Who delivers care in Neami National Medicare Mental Health Centres? Implementation Co-Evaluation Snapshot #2

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"I feel like we kind of fill gaps here." (Staff)

"you need to really make all the members aware of each other's skills and strengths and scope of practice. So, when people understand each other and what they can deliver, that makes it a lot easier" (Staff)

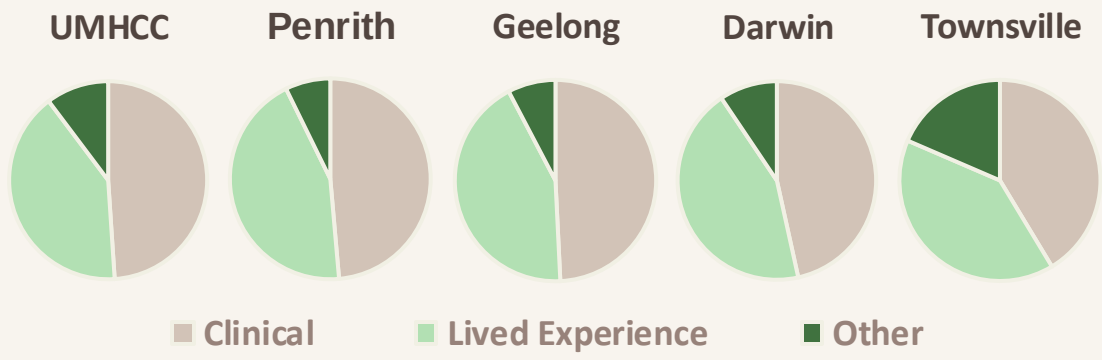

Image caption: **Pie charts illustrate a point in time FTE of peer clinical and other staff** (other staff are those outside the peer/clinical dichotomy (ie admin/ community engagement or homelessness workers).

The emergent practice approach in Centres two to three years into implementation

Staff identified that

- Services provided a welcoming, calm and safe environment for guests (service term for people seeking support).
- Guests were feeling supported and welcomed.
- Services filled gaps in the service system.
- Staff went above and beyond to look after each other and the community.
- Staff were committed to person centred care and creating safety with guests.
- There were some challenges in integrating within the service system.
- The service model and approach is positive but structure and care pathways in, out and through the services needs further development.

Geographic Differences based on Census 2021 Data

- Three services were in regions with higher than national averages of Aboriginal and Torres Strait Islander residents. Available service data indicated a higher proportion of First Nations guests attended than expected from census data.
- In four locations there were higher numbers of people told they had a mental health condition compared to the national average (8.8%), while Darwin was lower than the national average (5.9%).
- All sites were located in regional areas or centres across Australia.

Read more about this project at the ALIVE National Centre Website: https://go.unimelb.edu.au/69w8
This co-partnership commenced after the first year of services operating in 2022 with data collection in 2023-2024 when sites were named Head to Health. In May 2024 the Federal Government renamed them Medicare Mental Health Centres.

Staff responses to surveys* may include service managers and support staff

Demographics (N=106)

- average age of staff: 39 years
- average years worked in mental health: 6.9 years
- average months working in service: 14.3 months
- 62.5% identified as female
- 26.9% identified as LGBTQIA+
- 6% identified as Aboriginal and/or Torres Strait Islander people
- 21.6% identified as culturally or linguistically diverse background

Improvement Areas

- 76% agreed the service has effectively connected with the existing service system
- 69% agreed they were clear on their role of that of others in the team

*Respondents: 33% clinical/ 50% peer

Implementation journey conversations with all staff and governance

Over six months peer workers, clinical staff, and managers/governance met in separate groups where they selected images of how the implementation felt at that time. Examples such as the blue image were used to share views that:

- Services were developing and evolving.
- Connections were being made internally and across the sector but there was more to do.
- Development work was progressing but could be slow.
- Changes in staff, leadership structures, and inconsistent training creating process issues.
- Things were stabilising, but still be a bit rocky.
- Challenges delivering the model in practice with equity and meaningful inclusion between clinical and peer staff.

Good experiences for staff

"People experience connection in a way which is simply not possible in a hospital." (Staff)

"We focus on building a strong, well educated, well supported team so that they are able to provide the best care for our guests." (Staff)

Not so good experiences for staff

"..from the outset, lack of policy, lack of framework, lack of role definition, and so much changing." (Staff)

"They [guests] just come in, and we're just sort of bombarding them with the questions." (Staff)

Implementation Strategies for Staff Development in Centres

IMPLEMENTATION GAP 1: Peer and clinical staff have unclear scopes of practice. Training levels vary as does understanding of mental health care and specifically the model of care.

IMPLEMENTATION GAP 2: Staff turnover has been high and challenging for consistent care delivery. Development of service cultures have lagged.

IMPLEMENTATION GAP 3: There was a lack of clarity within the community and sector around what the services are seeking to do, and how they are delivering care. Word of mouth and other services were the most common ways people said that they found about Centres.

INDIVIDUAL LEVERS: .Develop clear scopes of practices to define role responsibilities and boundaries. Systematise training and development to the scopes and models of care.

ORGANISATIONAL LEVERS: Create a culture of staff retention through facilitated support and supervision. Foster whole of team co-learning, and safety to hold challenging conversations.

COMMUNITY LEVERS: There is a need to build community awareness of the service models and points of difference, and where the models sit in the service system for the general public and across service sectors.

Ethics approvals were obtained from: University of Melbourne Human Ethics Sub-Committee (ID 26525); Human Research Ethics Committee of NT Health and Menzies School of Health Research (NT HREC: ID 2023-4624); AH&MRC Ethics (ID 2133/23); Aboriginal Health Research Ethics Committee (ID 04-22-1066); NEAMI Research and Evaluation Committee.