 in 10 referrals and a declining trend over time. Given this is where a person's initial mental health needs and/or diagnosis is likely to be assessed and identified, this indicates a potential need to integrate more closely with the local primary care system. Feedback from service users strongly indicated a desire to be identified and connected to the hubs for support sooner in their 'journey', rather than following discharge from acute inpatient treatment.

***Recommendation 6:*** *Hubs to increase inward referrals to the hubs from the primary care setting through targeted engagement with GPs, particularly focusing on identifying and connecting people who are experiencing severe mental illness earlier.*

While hub staff and managers reflected positively on the nature of the co-located partnership with HHS service teams, there were opportunities identified for a deeper level of integration and collaboration. This was particularly focused on the ability of the hubs to 'step up' an individual with more acute needs or who was experiencing a mental health crisis. However, current operational constraints meant referring to HHS teams was not possible within the model. Collaboratively redesigning the scope of services and pathways between HHS teams, the Queensland Health-funded Individual Recovery Support Program and the hubs is needed to formalise this understanding as a regional approach and with executive-level support. As part of this, the PHN should aim to prioritise its investment in supporting the management of people with severe mental illness within the primary care setting, which would be reflected in the primary source of referrals being general practice or other primary care providers over time. This is consistent with the insights shared by other peer PHNs who emphasised the importance of facilitating partnerships and integrated care pathways with referrers, particularly GPs.

***Recommendation 7:*** *Brisbane North PHN to lead engagement with relevant Metro North HHS representatives to explore a more integrated approach to the provision of services for people with severe mental illness across the region, inclusive of HHS Acute Care and Continuing Care teams, Individual Recovery Support program and PHN-funded hubs.*

Finally, the evaluation highlighted a lack of onward connection or exit pathways for service users. The role of the hubs was characterised by some hub staff as identifying needs, finding services and making referrals for individuals. However, there was very positive feedback and experiences provided where relevant services and supports were made available within the hub environment itself, which included group sessions, social activities and therapeutic programs. A number of co-located and in-reaching services and activities were identified by each of the hubs, with new activities continuing to emerge based on the needs of clients. However, areas identified where in-reaching, co-located access would benefit service users included NDIS navigation/application assistance, medical services (e.g. visiting GP), community legal support and financial assistance (e.g. emergency relief).

Regarding limited exit pathways, this was potentially observed in the long duration of many episodes of service and reports of challenges with the intended time-limited nature of support through the hubs, with challenges in connecting service users with something else to meet their needs at that point in time. This is particularly important for effective demand management and ensuring service users can be appropriately stepped down to other supports at the end of their episode, allowing the hub to respond to waitlists and prioritise support to those who need it most.

Respondents noted that services to 'step down' to may not exist or may not have additional capacity, so this is likely not as simple as exiting more clients earlier. A broader body of work may be required to map existing services, make information on known services readily available to hub staff, and explore opportunities to fill service gaps where

needed — either within the hub's resourcing or by coordinating resourcing from other programs or service systems.

> ***Recommendation 8:*** *Brisbane North PHN and hubs to continue to explore opportunities to increase the support available to service users during an episode of service through a comprehensive suite of in-reaching, co-located services, and in considering what 'step down' supports look like in the context of the hubs.*

## Strengthening the use of outcome measurement tools by practitioners would enable greater demonstration of recovery outcomes being achieved

Where available, data showed a significant positive treatment effect for just over half of service users completing an episode of service when observing change in levels of psychological distress measured by the K10+ tool. Group-level outcomes show a reduction in the proportion of service users categorised as having *very high: likely severe mental disorder* over time, although this may be due to a combination of both sampling and treatment effects.

The RAS-DS tool was used to measure changes in recovery across four domains, which showed similar positive treatment effects although with considerably fewer matched pre and post data available for analysis. However, as most service users reported relatively high (positive) recovery scores at baseline, the RAS-DS tool may not be as sensitive to changes in outcomes over time.

As with any quantitative data analysis, demonstrating a treatment effect is challenged by limited completeness of the dataset, which was largely due to disengagement from the service and the number of open episodes at the end of the reporting period. For example, only 33% of planned closed/ceased episodes of service have both a pre and post K10+ score recorded, and only 71% of commenced episodes have a baseline K10+ score recorded.

Issues were raised by Hub staff and management around the implementation of the outcome measurement tools used within the model. These issues spanned suitability of the tools, potential tension between administering tools and building client rapport, and demands on client and practitioner time in collecting and recording data administratively.

These tools have previously been determined as suitable and prescribed as mandatory for collection as part of the PMHC-MDS for PHN-funded mental health services. As such, the focus should be strengthening the use of these prescribed tools by practitioners. Potential strategies include:

- communicating with Hub providers about the ongoing value and importance of systematically collecting outcome measurement data to demonstrate the achievement of recovery outcomes at a program-level
- providing appropriate orientation, training, coaching and/or administrative support to Hub staff to promote acceptance, understanding and uptake of the

selected tools. This should include utility of outcomes data at an individual/case-level and at a program-level.
- running regular data compliance reports on contracted KPIs relating to data collection and distributed via the Hub regional governance mechanisms.

***Recommendation 9:*** *Brisbane North PHN to work with Hub providers to strengthen the systematic use of selected outcome measurement tools.*

In addition to the above recommendation relating to the measurement of clinical and recovery outcomes, there is also an opportunity to more consistently capture intermediate outcomes that help to track progress of clients over time. Intermediate outcomes identified in the development of the program logic model for this evaluation included identifying and achieving a person's self-identified goals, building skills and knowledge, and responding to areas of unmet psychosocial need. One of the hubs reported using a standardised tool to measure psychosocial needs (i.e. CANSAS), but this was more to inform individualised care planning rather than systematically captured and reported on over time. All hubs document self-identified goals as part of a client's plan in a written document using organisational templates but not reported at a program level.

With the insights captured through this evaluation, it is timely to review the monitoring and evaluation framework with an additional focus on intermediate outcomes and appropriate data collection tools mapped against these outcomes. This would supplement the collection of the selected recovery outcomes (K10, RAS-DS).

***Recommendation 10:*** *Brisbane North PHN to update the monitoring and evaluation framework with an additional focus on intermediate outcomes such as goal attainment, skill-building, mental health knowledge/literacy and responding to psychosocial needs.*

## There are opportunities to strengthen the implementation of the hubs model

The implementation of the hubs model by Brisbane North PHN and each of the three hubs provider over its initial 2.5 years is a significant achievement, as demonstrated by the completion status of key objectives shown throughout this evaluation, including:

- delivering over 1,650 episodes of service to over 1,500 individuals, including over 38,000 service contacts
- transitioning numerous clients from the previous PHN-funded clinical care coordination and psychosocial support programs to the hubs program
- establishing shared governance and networking mechanisms between operational and senior management and the PHN
- establishing referral pathways and partnerships with local agencies
- establishing an extensive list of in-reaching and co-located activities together with directly delivered programs and services within each hub
- increasing the delivery of outputs over time, with an increasing caseload, demonstrating improved operational efficiency over time.

This achievement is also reflected through the positive experiences shared by service users, the high levels of satisfaction and strong culture reported by staff and managers working within the hubs and collaborating with the PHN, and in the positive perceptions of the hubs reported by many sector stakeholders.

Establishing and implementing a novel service model was made even more challenging by the ongoing COVID-19 pandemic in early-2020. Service contact data showed each of the hubs was successfully able to transition to remote service delivery during this period without a decline in service contact. In fact, service contacts were higher during the peak of COVID-19 disruption (Q2-Q3 2020) than any other period.

Enablers of effective implementation of the hubs model included:

- initial co-design process
- inclusive and accessible hub location and physical environment
- networked approach and joint governance model
- stewardship and support from program's funder
- selection of capable and experienced provider organisations, including existing (built and service) infrastructure and local presence
- skilled and supported workforce with diverse knowledge and backgrounds

Key barriers and challenges related to implementation included:

- role definition
- data collection and reporting requirements
- applying eligibility criteria and managing inappropriate referrals
- interface with other services and systems, particularly NDIS
- meeting service demand with finite resourcing
- gaps in broader service system

These implementation-related barriers, together with limitations of the program's initial design identified by service users and sector stakeholders, provide an insight into potential areas to strengthen the design and implementation of the hubs model into the future. These areas of improvement can be broadly categorised as the following, with each discussed in more detail below:

- expanded reach, accessibility and capacity
- responsiveness of referrals
- family-inclusive support
- data quality and consistency
- evaluation and reporting

A common challenge identified from several different perspectives throughout the evaluation was the need to increase the reach and accessibility of services and supports available through the hubs to meet demand. In particular, this related to increasing the availability of DBT therapy, opportunities for socialisation and peer support. The need to extend the accessibility and availability of supports geographically through greater use of outreach and by extending service hours (e.g. early evenings, part weekends) was identified.

In an environment of constrained resources and with each of the hubs delivering services efficiently and at full capacity, any increase in reach is likely to require additional

investment in the hubs model. While some internal stakeholders suggested allocating funding to hubs based on demographic need, it's likely that the level of investment doesn't reflect demand, so re-allocating investment between sites is unlikely to lead to any change in accessibility at a regional level. In preparing for additional investment, the PHN should work closely with the hubs to prepare for and prioritise where additional investment would best be directed to best respond to unmet needs, which could include more capacity (e.g. increased programs and activities), more accessibility (e.g. increased outreach and service hours) or more reach (e.g. additional hub locations). While it is likely that investment in community-based mental health supports will increase over the next few years as a result of recent national inquiries and ongoing reforms, other approaches to building the resourcing and capacity of the hubs model should be considered, including:

- engaging with other health services and non-health systems to secure additional in-reaching, co-located supports provided through existing funding (e.g. community legal services, financial assistance, disability support, employment and education support)
- exploring co-commissioning with other funders with overlapping responsibilities for commissioning similar services such as Metro North HHS, and with PHNs in neighbouring catchment areas where services are utilised by residents in their PHN regions (e.g. Brisbane South PHN for the Brisbane local government area)
- delivering additional activities within the hub that generate funding through demand-based systems (e.g. MBS, NDIS) or grant funding
- exploring the establishment of a volunteer program with a particular focus on increasing socialisation and skill-building activities within the hubs, while ensuring leading practice principles of volunteer management with adequate support are in place.

***Recommendation 11:*** *Brisbane North PHN to lead a strategic planning process to guide the future delivery of the hubs model with the aim of expanding reach, accessibility and capacity to optimally meet the needs of the region.*

There is a need to improve the responsiveness of referrals based on analysis of the available data, in particular for those referrals flagged with a suicide risk. Only just over 1 in 3 suicidal risk-flagged referrals received a service contact within 1 week of referral, which was less responsive than those without a suicide risk flag. While the hubs are not a crisis response, program guidelines generally indicate that referrals flagged as suicide risk do present a level of urgency and should be responded to in a more timely way.

Some of these referrals were waiting months for support. While recognising the hubs are not a crisis response that addresses suicidality directly, there is still a rationale for responding in a more timely way than 'standard' referrals in order to provide support quickly that aims to address those immediate stressors driving a person's suicidality. This may not be a waitlist or supply issue, rather it could be the nature of these referrals outside of the control of the hubs. Those people referred 'in crisis' may have less space or bandwidth to engage with the service.

It should be acknowledged that challenges exist with using the PMHC-MDS data to track the responsiveness of referrals, due to how dates are recorded in the dataset. For

example, an episode is defined as starting on the day of the first service contact, which may come after several instances of contact recorded as non-clinical activities.

***Recommendation 12:*** *Brisbane North PHN to develop a target and monitor a key performance indicator relating to the responsiveness to referrals, measured by time between referral date and first servcie contact, particularly for those flagged as at risk of suicide.*

While the integration of clinical and non-clinical supports within the hubs helped to create a holistic response to the needs of people with severe mental illness, the 'missing piece' identified by service users was creating opportunities for families, friends and other natural supports to be involved. This was reflected in service data, with only 1% of all service contacts completed being focused on a person's family or support network. Contemporary mental health policy and evidence highlights the vital role of carers, families and friends in supporting the mental health recovery and wellbeing of their loved ones. The impact of caring for someone else on a support person is also increasingly recognised. It is important for mental health services to involve and support families and friends both in a person's care plan but also in connecting them with their own support to sustain their wellbeing and prevent burnout.

***Recommendation 13:*** *Brisbane North PHN and hubs to develop a service component within the broader hubs program model focused on involving families and friends, reflecting leading evidence relating to 'what works' in carer-inclusive practice.*

Throughout undertaking this evaluation and highlighted through the experiences of hub staff and managers, numerous issues relating to data quality, consistency and comprehensiveness have been identified. It is acknowledged that a large dataset and the challenges arising from three separate providers complying with a documented data specification, PHN-level reporting requirements and their own organisational information management systems and protocols, brings considerable challenges. Additionally, data quality and capture has improved over time as a result of the PHN and hubs working together to find meaningful and practical solutions to data collection issues.

However, there is a need for more tailored guidance for each hub around data input and quality expectations. This should be developed by the PHN and provide a definition of key concepts in Redicase and counting rules based around common scenarios in the specific context of the hubs.

***Recommendation 14:*** *Brisbane North PHN to develop a guidance document for hub providers and staff, inclusive of data item definitions and counting rules based on common scenarios specific to the hubs program.*

There is also a need to establish lean, meaningful and regular performance monitoring and data compliance reporting based on agreed indicators and targets. This should be completed in the context of updating the hub program's monitoring and evaluation framework, which is a separate recommendation made within this evaluation. The regularly held hub manager meetings provide an ideal platform to consider periodic reporting and provide a data-driven approach to overseeing implementation and informing continuous improvement.

***Recommendation 15:*** *Brisbane North PHN to develop a regular performance monitoring and data compliance reporting mechanism as part of the joint governance approach and aligned to an updated monitoring and evaluation framework.*

## A hub-based model of integrated commissioning of mental health supports is becoming more common, with opportunities for replication into new areas and for learning from other regions

The hub-based model commissioned by the Brisbane North PHN in 2019 used a pooled funding approach to integrate Commonwealth-funded clinical care coordination, psychosocial support and structured psychological therapies. The model has demonstrated positive outcomes for service users, responded to a genuine need in the Brisbane North region and aligns closely with the guidelines for commissioning services under these streams provided by the Department of Health.

Current guidance from the Department of Health suggests that PHN-commissioned psychosocial supports should be separately funded, although closely linked, with clinical services (e.g. clinical care coordination, psychological therapies). Brisbane North PHN has trialled and tested this commissioning approach with the approval and interest of the Department of Health. The positive experiences and outcomes for service users highlighted in the evaluation findings suggest that the hub model using pooled funding is an appropriate and effective commissioning approach for this cohort.

Several peer PHNs were interviewed as part of the evaluation, who generally reported a broad intention to take an integrated approach to commissioning services for severe and complex mental illness. It was evident that the concept of 'integration' in the context of commissioning services for this cohort varied between PHNs, with most seeing integration as 'coordination' between separately commissioned services and providers rather than integration by design.

Evaluation findings demonstrated that the approach to commissioning services for people with severe and complex mental illness varies in design across PHNs and is largely driven by:

- line of sight of existing funding streams
- external forces such the NDIS and COVID-19
- historic funding and commissioning decisions
- the local service landscape and provider market
- outputs of previous co-design and consultation processes.

None of the PHNs interviewed had a pooled funding approach for severe and complex mental illness commissioned programs, although many noted that the landscape was evolving and some services were under review. Some peer PHNs reported that a hub model would not be suitable for their region due to their region's geography, while others noted that hub-like models currently or previously established in their region improved integration and accessibility to more supports for people, although an unintended

outcome was restricting accessibility to people geographically without having many hubs in many locations.

Commonalities between identified hub enablers and effective commissioning approaches reported by other PHNs suggests that the hub model could offer a service delivery model that is transferable to other PHN regions. These include:

- locally co-designed model
- person-centred care
- integration with other services, including State-funded mental health teams
- collaboration and co-location with local stakeholders
- mixed modalities and settings
- holistic program and service offering
- networked approach

This is further supported by the commissioning approaches in other PHN regions that demonstrate similarities to BNPHN's hub model.

As more PHNs consider integrated approaches to commissioning services for this cohort, which will likely include approaches with similar elements such as physical hubs and/or pooled funding, there is an opportunity for Brisbane North PHN to both lead the sharing of its expertise and experience with other PHNs, as well as to learn from what is happening elsewhere. Developing and maintaining relationships with key contacts in peer PHNs through a formal or informal community of practice may help to enable sharing of knowledge. One example of an opportunity to learn from models being implemented in other PHN regions is the centralised intake and assessment functions that Victorian PHNs have established as part of the HeadtoHelp model to improve service navigation for consumers, improve the referral experience for referring agencies, and assist commissioned providers to receive better quality and more appropriate referrals to respond more quickly.

***Recommendation 16**: Brisbane North PHN to lead or participate in networking and learning opportunities with relevant contacts from peer PHNs who are leading innovative approaches to commissioning services for people with severe mental illness.*

This same need can be observed in communities throughout Australia. Approximately 800,000 (5%) of Australians live with severe mental illness. Of this, 62.5% of people have episodic mental illness and 37.5% have persistent mental illness[2]. The economic impacts of severe mental illness include costs associated with the use of health and other services, as well as reduced productivity as people are unable to work[3].

In addition to their role in commissioning services in this area, PHNs are also identified as having several other expectations in coordinating services for people with severe mental illness who are supported in primary care. These include

- establishing links between clinical services and psychosocial support commissioned by PHNs for this group
- promoting the use of single multiagency care plans
- developing clear assessment and referral pathways with state/territory acute and community based mental health services.

The first of these points is being addressed directly through the implementation of the integrated hubs model, however there is an opportunity for Brisbane North PHN to progress the remaining two priorities and further improve the outcomes for people with several mental illness at a system-wide level. As identified by the Department of Health, these activities will require significant consultation and collaboration with local HHS, NDIS stakeholders and other key stakeholders. Given the nature of these priorities, they should be progressed jointly through the ongoing implementation of the *Planning for Wellbeing* joint regional plan.

***Recommendation 17:*** *Brisbane North PHN to progress system improvement opportunities relating to severe mental illness as part of Planning for Wellbeing, particularly around promoting the use of single multi agency care plans and developing clear assessment and referral pathways with other agencies. This should align with the Department of Health guidance for Initial Assessment and Referral for Mental Healthcare.*

## Limitations

The evaluation team acknowledges several limitations in undertaking this evaluation that should be considered when interpreting the findings. These included:

- The scope of the evaluation was primarily focused on the hubs model at a regional-level, and specifically the extent to which the integration enabled by the hub model achieved outcomes in comparison to other commissioning approaches. The scope of the evaluation does not intend to compare the differences between hubs at a service-level.
- Client and program data collected by each hub was of variable quality. The evaluation team undertook a limited amount of cleaning of records where data inputted was not logical (e.g. data entered outside of range), but more extensive cleaning was not completed.
- Client and program data was supplied through extracts from both Redicasae and the PMHC-MDS reporting portal. Most analysis was completed using data from the Redicase dataset as it has greater availability of records (e.g. declined referrals) and data fields not included in PMHC-MDS. There may be differences between datasets as some records and items captured in Redicasae aren't uploaded to PMHC-MDS.
- Qualitative data from the perspective of service users and sector stakeholders was limited to open-ended responses to items in the service experience survey. Interviews and focus groups were limited to hub staff, hub managers and Brisbane North PHN staff.
- Both group-level and individual-level changes for K10+ and RAS-DS scores are included in this evaluation.
    - Group-level changes should be treated with a degree of caution, as some portion of the change in outcomes observed between timepoints is likely due to individuals with relatively worse scores at baseline disengaging from support and not being included in the episode end analysis.
    - Individual-level change in outcomes provide a greater level of clarity around change in outcomes using a smaller sample, but shouldn't be generalised to the outcomes experienced by those who didn't remain engaged until episode end.

# Recommendations

1. Brisbane North PHN to communicate the positive outcomes achieved through the establishment and implementation of the hubs through targeted reporting products to build continued confidence in the model and contribute to the evidence base.
2. Hubs to directly engage with key stakeholders such as referring partners and consumer/carer representatives using a consumer journey mapping approach to (re)design the journey of someone accessing support through the hubs at key touchpoints to proactively address factors driving the relatively high rate of non-engagement and disengagement from the service.
3. Brisbane North PHN to develop data collection protocols to strengthen the capture of data insights around service non-engagement or disengagement as part of the broader implementation of the Initial Assessment and Referral (IAR) mechanism.
4. Hubs to engage with referring organisations to better understand their information needs and develop a targeted communications plan to increase sector awareness of the hubs.
5. Brisbane North PHN and hubs to collaboratively develop service-level expectations for referring organisations covering response times and communication.
6. Hubs to increase inward referrals to the hubs from the primary care setting through targeted engagement with GPs, particularly focusing on identifying and connecting people who are experiencing severe mental illness earlier.
7. Brisbane North PHN to lead engagement with relevant Metro North HHS representatives to explore a more integrated approach to the provision of services for people with severe mental illness across the region, inclusive of HHS Acute Care and Continuing Care teams, Individual Recovery Support program and PHN-funded hubs.
8. Brisbane North PHN and hubs to continue to explore opportunities to increase the support available to service users during an episode of service through a comprehensive suite of in-reaching, co-located services, and in considering what 'step down' supports look like in the context of the hubs.
9. Brisbane North PHN to work with Hub providers to strengthen the systematic use of selected outcome measurement tools.
10. Brisbane North PHN to update the monitoring and evaluation framework with an additional focus on intermediate outcomes such as goal attainment, skill-building, mental health knowledge/literacy and responding to psychosocial needs.
11. Brisbane North PHN to lead a strategic planning process to guide the future delivery of the hubs model with the aim of expanding reach, accessibility and capacity to optimally meet the needs of the region.

12. Brisbane North PHN to develop a target and monitor a key performance indicator relating to the responsiveness to referrals, measured by time between referral date and first servcie contact, particularly for those flagged as at risk of suicide.
13. Brisbane North PHN and hubs to develop a service component within the broader hubs program model focused on involving families and friends, reflecting leading evidence relating to 'what works' in carer-inclusive practice.
14. Brisbane North PHN to develop a guidance document for hub providers and staff, inclusive of data item definitions and counting rules based on common scenarios specific to the hubs program.
15. Brisbane North PHN to develop a regular performance monitoring and data compliance reporting mechanism as part of the joint governance approach and aligned to an updated monitoring and evaluation framework.
16. Brisbane North PHN to lead or participate in networking and learning opportunities with relevant contacts from peer PHNs who are leading innovative approaches to commissioning services for people with severe mental illness.
17. Brisbane North PHN to progress system improvement opportunities relating to severe mental illness as part of Planning for Wellbeing, particularly around promoting the use of single multi agency care plans and developing clear assessment and referral pathways with other agencies. This should align with the Department of Health guidance for Initial Assessment and Referral for Mental Healthcare.

# Appendix A - Program theory

## Program theory

The program theory developed is outlined in Figure 28. Each box represents a change or outcome that can be logically chained together to achieve the program's goal, while the links between boxes represent assumptions that can be tested within the evaluation plan.

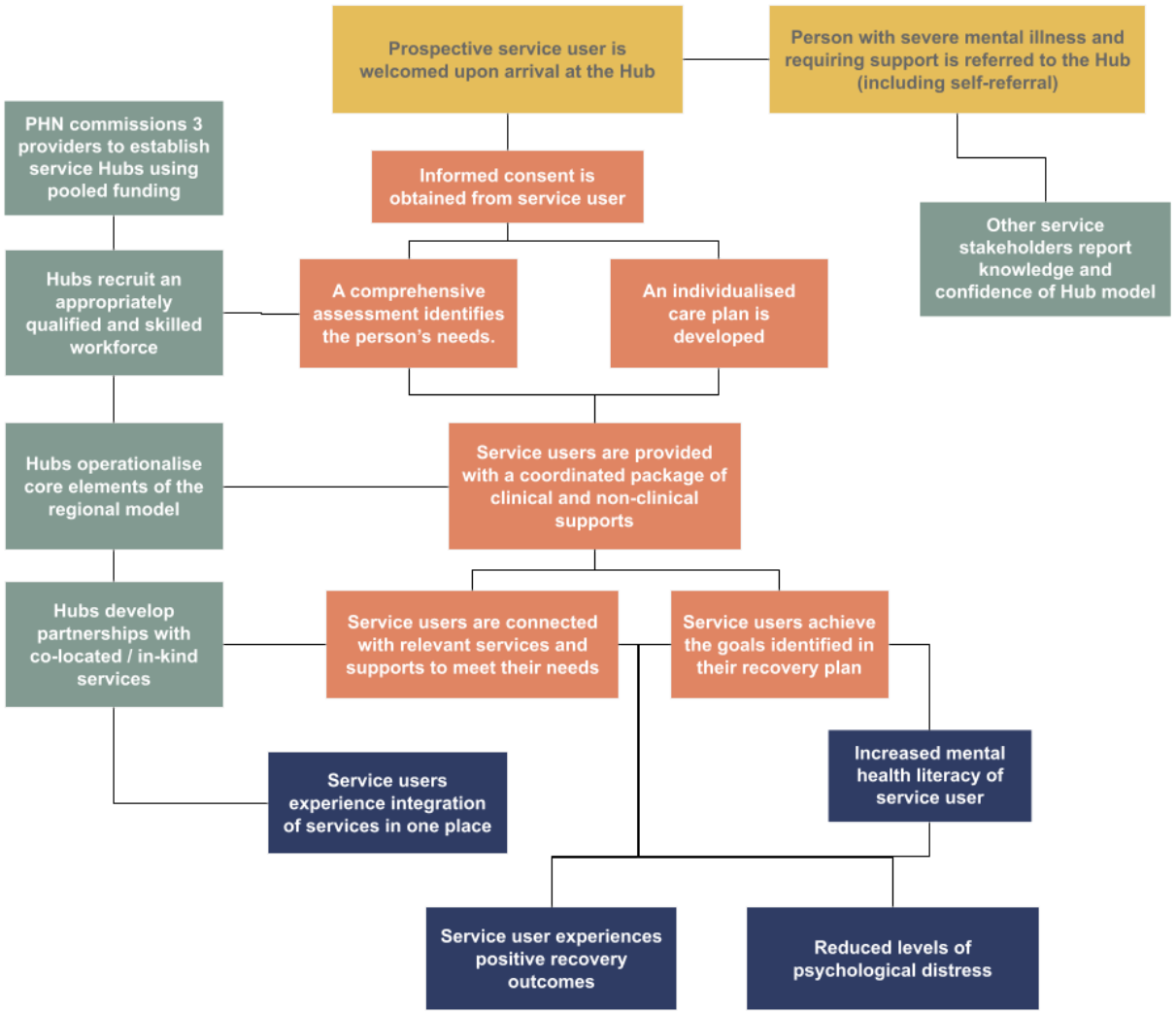


***Figure 28: Theory of change for Integrated Mental Health Service Hubs***

# Appendix B - Data collection plan

| Domain | Evaluation question | Indicator | Source / method of collection |
|---|---|---|---|
| Appropriateness | Does the hub model meet the needs of service users? | Service user-rated experience of service | Hub Experience Survey - Service Users [Q2, Q4, Q6] |
| | | Service user-rated perceived value/impact of hub | Hub Experience Survey - Service Users [Q3] |
| | | Case examples of service user experience with hub described by hub staff | Focus groups with hub staff |
| | | Number and rate of enquiries / referrals not commencing an episode of service | Review of routine program data collected in PMHC-MDS |
| | | Length of time waiting between key steps of service user journey | |
| | | Number and rate of unplanned disengagement from episode of service | |
| | Does the hub model meet the needs of local system stakeholders? | Staff-rated experience of service | Hub Experience Survey - Staff [Q2, Q5] |
| | | Staff-rated perceived value/impact of hub | Hub Experience Survey - Staff [Q3, Q6] |
| | | Stakeholder-rated experience of service | Hub Experience Survey - Stakeholders [Q1, Q2, Q3, Q4, Q7] |
| | | Stakeholder-rated perceived value/impact of hub | Hub Experience Survey - Stakeholders [Q4, Q5, Q6] |

| | | | |
|---|---|---|---|
| | Does the hub model improve integration of services for service users? | Nature of in-reaching services available within each hub service | Desktop review of program documentation |
| | | Staff-identified factors supporting integration of services | Hub Experience Survey - Staff [Q4] |
| | | Integration-related success factors and process learnings | Focus group with hub senior manager and operational manager groups |
| | | Case examples of integrated support for people with severe mental illness supported through hubs | Focus group with hub staff |
| | | Comparison of hub model components against other service models for same target audience | Desktop review of program documentation against evidence |
| | | | Interviews with sample of peer PHNs |
| | What are the strengths and weaknesses in the design of the hub model? | Perceived strengths and weaknesses of the model's design from perspective of:<br>• Service users<br>• Hub staff<br>• Hub management | Hub Experience Survey - Service Users [Q10, Q11, Q12] |
| | | | Hub Experience Survey - Staff [Q7, Q8, Q9] |
| | | | Focus group with hub senior manager and operational manager groups |
| Effectiveness | Does the hub model improve access to clinical and non-clinical support for people with severe and complex mental illness? | Trend of number of service episodes commenced and completed over time, by hub site | Review of routine program data collected in PMHC-MDS |
| | | Trend of number of service contacts completed over time, breakdown by hub site and type/modality of service contact | |
| | | Demographic and baseline indicators of service users | |
| | | Number and source of referrals/intake | |

| | | | |
|---|---|---|---|
| | | Average dosage (service contacts) and duration (time) of service contacts per participant | |
| | | Psychosocial needs of Service Users identified during intake/assessment | Analysis of documented needs identified in intake assessment |
| | | Service user-rated change in ability to access services needed | Hub Experience Survey - Service Users [Q5a] |
| | Do service users achieve their support goals? | Proportion of self-identified goals being achieved upon completion of episode of service | Analysis of care planning documentation |
| | | Examples of positive life changes after engaging with hub self-reported by Service Users | Hub Experience Survey - Service Users [Q9] |
| | | Case examples of ability of hub to meet psychosocial needs of Service Users as reported by hub staff | Focus group with hub staff |
| | Do service users report lower levels of psychological distress? | Individual-level change in pre- and post- measure of psychological distress | Analysis of Kessler Psychological Distress Scale (K10+) completed by Service User and recorded in PMHC-MDS |
| | Do service users experience a positive change in recovery outcomes? | Self-reported change in recovery outcomes | Hub Experience Survey - Service Users [Q5] |
| | | Individual-level change in pre- and post- measure of recovery measures, total score and broken down by subscales of:<br>• Connecting and belonging<br>• Looking forward<br>• Doing things I value<br>• Mastering my illness | Analysis of Recovery Assessment Scale - Domains and Stages (RAS-DS) completed by Service User and recorded in client info mgmt system |
| | | Case examples demonstrating a change in recovery outcomes for people with a severe mental illness | Focus group with hub staff |

| | | | |
|---|---|---|---|
| Implementation | Has the hub model been implemented as intended? | Completion status of contracted service outputs | Desktop review of service contract against recorded outputs |
| | | Level of compliance with data collection requirements | Review of PHMC-MDS and other datasets |
| | | Identification of planned variations to regional model to meet local context | Focus group with hub staff |
| | What are the barriers and enablers to implementing the hub model? | Identified implementation barriers, enablers and process learnings from perspective of:<br>• Hub staff<br>• Hub management<br>• Brisbane North PHN | Focus group with hub staff |
| | | | Focus group with hub senior manager and operational manager groups |
| | | | Focus group with Brisbane North PHN |
| | What are the direct and indirect resources required to implement the hub model? | Average cost per episode of care and per service contact | Calculated based on data collated in PMHC-MDS and review of contract documentation |
| | | Number and volume of directly funded and in-reaching services provided in each hub, by type of service and funding source | Desktop review of program documentation supplied |
| | | | Focus group with hub staff |
| | | Type and volume of in-kind non-service contributions provided by hub providers (e.g. infrastructure) | Desktop review of program documentation supplied |
| | | | Focus group with hub staff |
| Sustainability | Does the hub model contribute to building the evidence base for effective commissioning approaches for severe and complex | Alignment of service model against identified needs and priorities | Desktop review of program outcomes against PHN priorities and DoH guidelines |
| | | | Focus group with Brisbane North PHN staff |

| | | | |
|---|---|---|---|
| | mental illness? | Comparison of program design, implementation and outcomes against similar commissioning approaches | Interviews with sample of peer PHNs |
| | | | Desktop review of publicly available and/or supplied documentation from peer PHNs |

# Appendix C - Qualitative interview / focus group guide

## Hub senior and operational managers

| Evaluation Domain | Question |
|---|---|
| Appropriateness | • In implementing the hub model, what factors have enabled the successful integration of services (clinical and non-clinical) for service users? |
| | • What are the strengths in the design of the hub model? |
| | • What are the weaknesses in the design of the hub model? |
| Implementation | • What have been some of the barriers to implementing the hub model? |
| | • What have been some of the enablers for implementing the hub model? |
| | • In implementing the Hub model, what process learnings have you identified? |
| Implementation | • What directly funded in-reach services are available at the hub? |
| | • In operationalising the hub, are/were there in-kind, non-service contributions provided by Neami National/Communify Qld/Stride? (e.g. infrastructure)? |
| | • Has there been a need to adapt the regional hub model and, if so, what adaptations have been required? |

## Hub staff

| Evaluation Domain | Question |
|---|---|
| Appropriateness | • How well do you feel the hub model creates a positive service experience for service users? |
| | • How well do you feel the hubs improve the integration of services for service users? |
| Effectiveness | • Can you provide some examples that demonstrate the ability of the hub in meeting the psychosocial needs of service users? |
| | • Can you provide case examples that demonstrate a change in recovery outcomes for people with a severe mental illness? |

| | |
|---|---|
| Implementation | • What have been the biggest barriers to implementing the hub model from your perspective working in the hub? |
| | • What have been the biggest enablers for implementing the hub model from your perspective working in the hub? |
| | • In implementing the hub model, what are the top few process learnings you've identified? |

## PHN staff

| Evaluation Domain | Question |
|---|---|
| Implementation | • Overall, how well would you say the hub model has been implemented as it was designed? |
| | • What would you say are the strongest barriers to implementing the hub model? |
| | • What would you say are the strongest enablers for implementing the hub model well? |
| | • In implementing the hub model, what process learnings have you identified? |
| Sustainability | • How well does the hub model align with Commonwealth and PHN identified needs and priorities? |

## Peer PHN

| Evaluation Domain | Question |
|---|---|
| Appropriateness | • Your PHN's commissioning approach for people with severe and complex mental illness |
| | • Rationale for your commissioning approach |
| | • Key differences you identify with your approach and that of BNPHN |
| | • Your learnings or reflections on effective commissioning approaches |

| | |
|---|---|
| | • Can you provide an overview of your PHN's approach to commissioning services for people with severe and complex mental illness?<br>• If not already addressed, follow up question: how does your commissioning approach differ for each of the following funding streams:<br>  • Primary mental health services for people with severe and complex mental illness<br>  • Psychological therapies provided by mental health professionals for underserviced groups<br>  • The National Psychosocial Support Measure<br>  • Continuity of Support |
| | • Can you describe the rationale or drivers that contributed to your PHN taking that commissioning approach? |
| | • After reviewing the hub program logic and theory of change, what would you say are the key differences in your PHN's commissioning approach? Particularly in terms of:<br>  • the service components within your model<br>  • the desired outcomes your approach seeks to achieve |
| Sustainability | • What are some of the key learnings or reflections from your approach to commissioning services for people with severe and complex mental illness? Particularly in terms of:<br>  • Experience and engagement of service users<br>  • Referral and integration of service system<br>  • Outcomes being achieved (including monitoring/evaluation processes)<br>  • Delivery of commissioned providers |

# Appendix D - Online survey questions

## Service users hub experience Survey

### Survey questions

1. What is the date the survey was completed?
2. Please indicate which Mental Health Service Hub you received services from.
    a. The Recovery and Discovery Centre *(operated by Communify Qld in the Royal Brisbane and Women's Hospital catchment)*
    b. The Living and Learning Centre *(operated by Neami National in the The Prince Charles Hospital catchment)*
    c. Stride Hub Caboolture *(operated by Stride (formally Aftercare) in the Redcliffe/Caboolture catchment)*
3. How did you complete this survey?
    a. By myself
    b. With the support of my care worker
    c. With the support of a peer worker
    d. Other (please specify)
4. Thinking about the care you have received from the hub, what was your experience in the following areas?
    a. You felt welcome using this service
    b. You felt safe using this service
    c. You had access to this service when you needed
    d. You had opportunities for your family and friends to be involved in your support of care if you wanted
    e. Staff were able to provide information or advice to help you manage your physical health if you wanted
    f. Your individuality and values were respected (such as your culture, faith, gender identity, etc.)
    g. The service listened to and followed up feedback or complaints
    h. The service respected your right to make decisions
    i. The support or care available met your needs

    *Response scale: N/A; Always; Usually; Sometimes; Rarely; Never*
5. Thinking about the care you have received from the hub, please rate the following:
    a. The effect the service had on your hopefulness for the future
    b. The effect the service had on your skills and strategies to look after your own health and wellbeing
    c. The effect the service had on your ability to manage your day-to-day life
    d. Overall, how would you rate your experience with this service?

    *Response scale: Excellent; Very good; Good; Fair; Poor*

6. Thinking about the care you have received from the hub, what was your experience in the following areas?
    a. Access to a peer worker / lived experience worker, if you wanted
    b. Information available to you about this service (such as how the service works, your rights and responsibilities, how to give feedback, etc.)
    c. Development of an individualised care plan that considered all your needs (including support, coordination and follow up)

    *Response scale: N/A; Excellent; Very good; Good; Fair; Poor*

7. The following questions ask you to compare how things are now, compared with prior to engaging with the hub. Since engaging with the hub:
    a. How has your ability to access the services you need changed?
    b. How has your overall wellbeing changed?
    c. How have your social connections (with family and/or friends) changed?
    d. How has your hope for the future changed?
    e. How have your day-to-day living skills changed?
    f. How has your self-efficacy, or your belief in your ability to manage your illness, changed?

    *Response scale: Much worse; Somewhat worse; About the same; Somewhat better; Much better*

8. These questions are about the range of professional people you have spoken with about your mental health since being connected with the hub:
    a. How often did you have to do or explain something because different service providers did not share information with each other?
    b. How often were you confused because different service providers have conflicting information or advice?
    c. How often did you feel uncomfortable because different service providers did not get along with each other?
    d. How often were you unclear whose job it was to deal with a specific question or concern?

    *Response scale: Always; A lot; A little; Never*

9. Please rate your agreement / disagreement with the statements below:
    a. The hub is the best use of resources to achieve the desired outcomes
    b. The hub supports people with severe mental illness to live well in the community
    c. The hub supports integration of clinical (e.g. psychology) and non-clinical (e.g. peer support) services, matched to people's level of need
    d. The hub supports people with severe mental illness to achieve their recovery goals
    e. I would recommend the hub to family or friends if they had similar needs to me

    *Response scale: Strongly agree; Agree; Netural; Disagree; Strongly disagree*

10. This question is about your use of HHS Services - including emergency services and in-patient mental health services. Please rate your agreement / disagreement with the statement below:
    a. I believe the hub will reduce my need to access HHS Services

    *Response scale: Strongly agree; Agree; Netural; Disagree; Strongly disagree*

11. In your own words, what is different about your life since engaging with the hub? *(open-ended response)*

12. In your own words, what was it, (or is it) about the hub that had the greatest impact on your recovery? *(open-ended response)*

13. In your own words, what would have assisted you further? *(open-ended response)*

14. Do you have any feedback you'd like to provide to the hubs? *(open-ended response)*

**Demographic questions**

15. What is your gender identity?
    a. Male
    b. Female
    c. Gender diverse
    d. Transgender
    e. Unsure/undecided
    f. Decline to answer

16. What is your sexual orientation?
    a. Heterosexual
    b. Homosexual
    c. Bisexual
    d. Something else
    e. Don't know
    f. Decline to answer

17. Are you of Aboriginal or Torres Strait Islander Origin?
    a. Yes - Torres Strait Islander
    b. Yes - Both Aboriginal and Torres Strait Islander
    c. Yes - Aboriginal
    d. No

18. What is your age (in years)?

19. What is the name of the suburb and postcode where you live?

20. Which of the following best describes your living situation?
    a. In a group

b. With other family
c. Single parent with children
d. Couple with children
e. Couple, no children
f. Live alone

21. Which of the following best describes your highest level of education?
    a. University degree
    b. Certificate / Diploma
    c. Trade / Apprenticeship
    d. Completed year 12 or equivalent
    e. Completed year 10 or equivalent
    f. Did not complete high school

## Sector stakeholder hub experience survey

### Survey questions

1. How often have you referred someone to the hubs? *(tick one response for each statement)*
    a. The Recovery and Discovery Centre *(operated by Communify Qld in the Royal Brisbane and Women's Hospital catchment)*
    b. The Living and Learning Centre *(operated by Neami National in the The Prince Charles Hospital catchment)*
    c. Stride Hub Caboolture *(operated by Stride (formally Aftercare) in the Redcliffe/Caboolture catchment)*

    *Response scale: Never; 1 to 3 times; 4 to 10 times; More than 10 times*

2. How often has someone from the hubs referred a person to your service? *(tick one response for each statement)*
    a. The Recovery and Discovery Centre *(operated by Communify Qld in the Royal Brisbane and Women's Hospital catchment)*
    b. The Living and Learning Centre *(operated by Neami National in the The Prince Charles Hospital catchment)*
    c. Stride Hub Caboolture *(operated by Stride (formally Aftercare) in the Redcliffe/Caboolture catchment)*

    *Response scale: Never; 1 to 3 times; 4 to 10 times; More than 10 times*

3. Thinking about your experience of the hubs, please indicate your agreement / disagreement with the following statements: *(tick one response for each statement)*
    a. The hubs provides a high quality service to people with severe mental illness
    b. When referring eligible people to the hubs, I feel confident they will receive the supports they need

c. I am likely to refer eligible people to the hubs in the future
d. I have a strong relationship with the staff who work within the hub
e. I am already, or am considering, collaborating with one or more of the hubs to better integrate our services

*Response scale: Strongly disagree; Disagree; Natural; Agree; Strongly agree; N/A*

4. The overarching outcome of the hubs is to support people with severe mental illness to:
   - Live well in the community;
   - Access integrated clinical and non-clinical services, matched to their level of need; *and*
   - Achieve their recovery goals, including:
     - *Reduced psychological distress;*
     - *Improved social connectedness;*
     - *Improved hope for the future;*
     - *Improved day to day living skills; and*
     - *Improved self-efficacy, or belief in your ability to manage your illness*

   With consideration to the above, please rate your agreement / disagreement with the statements below: *(tick one response for each statement, or N/A if you have no experience with the hubs)*
   a. The hubs are the best use of resources to achieve the desired outcomes
   b. The hubs supports people with severe mental illness to live well in the community
   c. The hubs support integration of clinical and non-clinical services that are matched with people's level of need
   d. The hubs are supporting people with severe mental illness to achieve their recovery goals

   *Response scale: Strongly disagree; Disagree; Neutral; Agree; Strongly agree; N/A*

5. How would you rate your overall experience with the hubs? *(tick one response for each statement, or N/A if you have no experience with the hubs)*
   a. The Recovery and Discovery Centre *(operated by Communify Qld in the Royal Brisbane and Women's Hospital catchment)*
   b. The Living and Learning Centre *(operated by Neami National in the The Prince Charles Hospital catchment)*
   c. Stride Hub Caboolture *(operated by Stride (formally Aftercare) in the Redcliffe/Caboolture catchment)*

   *Response scale: Poor; Fair; Good; Very good; Excellent; N/A*

6. Based on your experience, how could the hubs be improved?
   *(open-ended response)*

7. Based on your experience, what are the key strengths of the hubs?
   *(open-ended response)*

8. In your own words, what feedback would you like to provide to the hubs? *(open-ended response)*

### Demographic questions

9. Which of the following options best describes the organisation you work in?
    a. NGO mental health service
    b. NGO homelessness service
    c. HHS mental health service
    d. Employment service
    e. Disability service
    f. Correctional service
    g. Government department
    h. Private allied health practice
    i. AOD service
    j. Aboriginal and Torres Strait Islander service
    k. Specialist service for culturally and linguistically diverse communities
    l. General practice
    m. Education service
    n. Emergency relief / community services provider
    o. Other - please specify

10. Which of the following best describes your role?
    a. Peer worker
    b. Support worker
    c. Medical practitioner
    d. Carer Advocate
    e. Mental health professional (e.g psychologist, social worker, mental health nurse)
    f. Other allied health professional
    g. Consumer advocate
    h. Other - please specify

## Hub staff hub experience survey

### Survey questions

1. Please indicate which Mental Health Service hub you work / worked at. If you work / worked at more than one hub, please indicate:
    a. The Recovery and Discovery Centre *(operated by Communify Qld in the Royal Brisbane and Women's Hospital catchment)*
    b. The Living and Learning Centre *(operated by Neami National in the The Prince Charles Hospital catchment)*
    c. Stride Hub Caboolture *(operated by Stride (formally Aftercare) in the Redcliffe/Caboolture catchment)*

2. Workload *(tick one response only for each statement)*
    a. My workload is manageable
    b. I can manage all the conflicting demands on my time

    *Response scale: Strongly agree; Agree; Netural; Disagree; Strongly disagree*

3. Regarding workload - My experience would have been better if:
*(open-ended response)*

4. Regarding workload - The best thing about my experience is:
*(open-ended response)*

5. Responsibility *(tick one response only for each statement)*
    a. The depth and breadth of my role, as described in my role description, is appropriate
    b. The level of work I delegate to other is appropriate
    c. The level of work delegated to me is appropriate

    *Response scale: Strongly agree; Agree; Netural; Disagree; Strongly disagree*

6. Regarding responsibility - The best thing about my experience is:
*(open-ended response)*

7. Regarding responsibility - My experience would have been better if:
*(open-ended response)*

8. Structure *(tick one response only for each statement)*
    a. The level of training provided to me is appropriate
    b. The organisational structure, including reporting lines, is appropriate
    c. Communication within and between different parts of the hub is appropriate

    *Response scale: Strongly agree; Agree; Netural; Disagree; Strongly disagree*

9. Regarding structure - My experience would have been better if:
*(open-ended response)*

10. Regarding structure - The best thing about my experience is:
*(open-ended response)*

11. Role *(tick one response only for each statement)*
    a. My role has clear goals and objectives
    b. I understand how my role fits in the hub model
    c. My role is interesting
    d. The level of flexibility in my role is appropriate
    e. I have adequate resources to undertake my role

    *Response scale: Strongly agree; Agree; Netural; Disagree; Strongly disagree*

12. Regarding role - My experience would have been better if:
*(open-ended response)*

13. Regarding role - The best thing about my experience is:
*(open-ended response)*

14. Teamwork *(tick one response only for each statement)*
    a. There are clear lines of accountability within the team
    b. The team meets regularly to discuss service improvements
    c. The team works well together implementing the hub model
    d. The team has clear objectives that are well understood

    *Response scale: Strongly agree; Agree; Netural; Disagree; Strongly disagree*

15. Regarding teamwork - My experience would have been better if::
*(open-ended response)*

16. Regarding teamwork - The best thing about my experience is:
*(open-ended response)*

17. Service provision *(tick one response only for each statement)*
    a. I am satisfied with the quality of care I provide to people
    b. My role makes a positive difference to people
    c. I am able to perform my role to a standard I am pleased with
    d. The staff who provide care to people work well together
    e. A 'seamless service' is a good description for the care people receive at the hub
    f. An 'integrated service' is a good description for the care people received at the hub
    g. There is good communication with other organisations providing care to people who use the hub
    h. The hub model represents an improvement in care provided to people with severe mental illness

    *Response scale: Strongly agree; Agree; Netural; Disagree; Strongly disagree*

18. Regarding service provision - My experience would have been better if:
*(open-ended response)*

19. Regarding service provision - The best thing about my experience is:
*(open-ended response)*

20. Please rate your agreement / disagreement with the statements below: *(tick one response only for each statement)*
    a. The hub is the best use of resources to achieve the desired outcomes
    b. The hub supports people with severe mental illness to live well in the community
    c. The hub supports integration of clinical and non-clinical services, matched to people's level of need

d. The hub supports people with severe mental illness to achieve their recovery goals

*Response scale: Strongly agree; Agree; Netural; Disagree; Strongly disagree*

21. Thinking about the integration of clinical and non-clinical services, match to people's level of need, in your own words:
    a. What activities/roles/mechanisms supported integration? *(open-ended response)*
    b. What else is needed to improve integration? *(open-ended response)*

22. Thinking about your role at the hub, please rate your agreement / disagreement with the statements below: *(tick one response only for each statement)*
    a. The hub is a great place to work
    b. I would recommend the hub to others as a great place to work

    *Response scale: Strongly agree; Agree; Netural; Disagree; Strongly disagree*

23. In your own words, what's the best thing about working at the hub? *(open-ended response)*

24. In your own words, what is different about people's lives since engaging with the hub? *(open-ended response)*

25. In your own words, what was it (or is it) about the hub that had the greatest impact on people's recovery? *(open-ended response)*

26. In your own words, what would have assisted people further? *(open-ended response)*

27. In your own words, what is different about working within the hub model, compared with your previous working experiences? *(open-ended response)*

**Demographic questions**

28. What is your gender identity?
    a. Male
    b. Female
    c. Gender diverse
    d. Transgender
    e. Unsure/undecided
    f. Decline to answer

29. What is your sexual orientation?
    a. Heterosexual
    b. Homosexual

c. Bisexual
d. Something else
e. Don't know
f. Decline to answer

30. What is the main language you speak at home?
    a. English
    b. Other - please specify

31. Are you of Aboriginal or Torres Strait Islander origin?
    a. Yes - Torres Strait Islander
    b. Yes - Both Aboriginal and Torres Strait Islander
    c. Yes - Aboriginal
    d. No

32. How long have you been working at the hub?
    a. More than 2 years
    b. 18 to 24 months
    c. 12 to 18 months
    d. 6 to 12 months
    e. Under 6 months

33. What is your age?
    a. Age (in years)
    b. Decline to answer

34. What is your role at the hub?
    a. Administrative support
    b. Manager
    c. Mental health nurse
    d. Allied health worker (Psych, SW, OT)
    e. Support worker
    f. Peer / lived experience worker
    g. Other (please specify)

# Appendix E - Overview of in-reaching services at each hub

## Living and Learning Centre (Strathpine)

| Organisation | Service provided | Frequency | Arrangement | Formal |
|---|---|---|---|---|
| Art 4 Art Sake – community group (volunteer run) | Open Community group. A gold coin donation. | Weekly | Co-location | No |
| Inside Out Theatre Company | Expressive theatre and mental health support group | Program blocks e.g. weekly for 6 weeks. | Collaboration and co-location | Service level agreement in place |
| Anytime Fitness Gym and Total Vision Allied Health | Mobility group onsite (Exercise Physiologist) and strength group at the local gym for Neami consumers | 2x per week, 6-week programs. | Co-location | MOU |
| Centre Against Domestic Abuse (CADA) | Consult with the team on client work related to domestic violence (DV) and warm referral for Neami consumers | Monthly | Co-location and outreach | MOU |
| Lives Lived Well | Consult with the team on client work related to AOD and warm referrals for Neami client | Monthly | Co-location | MOU |
| World Wellness Group (WWG) | Psychotherapeutic support to people with CALD backgrounds | 2x per week | Co-location | MOU |
| headspace | Neami collocated at headspace and involved in clinical reference group meetings and consortium meetings | Fortnightly | Outreach | Service level agreement |

| | | | | |
|---|---|---|---|---|
| Wellways | Carers counselling service | 1-2x per week | Co-location | No |
| Mens Information Support Association (MISA) | Warm referral pathways for men across both organisations | N/A | Warm referrals and training opportunities | MOU |
| At Work Australia | Provide workshops for resume writing, cover letter writing. | Program based | Co-location | No |
| Queensland Health | Smoking Cessation Program | Program based | Co-location | No |
| Queensland Health | Clinician runs a brief intervention clinic onsite. Available to the team for case consultation | 3 -5 day per week | Co-located and referral into the hub | No |
| Health Justice | Legal partner organisation. Partnership with Neami National that will support all of Neami's programs | To be confirmed | Partnership agreement | Yes |
| We Listen | Telehealth provider of psychological supports | To be confirmed | Partnership agreement | Yes |
| The Prince Charles Hospital | Safe Space on hospital grounds – working collaboratively across teams | - | Staff engaged across teams – referral into the hub | No |
| Encircle | Collaboration in setup of a local community-based peer support group. Encircle location + Neami staff | Weekly | Outreach | No |

## Recovery and Discovery Centre (Bardon)

| Organisation | Service provided | Frequency | Arrangement | Formal |
|---|---|---|---|---|
| Brisbane Youth Service | Psychosocial position and therapeutic programs | 2x per week, group activities (rotating) | Subcontract | Yes |
| Eating Disorders QLD | Eating disorders specific programs:<br>Wise Choices (WC) and Recovery Warriors (RW) Group | WC: Bi-annual 10 week, 2 hour course<br>RW: Monthly 2 hours | Subcontract | Yes |
| Toowong Private Hospital | Mental Health Nursing<br>Tailored Therapy Groups – both internal and with external partners | - | Subcontract | Yes |
| Queensland Positive People | Positively Well psycho-education course – a program tailored for people who identify as living with HIV. | Bi-annual, 6 week, 2 hours course | Subcontract | No |
| Open Minds, headspace Taringa | Youth specific DBT skills program (funded through psychological therapies stream) | Bi-annual 12 week, 2 hours course | Subcontract | Yes |
| Strong Women Talking | Aboriginal and Torres Strait Islander domestic violence service providing therapeutic groups | Bi-annual 10 week, 2 x hours course | Subcontract | No |
| Act for Kids in conjunction with Communify's Intensive Family Support Service | Trauma-Informed Play Group & Paternal Attachment & Learning Skills (PALS) Program | School Term, weekly 2 hour programs. | Subcontract | No |
| Communify Asylum Circle | Weekly BBQ Dinner for residents at crisis accommodation for single male asylum seekers | Weekly evening BBQ | Subcontract | No |

## Stride Hub Caboolture

| Organisation | Service provided | Frequency | Arrangement | Formal |
|---|---|---|---|---|
| Dietitian (Healthy Lifestyle) | Clinic, including visits for eating disorders | Fortnightly | Co-location, share referrals | No |
| Health Enterprise | Supported work placements for people with disability | Fortnightly | Co-location | No |
| Wellways | Counselor who works with carers | Fortnightly (sometimes twice in that week) | Share referrals | No |
| Centrelink | Liaison staff member | As required | Co-location | No |
| Moreton Aboriginal and Torres Strait Islander Community Health Services (MATSICHS) partnership | Qualified DBT facilitator and support worker. Help to deliver DBT group | Weekly | Refer into Stride Hub and bring facilitators | No |
| Neami | Wise Choices | Weekly | Shared referrals | No |
| Queensland Health | Smoking Cessation Group | Weekly | - | No |
| New-R | Occupational Therapy Group provides physical health supports | Weekly | Use Stride Hub space and accept referrals into that group | No |
| Queensland Health | DBT Group | Weekly | Co-location | No - Stride Hub provides space for this group |

| | | | | |
|---|---|---|---|---|
| Queensland Health | Brief intervention clinic | 1 FTE | Co-location | Yes |
| Lives Lived Well (LLW) | Communicate and come to meetings. LLW is in the same building | Monthly | - | No |
| World Wellness Group (WWG) | Outreach online since COVID-19 | Prior to COVID-19, WWG co-located fortnightly. | - | No |

# Appendix F - Overview of programs and services at each hub

## Living and Learning Centre (Strathpine)

| Program/service | Description |
|---|---|
| Wellbeing Coaching | Individual and group based psychosocial support can be provided for 6-12 months to support improved mental health and wellbeing.<br><br>Wellbeing Coaches work within a collaborative recovery model to promote individually defined wellbeing, identify personal strengths and values, and determine what skills, support or knowledge is needed to allow individuals to lead a rich and meaningful life. Support can include linkage with other services, including access to NDIS. |
| Peer Wellbeing coaching | Peer wellbeing coach support involves the same support as the Wellbeing coaching, with the addition of intentional shared lived experience perspective.<br><br>Peer Wellbeing coaches utilise their own unique lived experience in a purposeful way to support recovery and goal progression for individuals accessing our service. |
| Care Coordination | A team of Mental health nurses can assist with the clinical care coordination for individuals that need support to manage multiple service involvement in their care, or link with needed services to address multiple needs the person may have. The mental health nurse can provide clinical monitoring, communication to clinicians and promote self-efficacy regarding physical or mental health needs when connecting with other service providers. |
| Psychological therapies | Group-based psychological therapy – currently offering Dialectical Behavioural Therapy Skills groups on an ongoing basis covering skills including Mindfulness, Distress tolerance, Emotion regulation and Interpersonal effectiveness.<br><br>Short term, one-on-one psychological support available to you if you're unable to access psychological services through the Medicare Better Access Scheme. |

| Psychosocial Groups | |
|---|---|
| Flourish | 12-week self-development program facilitated by support workers with a lived experience of recovery. |
| Recovery Support Group | A weekly peer-led group that offers a safe and understanding space to talk through your feelings and experiences, with the aim of supporting and learning from each other. |
| Health Matters | 7-week program to promote people to engage with and manage their physical and mental health by identifying goals and working through barriers. This program promotes hope, growth and sustainable change. |
| Wise Choices | Develop the skills to manage difficult thoughts and feelings to lead a healthy life and improve relationships in this 10-week Acceptance and Commitment Therapy-based program. |
| Eat, Plant Learn | This program offers people affordable ways to improve their health, wellbeing and social inclusion. Supportive workshops focus on various topics including health budget friendly cooking and sustainable gardening. |
| Additional groups | Rhythm 2 Recovery (drumming recovery-based program), Shark Cage (Women's group for those that have experienced ongoing trauma and abuse), Circle of security (parenting program), |

## Recovery and Discovery Centre (Bardon)

| Program/service | Description |
|---|---|
| Mental Health Nursing | Mental health nurses liaise effectively with a range of health care providers, provide information and education on mental health maintenance and restoration and can support to coordinate both physical and mental health care needs. |
| Psychosocial Support | Our social workers and mental health support workers provide a range of non-clinical, community based support services. These supports can be individual or within a group and use a trauma-informed, recovery orientated approach to support goal-setting and working towards independence. |
| Physical health care | We do not offer physical health care services though we can link people with supports as needed. |
| Psychological therapies | Access to a range of specialist health and wellbeing programs, tailored to specific mental health concerns and wellbeing goals. |
| NDIS Assistance | Support for participants of the Recovery and Discovery Centre to test their eligibility for the NDIS if they live with a psychosocial disability and could benefit from life-long supports. NDIS readiness can support people to gather evidence from health professionals, complete an application and support through the pre-planning, planning and implementation stages. |
| Service Navigation | The Recovery and Discovery Centre's pathways facilitator can ensure that if the hub is not the best service for them or they don't meet eligibility that an appropriate service will be sourced for them.<br><br>Both mental health nursing and psychosocial supports help participants with service navigation also. |
| Group work | Programs provided during the period January to December 2021:<br>• Virtual Trauma Sensitive Yoga<br>• Music Therapy |

| | |
|---|---|
| | • BOSS Box-Fit Program<br>• Creative Wellbeing<br>• Aqua Yoga<br>• Compass Crew<br>• Health Living (January to July 2021)<br>• Living Well With Anxiety (July to December 2021)<br>• Living Well With Depression (July to December 2021)<br>• DBT Skills<br>• Feel Good Food (July to December 2021) |

## Stride Hub Caboolture

| Program/service | Description |
|---|---|
| **Services** | |
| Clinical Care Coordination | Mental health nursing service as part of case management to help with coordination and stabilisation of physical and mental health care needs. Can work alongside any of the other hub services. Can provide outreach to any location including home visits. |
| Psychosocial supports - Support Workers | Support workers provide case management in terms of engagement with social support systems and access to wellness in the community (e.g. housing and income supports, as well as connection to groups and other community services). Can provide outreach to any location including home visits. |
| NDIS Pathway | Support to make an application and submission for access to the NDIS as well as support all the way through the planning and engagement stages. |
| COVID Older Persons Support | Engagement with the senior's wellbeing coordinator in case management one to one or as a part of Stride groups, or outside community groups. |
| DBT Comprehensive | Accredited DBT 30 weeks of groups with the individual sessions component. |
| DBT First Nations partnership | Accredited DBT adaption for First Nations populations – (30 weeks) |
| DBT lite | 12 weeks DBT adaption (skills only) |
| Art Therapy | Ten weeks of therapy using art processes. |
| Mac and Yac (Caboolture) | Music and coffee / yarning and coffee social skills development group |
| Mac and Yac (Redcliffe) | Music and coffee / yarning and coffee social skills development group |
| Peer support group (Caboolture) | Peer led discussion and sharing around living with Mental health concerns. |

| | |
|---|---|
| Peer support group (Redcliffe) | Peer led discussion and sharing around living with Mental health concerns. |
| Yoga and support | Seated Yoga with talk supports. |
| PAC (Peer Advisory Collective) | A select group of peers who meet with a view of advocating for the improvement of Mental Health experiences in their community. |
| On-Line social skills group | Via Zoom social skills building with on-line group games. |
| Wise Choices | Acceptance Commitment Therapy group for depression and anxiety. (ten weeks) |
| Senior's Wellbeing group | Monthly morning tea to discuss and promote seniors' connection and well-being. |
| Carer's support group | Monthly morning tea to discuss and promote Carer's connection and well-being. |
| Hearing voices peer group | Weekly connection for those experiencing psychosis. Includes psychoeducation and peer support. |
| Outdoor living group | Every three weeks a group explores outdoor activities including fishing day tours and outdoor cooking. |
| Rhythm to Recovery | 8 weeks of drumming for wellness using the theory of the Rhythm to Recovery Model. |