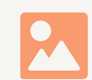
HeadtoHealth Gippsland Evaluation Summary

HEAD TO HEALTH

phn GIPPSLAND

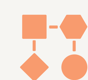
An Australian Government Initiative

Background



- Head to Health (H2H) was introduced to meet the mental health needs of Victorian residents following a rapid COVID-19 response by the Commonwealth government in 2020.
- Gippsland Primary Health Network (Gippsland PHN) applied a 'hub and satellite' model with hubs in Baw Baw and Wellington supported by satellite services across Gippsland. The Initial Assessment and Referral (IAR) Decision Support Tool, telehealth and use of peer workers were part of the approach.
- An independent Victorian evaluation of H2H was completed in March 2022 and included data on service provision in Gippsland.
- In mid-2021, Monash Rural Health was awarded the tender to evaluate the Gippsland H2H initiative over 18 months September 2020 to March 2022.[1]

Method



The evaluation aimed to:

- Determine how H2H was used in the context of COVID-19 and its impact on the mental health of target populations.
- Evaluate the effectiveness of the Gippsland intake service within the new hub and satellite model.
- Evaluate the use of the new Initial Assessment and Referral (IAR) tool.

Mixed methods approach:

- Quantitative data included service use information regarding intake, treatment and outcomes.
- Quantitative and qualitative data were collected by an online survey of Gippsland service providers.
- Interviews were undertaken with groups of service users and service providers.

Findings

Service use

- Service users and providers thought H2H was successful in engaging community members of different ages, genders, and various socioeconomic backgrounds. Access to a free service was a major contributor to service uptake.

Of the 2,604 service users

- **63.4%** Were female
- **94.2%** Were born in Australia
- **99.4%** Were English speaking
- **1.7%** Identified as Aboriginal and/or Torres Strait Islander
- **34.1%** Were employed

- Anxiety and depression were the most common reasons for referral (60% of episodes).
- Most common referral sources were GPs (almost half of total) and self-referral.
- Psychological therapy was the most common form of treatment.
- There were over 15,000 service contacts; average 5.6 contacts per episode.
- 44.8% of contacts were face-to-face and 39.6% were by telephone.

Changes in levels of distress

- 64% of service users reported significant improvement.[2]
- Wellington and Baw Baw service users had reduced mental distress scores over time of treatment.
- Greater reductions in levels of distress[3] were seen in:
  - Older service users, particularly in Baw Baw.
  - Self-referrers compared to those referred to H2H by their GP.
  - Service users aged 26-40 years showed significantly greater improvement than 0-18 and 18-25 age groups.

H2H Service model

- Main source of referral was from GP clinics co-located with H2H.
- Co-location allowed greater continuity of care for service users with doctors and other health professionals. The reverse was true when services were not co-located.

> "Excellent model; free; multidisciplinary team; easy to access; minimal wait times when other services have long wait times or closed books."
> **- Service User**

Initial Assessment and Referral

> "It is a good training tool for new workers, it covers a range of important factors and standardises [sic] everyone within the service."
> **- Service Provider**

- IAR level of care provided was level 3[4] or higher in two thirds of all referrals.
- Service users were mostly unaware of the IAR process and the way the tool was implemented felt to most like a "casual chat".
- Some service users were left in a state of limbo after the assessment while awaiting the allocation of a clinician.

Workforce

- Peer worker involvement at early stages of intake was important for building rapport.
- Service providers noted the positive contribution of peer workers.

> "People with lived experiences are able to better understand and identify important issues in people with similar mental health problems."
> **- Service Provider**

Limitations:

- Staffing models meant that staff were often inexperienced, lacked local knowledge and provided only general, non-specialist therapy.
- Understaffing and a high staff turnover rate created significant disruption for many service users.
- Service exit was often abrupt and occurred without adequate referral or handover.
- Mental health needs of families and carers were not always addressed.

Telehealth

- Telehealth worked well when the organisation was committed to using technology and users were able to independently set up and use technology. Outcomes were positive when clients were comfortable using telehealth, were generally doing well and were working on maintaining their recovery.
- It was not helpful when clients could not afford a phone or internet, for Culturally and Linguistically Diverse communities, children, older clients (over 60 years) and those in distress or at risk of suicide.

> "Hugely beneficial given the large distances people in Gippsland often have to travel to attend for mental health treatment; [it] makes the services more accessible for many."
> **- Service Provider**

> "I was scared... absolutely scared, And I thought, how will we make the connection by phone, when... my accent, my limitation, and vocabulary and things like this. Plus, the situation, a personal situation that is hard to open yourself, when you don't know the other person."
> **- Service User**

- Treatment activities not possible over the phone included observation of client behaviour and engagement, assessing safety levels and conducting mental state examinations.

Recommendations

H2H Service Model

- Co-location should not be limited to clinical or medical services.
- Intervention types need to be extended to meet other needs such as relations with family and carers, housing, and employment.
- Improvements in administration processes, documentation and treatment planning were needed for effective follow up and better communication between GPs, service users and other service providers.

Initial Assessment and Referral

- Support service users with higher levels of distress to engage with the approach.
- Improve links with service providers soon after the assessment where a need for a clinician is established.
- Further training and upskilling is needed in the use of IAR tool.

Telehealth

- Ensure telehealth is an option for all service users after a relationship has been established.
- Provide telehealth training to H2H practitioners and support service users to overcome barriers before using the model with them.
- Establish telehealth hubs in remote areas where service users could engage with telehealth services in a safe and private environment.

Workforce

- Increase structures and supports for staff to reduce staff turnover, increase local knowledge and harness clinical experience.
- **Develop and implement**
  - structured programs to support peer workers to look after their social and emotion wellbeing.
  - workforce training to improve recording of service user background, assessment, treatment, and outcomes variables
- **Offer**
  - professional development in diversity, inclusion and trauma informed care at orientation for all staff (not only mental health professionals).
  - training for clinical staff aimed at recovery-oriented practice, reducing stigma and the positive impacts peer workers have on clients' recovery.

Next steps

Gippsland PHN is drafting an action plan to respond to the recommendations from the evaluation, noting that there have been refinements in the model since the evaluation was undertaken.

A workshop will be held with H2H hubs to help develop the action plan and commence implementation.

[1] This project was funded by the Commonwealth Department of Health via Gippsland PHN.

[2] Extract PMHC-MDS, N=371 matched pairs for completed treatment, 14/9/2020 13/3/2022

[3] Measured by Kessler 5/10

[4] Level 3 = mild to moderate symptoms with some complexity likely but not at severe levels and Interventions should be reasonably frequent with moderate intensity and structure.