# EVALUATION OF THE EAST GIPPSLAND MENTAL HEALTH INITIATIVE

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*"Mental health is a state of emotional and social wellbeing. It influences how an individual copes with the normal stresses of life. Mental health describes the capacity of individuals and groups to interact, inclusively and equitably with one another and with their environment in ways that promote subjective wellbeing and optimise opportunities for development and use of mental abilities."*
(Australian Health Ministers, 2003)

*"All Victorians have the opportunities they need to maintain good mental health, while those experiencing mental health problems can access timely, high quality care and support to live successfully in the community."*
*(Vision for mental health in Victoria, Mental Health Reform Strategy, 2009)*

*"If you want to go fast, go alone. If want to go far, go together." (African proverb)*

## EXECUTIVE SUMMARY

This document reports on the evaluation of the East Gippsland Mental Health Initiative. The evaluation examined the implementation (process) of the project and its outcomes (impact).

The Initiative was the result of an iterative process from an initial 2010 State election campaign commitment. The program had the following aims:

- To build the capacity of services and communities the better to respond to the needs of people with mental illness, their families and carers.
- To work in a collaborative manner with local service providers in East Gippsland to deliver appropriate support services and self-management programs to consumers with a mental illness, to ensure they receive a continuum of care that addresses their needs and leads to better recovery outcomes for them and their families.
- To assist consumers to develop self-management skills through training in programs such as the *Optimal Health Program* and *Action over Inertia* that will fulfil their own care needs and achieve optimal health outcomes.

The final program structure comprised:

- a Youth Intensive Care Coordination program (YICC) for 16 to 21 year olds in the mainstream community
- an Aboriginal Youth Intensive Care Coordination program (AYICC) for 16 to 21 year olds in the Aboriginal community
- building capacity around spiritual work and wellbeing in the community
- building mental health support community capacity for farmers and their families

Funding was released in late 2014, with program staff appointed in early 2015.

## EVALUATION APPROACH AND METHODOLOGY

This project reports on the process (that is, roll-out or implementation) and the outcomes of the East Gippsland Mental Health Initiative.

The evaluation largely used qualitative methods, although some data sets were interrogated to determine achievement (or not) of targets. A list of key respondents was developed, in collaboration with EGMHI management. This included: governance group members, Initiative staff and clinicians and other health practitioners in a wide range of service providers. Interviews were conducted by telephone and face-to-face.

## PROGRAM DESCRIPTION

The East Gippsland Mental Health Initiative (EGMHI) is a co-ordinated response to the mental health support needs of East Gippsland residents, with dual emphases on meeting the needs of some of the area's disadvantaged young people and its more remote, bushfire affected communities.

### Youth Intensive Care Coordination – YICC and AYICC

Youth intensive care coordination is driven by a commitment to integrated, holistic, wraparound support, which obviates a need for the individual to try to engage what is a highly complex, fragmented mental health support service system. The Coordinated Care Plan is developed in partnership with the young person, incorporating their personal goals, identifying barriers to achievement and identifying appropriate support services and referring them to particular service providers. The YICC or AYICC worker monitors progress through periodic meetings with the provider(s) and with the client. The length of a Care Plan is flexible and can be terminated by the

young person or by AYICC or YICC program staff. Referrals for a Coordinated Care Plan may come from a range of sources including self-referral, DHHS agencies, community-based service providers and other youth sector stakeholders.

Both the YICC and AYICC programs adopt age and culturally appropriate approaches, through specifically designed tools and methodologies.

**Building capacity around spiritual work and wellbeing in community mental health support service delivery**

This element of the Initiative has been included in the Initiative as a response to increasing recognition by EGMHI partners and DHHS of a role for spirituality as a healing and protective factor in mental illness. It aligns well with the current focus on 'recovery orientated' programs which promote a 'culture of hope and optimism' and 'holistic' and 'person centred' care.

The intention was to establish relationships with spiritual leaders (Aboriginal cultural and religious and other spiritual organisations) in East Gippsland and work in partnership to improve the capability of both service providers and local communities to respond to people with a mental illness.

**Building mental health support and community capacity building.**

This component of the EGMHI has two parts.

1.1 A community education program to improve community awareness and understanding of mental health; increase access to support services and increase community capacity to support people with a mental illness. The particular target group is communities in remotes areas of East Gippsland.
1.2 An education program to improve the capacity of providers delivering services in remote communities, to work with and support people with a mental illness. The program would also aim to strengthen collaboration and coordination among service providers and to develop partnerships between EGMHI partners, service providers and communities.

Two fire-affected farming communities were to be targeted. Numerous one-off community forums and training sessions were planned. These would, in an integrated, place-based approach, address a number of issues that (directly or indirectly), might affect mental health.

**CONCLUSIONS**

**Overall…**

- The evolution of the EGMH Initiative was an iterative process, negotiated among a large network of stakeholders. This has had advantages and disadvantages. The extent of the network brought a breadth of expertise and connections, which was vital when delivering to such a dispersed population. Conversely, numerous interests needed to be addressed in the shaping of the program. There were also varying levels of commitment to delivery of the Initiative, from consortium members, which, at times, hampered the work of program staff.
- The mental health support service system – in East Gippsland at least – is characterised by a plethora of programs, funding streams, silos and poor coordination. It can present to 'lay' people as an impenetrable jungle. YICC staff did not appear to have the necessary skills to 'navigate' the system effectively.
- The disparate elements of the Initiative sought to address a range of needs for mental health support services in East Gippsland. However, the four elements were not necessarily complementary and so did not generate any synergy of effort towards achieving the overall objectives.
- The genesis of the Initiative was political, rather than strategic and the fact that the Initiative did not emerge directly from DHHS's own strategic planning processes, militated against sustainable outcomes, particularly for the YICC and AYICC components.
- Funding for the Initiative was brokered by the then Department of Health (DH). Following the amalgamation of this Department with the Department of Human Services (DHS) to form DHHS it appears possible that communication about the Initiative, to agencies formerly within DHS was not actively pursued. Further, as the Initiative rolled out and YICC referrals from DHHS agencies were not forthcoming, no action appeared to be taken by DHHS to promote the Initiative to potential Departmental agencies.
- Targets were set based on the funding available, rather than established Departmental data on the numbers of potential clients. This makes it difficult to determine what is the realistic need for the YICC program particularly given the narrow eligibility criteria, (more so than the AYICC).

**In the short term…**

The outcomes of the Initiative's four elements were successful to varying degrees.

- The Youth Intensive Care Coordination Program has struggled to achieve its targets and the limited outcomes data available indicates it has not achieved successful outcomes. Based on the small number of referrals and engagements, and without further data on youth mental health needs in East Gippsland, the need for a youth intensive care coordination service is unclear.
- The Aboriginal Youth Intensive Care coordination has achieved its targets and the limited outcomes data available suggests that it was moderately successful (based on the small number of successful closures).
- The Spirituality component of the Initiative represented an innovative approach to enhancing mental health support service delivery. It produced some encouraging results although these were rather limited, which was not surprising given the exploratory/experimental nature of its subject matter.

- The community capacity building component was partially successful. One group of communities – the Glenaladale group – did not engage, however this was more a reflection of those communities and their priorities at the time, than on the Initiative itself. The Initiative's impact on the second group of communities – the Mountain Rivers group – was largely successful.
- Overall, the impact of this component of the Initiative was positive among service providers and in one of the two targeted communities. It has resulted in:
  - Strengthened partnerships and collaboration among service providers
  - Increased community awareness of mental health as an important health issue
  - Improved community capacity to support people with a mental illness, and
  - Some improvement in services.

**In the medium term…**

- There are positive indications of:
  - ***Strengthened partnerships*** and improved collaboration among providers, including Aboriginal Community Controlled Health Organisations.
  - ***Increased flexibility of health providers*** to meet the needs of remote communities. This flexibility is based on a modest shift in organisational culture *in some providers.*
  - ***Increased community capability*** (in some of the targeted remote communities) to recognise and support people with mental health issues.
  - ***Increased community cohesion*** in some of the targeted remote communities, which has resulted in incidental integration of some health and emergency services.

These developments appear likely to continue beyond the life of the EGMHI.

- ***There also appears to be an emerging recognition of the efficacy of spirituality*** as an aid in approaches to mental health support services. Overall this component can probably best be considered as an interesting pilot program, which demonstrated that there is an interest in exploring the use of spirituality in the mental health area. Despite the lack of interest from institutional religious leaders, and although the exposure that people have had through the few workshops is rather limited, this component of the EGMHI will have the best opportunity to leave a sustained impact if it encourages the approach to be included in programs in the future.

**In the long term…**

- To the extent that the Initiative has produced positive outcomes in its target areas, these will be given the best chance to have a lasting, sustainable impact if the experience gained is used to inform future programs in this area.

**RECOMMENDATIONS**

1. That future programs addressing psychological and mental health support are required to operate under a collaborative model. Such a model will require a formal commitment from partners and a structure with embedded monitoring and accountability of partners' contributions to delivery and outcomes. A recommended option is the Collective Impact model[1]. See Appendix C.
2. That program governance arrangements comprise senior management representatives of member organisations.
3. That future mental health programs are funded based on sound evidence of need, such as service mapping and gap analyses.
4. That future community resilience programs, which seek to address recovery following natural disaster, include a dedicated mental health support position.
5. That both clinical and community-managed mental health programs recognise the importance of a flexible approach, which takes account of the target communities' particular social circumstances and expressed needs.
6. That future mental health programs (in East Gippsland) recruit staff with strong background knowledge of the local mental health sector and the skills to negotiate the labyrinthine 'system'. Where this is not possible, appointed staff should be provided with comprehensive training and support.
7. That place-based services to remote communities are designed on a collaborative model, to include local organisations such as Neighbourhood Centres, schools and others and provide both mental health support services and self-management programs. They should be adequately funded to ensure sustainability. This would include the additional costs of outreach delivery and infrastructure support at sub-regional level.
8. That clinical mental health services undertake professional development sessions for their staff, which increase awareness and appreciation of community-managed mental health services.
9. That funding be sought to build on the work of Simon Jones and Spiritual Health Victoria to support continuing professional development on the use of spirituality as an aid to health practitioners in providing support to people with a mental illness.
10. That a process evaluation is commenced early in any project, in order to identify successes and opportunities for improvement. This then contributes to the continuous improvement cycle, so important in any project.

[1] https://collectiveimpactaustralia.com/about See also Appendix C

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**CONTEXT**

East Gippsland is a Local Government Area (LGA) with a small, highly dispersed population (the average population density is 0.02 per hectare)[2]. In fact, the population is mainly concentrated in the south-western corner of the Shire which means that people living in small, remote communities are particularly isolated and have difficulty accessing services (conversely it is difficult for providers to service these areas adequately). Distribution of the population across the Shire is a significant consideration for social planners. Public transport is also limited which restricts the ability of young people and others without their own transport to access services.

The region has a higher than average population in the 50+ cohort, boosted by inbound migration. It has the second largest Aboriginal and Torres Strait Islander community, by municipality, in Victoria. The Aboriginal population is growing at twice the rate of overall growth, with an average age of 20 years, compared to the average age of 48 years in the population as a whole.

East Gippsland has a SEIFA Index of 958[3], indicating that the municipality is relatively more disadvantaged than most municipalities in Victoria, ranking it 16th most disadvantaged (out of 79 LGAs) in Victoria. This means East Gippsland is more disadvantaged than most Victorian LGAs. Median family income is much lower than average ($868 per week as compared with a value for the State of $1170 per week); affordable housing is in short supply and homelessness is a significant issue.[4]

Data from DHHS Health profiles[5] indicates that the number of registered mental health clients per 1000 is higher in East Gippsland than the Victorian average; intentional self-harm hospitalisations are double that of the Victorian average and drug and alcohol clients are more than double the Victorian average.[6]

The experience of the EGMHI consortium members is that East Gippsland residents can experience high levels of isolation and can be reluctant to engage with mental health services through conventional means, i.e. attending a clinic with a referral from a general practitioner or nurse. Community stigma around mental illness is compounded in small communities where everyone knows everyone else.

People with a severe and enduring mental illness often have multiple and complex needs, which can include alcohol and other drug problems; acquired brain injury; intellectual disability; physical health problems; forensic issues; homelessness and being at high risk of

[2] East Gippsland Shire Community Profile http://profile.id.com.au/east-gippsland (most recently accessed 26/04/2017)

[3] ABS: 2011 Census

[4] Care in Your Community, DHS at http://www.health.vic.gov.au/regions/gippsland/resources/Care-in-Your-Community,-Integrated-Area-Based-Planning,-Gippsland-Trial,-Priority-Setting-report.pdf (most recently accessed 26/04/2017)

[5] Dept. Health and Human Service Profiles 2014

[6] *Chamberlain C, MacKenzie D 2009. Counting the homeless 2006: Victoria. Cat. no. HOU 203. Canberra: AIHW.*

"falling through the cracks" of the existing service system. This generally results in poor outcomes and an inability for services to provide a good continuum of care.

The Department of Health and Human Services (DHHS) planning framework: *'Care in your Community'* identified mental health as one of the 4 key areas of focus in the East Gippsland region.

**BACKGROUND**

*Election commitment*

The program that has become the EGMHI was developed through a number of iterations. It arose out of a commitment of $1m - from a candidate during the 2010 State election campaign - to refurbish an existing building and help establish a Bairnsdale Mental Health Wellbeing Centre. Although the candidate was not successful the incoming Government agreed to implement the proposal.

*Working Group proposal*

Following strong advocacy from local groups that the money would be better spent providing services rather than 'bricks and mortar', the East Gippsland Mental Health Initiative working group was established to develop a proposal for consideration by the Minister (the membership of this group is given as Appendix A).

The EGMHI working group submitted a proposal in late 2011, naming SNAP Gippsland as Lead Agency (subsequently SNAP was renamed ***within Australia***). The proposal recognised the opportunity to deliver a Care Coordination service in East Gippsland in parallel with the statewide Care Co-ordination Initiative, in the hope of ensuring its sustainability in the region into the future. The proposal sought to be consistent with the current government policies as described in *Mental Health Reform Strategy: Because Mental Health Matters*.

At this stage, the program was aimed at those between 16 and 64 years of age who had a primary diagnosis of a major psychiatric condition.

*Funding approval and revisions*

Funding was finally approved in the 2013/14 budget. Further minor iterations occurred prior to commencement of the Initiative, aiming to remove any duplication and to complement existing programs. This ensured that EGMHI funding could be targeted to what were seen as current needs and priorities at the time and to maximise consumer outcomes.

The key changes to the Intensive Care Coordination components of the program were a restriction in age range to 16 to 21 years and the requirement that clients be registered with DHHS as having co-existing complexities and a mental illness. These amendments were intended to enable the Initiative *"…to link with other programs, for example Mental Health Support for Secure Tenancies, Youth, Justice, Child Protection, Disability" (Ministerial Briefing Paper, 2013)* .

The revised program had the following aims:

- To build the capacity of services and communities the better to respond to the needs of people with mental illness, their families and carers.

- To work in a collaborative manner with local service providers in East Gippsland to deliver appropriate support services and self-management programs to consumers with a mental illness and to ensure they receive a continuum of care that addresses their needs and leads to better recovery outcomes for them and their families.
- To assist consumers to develop self-management skills through training in programs such as the *Optimal Health Program* and *Action over Inertia* that will fulfil their own care needs and achieve optimal health outcomes.

The final program structure comprised:

- a Care Coordination program for 16 to 21 year olds in the mainstream community
- a Care Coordination program for 16 to 21 year olds in the Aboriginal community
- building capacity around spiritual work and wellbeing in the community
- building mental health support community capacity for farmers and their families

Funding was released in late 2014, with program staff appointed in early 2015.

## EVALUATION APPROACH AND METHODOLOGY

This project reports on the process and the outcomes of the East Gippsland Mental Health Initiative.

An evaluation framework was developed, based on the Initiative's Program Logic, setting out indicators of success (including DHHS targets) and how information would be gathered. The full program logic is at Attachment A.

The process evaluation explored how the roll-out of the program progressed and the outcome component of the evaluation sought to determine if the program was achieving its goals, plus any unintended (negative or positive) outcomes.

The evaluation largely used qualitative methods, although some data sets were interrogated to determine achievement (or not) of targets. A list of key respondents was developed, in collaboration with EGMHI management. This included: governance group members, Initiative staff and clinicians and other health practitioners in a wide range of service providers. Interviews were conducted by telephone and face-to-face.

## PROGRAM DESCRIPTION

The East Gippsland Mental Health Initiative (EGMHI) is a co-ordinated response to the mental health support needs of East Gippsland residents, with dual emphases on meeting the needs of some of the area's disadvantaged young people and its more remote, bushfire affected communities.

The Initiative seeks to build the capacity of both existing service providers *and* communities to support people with a mental illness. Strengthened and expanded delivery of mental health support services and improved access to those services are key goals. Community capacity building is place-based, with an integrated mix of interventions and strategies to maximise reach and impact.

The Initiative has four related components, which address these goals and the program logic describing these relationships is at Appendix A:

**2. Youth Intensive Care Coordination (YICC)**

This is a service offered to 16-21 year olds with a mental illness and co-existing complexities (this age range was to be subsequently extended to 16-24 years). Eligibility for the Initiative requires the young person to be involved with the Department of Health and Human Resources (DHHS), through agencies such as Youth Justice, Out of Home Care (OOHC) and others, to have complex needs and a mental illness.

Intensive care coordination is driven by a commitment to integrated, holistic, wraparound support, which obviates a need for the individual to try to engage what is a highly complex, fragmented support service system. The Coordinated Care Plan is developed in partnership with the young person, incorporating their personal goals, identifying barriers to achievement and identifying appropriate support services and referring them to particular service providers. The YICC worker monitors progress through periodic meetings with the provider(s) and with the client. The length of a Care Plan is flexible and can be terminated by the young person or YICC program staff.

Referrals for a Coordinated Care Plan may come from a range of sources including self-referral, DHHS agencies, community-based service providers and other youth sector stakeholders.

In the early stages of the EGMHI, a range of agencies and other stakeholders were approached in order raise awareness of the Initiative and to establish referral pathways for eligible young people. These referral pathways - between the YICC program and service providers - could carry two-way traffic: an agency, service provider or other stakeholder (such as a school) may refer a young person for assessment and development of a Coordinated Care Plan and the YICC worker will then refer the young person to one or more service providers, for specialist support.

**3. Aboriginal Intensive Care Coordination (AYICC)**

This a service offered to Aboriginal young people 16-21 years old, with a mental illness and co-existing complex needs. In a similar approach to the YICC, an AYICC worker develops collaborative links and referral pathways with Aboriginal Community Controlled Health Organisations (ACCHOs). The worker assesses eligibility and then works with the young Aboriginal person to build a Coordinated Care Plan, refers them to one or more appropriate providers and monitors progress with both the provider(s) and the young person.

Both the YICC and AYICC programs adopt age and culturally appropriate approaches, through specifically designed tools and methodologies.

**4. Building capacity around spiritual work and wellbeing in community mental health support service delivery**

This element of the Initiative is a response to increasing recognition (by EGMHI partners and DHHS) of a role for spirituality as both a healing and a protective factor in mental health. It aligns well with the current focus on 'recovery orientated' programs which

promote a 'culture of hope and optimism' and 'holistic' and 'person centred' care. Such approaches are to be found, for example, in the Australian Government *National Framework for Recovery Oriented Mental Health Services, 2013*[7] and the Victorian Government *Mental Health Act, 2014*[8].

The intention was to establish relationships with spiritual leaders (Aboriginal cultural and religious and other spiritual organisations) in East Gippsland and work in partnership to improve the capability of both service providers and local communities to respond to people with a mental illness. The EGMHI, in collaboration with Spiritual Health Victoria and an independent practitioner, developed a series of one-off workshops for provider staff and community members. The workshops specifically target those people whose work (paid or unpaid) places them in contact with clients, patients or loved ones who have a lived experience of mental illness. These sessions encourage participants to explore the role of spirituality in their own lives and as an approach in working with others to improve and maintain mental health.

A strategic objective of these workshops is to establish a network of interested practitioners and community members that might continue to explore the issue, raise awareness and promote the efficacy of spirituality in enhancing approaches to mental health support, beyond the life of the Initiative.

**5. Building mental health support and community capacity building.**

This component of the EGMHI has two parts.

5.1 A community education program to improve community awareness and understanding of mental health; increase access to support services and increase community capacity to support people with a mental illness. The particular target group is communities in remotes areas of East Gippsland.

5.2 An education program to improve the capacity of providers delivering services in remote communities, to work with and support people with a mental illness. The program would also aim to strengthen collaboration and coordination among service providers and to develop partnerships between EGMHI partners, service providers and communities.

Two fire-affected farming communities were to be targeted. Numerous one-off community forums and training sessions were planned. These would, in an integrated, place-based approach, address a number of issues that (directly or indirectly), might affect mental health.

[7]http://www.health.gov.au/internet/main/publishing.nsf/content/67d17065514cf8e8ca257c1d00017a90/$file/recovgde.pdf

[8]https://www2.health.vic.gov.au/mental-health/practice-and-service-quality/mental-health-act-2014

## FINDINGS AND DISCUSSION

### A. The Youth Intensive Care Coordination program (YICC) for 16-21 year olds with DHS, with a mental illness and co-existing complexities, in East Gippsland.

An underpinning objective of the YICC was to strengthen links and increase collaboration among the service provider network in East Gippsland. The program

*"… would encourage cross sector co-ordination and practice…and develop the capacity of service agencies to work with young people and their co-morbidities" (Ministerial briefing paper, 2013)*

The YICC program commenced late 2014 with targets, set by then Department of Health (DH), of 12 clients per year. This proved to be a challenge from early on. The program relied on referrals from agencies, such as relevant DHHS agencies; providers such as community mental health services; community-based providers and organisations, such as local GPs; schools, housing organisations and Job Active providers, and self-referrals. EGMHI staff made visits to the range of potential referrers, promoting the Initiative and explaining eligibility criteria. The YICC workers also attended numerous and varied community-based events in order to establish a profile for the Initiative in the community. As the difficulty of achieving the targets became apparent, the age range was extended to 24 years.

Despite these efforts, the YICC program was unable to meet its referral targets over 2015-16 and 2016-17.

#### Outcomes of YICC program

Data Collection arrangements have focussed on activity (rather than outcomes), which, together with financial reports have provided sufficient data to meet DHHS reporting requirements. However, care coordination outcomes do not seem to be reported in any detail. This has created difficulties in gauging client outcomes beyond actual referral targets, without interrogating individual case notes (which was not within the resources of this evaluation). Activity reports show a range of referral destinations for young clients including but not only, housing, family, employment, drug and alcohol, legal aid and counselling services. The data collection platforms, record the results of needs assessments and reviews. There appears to be no systematic record of client outcomes, in terms of successful completions (of Care Coordination Plans) or attrition (disengagement, moving away from the district). Reports to the governance group often (but not always) list active client numbers, completions and early exits but these do not always easily align with CANSAS other reports. Table 1 below sets out referral sources, client numbers and outcomes by year.

*Table1: Referral sources to YICC program and outcomes*

| YEAR | REFERRAL SOURCE | Referral Nos | Outcomes |
|---|---|---|---|
| 2015 | • Allied Health service | 7 | 1 completion |
| 2016 | • Education and training sector (schools, RTOs)<br>• Adult Community Mental Health<br>• Self<br>• Family<br>• Within Australia<br>• Community-based service provider | 8 | 4 early exits<br>1 completion<br>2 unknown |
| 2017 (first quarter) | | nil | 7 active |
| 2017 Second quarter | | nil | 1 completion<br>2 transfers<br>4 early exits |
| **TOTAL clients since program commenced** | | **12-15*** | *approximation only is possible |

With the resignation of the third YICC worker in February 2017 and given the inability to meet YICC targets, the governance group addressed the issue of unspent funds for this component of the EGMHI. A decision was taken to divert funds in two ways:

1. Employment of a worker to maintain care coordination for the seven active clients (without seeking new referrals) and to deliver a Suicide Intervention Program at Paynesville. Of the seven clients, two clients are being transitioned to the ICS Program operated by within Australia, one client has completed and the remainder have disengaged.
2. Production of a documentary of the fire-affected remote communities in the Mountain Rivers district.[9] This activity has garnered increasing support from those communities, as filming and interviewing has progressed. This activity is a joint exercise between within Australia and the East Gippsland Shire Council. Given the timing - at the end of the Shire's AfR program and towards the end of the EGMHI -

[9] Tubbut, Goongerah, Deddick, Bonang and Bendoc

community members reported that it helped as: *"in some way a rounding up of the overall experience [of the recovery effort]".*

Several factors affected the outcomes of the YICC component of the Initiative:

1. ***Eligibility***

The funding agreement required eligibility criteria to include young people with existing involvement with the then Department of Health (through its various agencies), assessed as having complex needs and a mental illness. This created a narrow field from which to 'recruit' participants. Although these criteria were subsequently relaxed somewhat, referral numbers remained low.

2. ***Pre-existing case management arrangements***

Given the requirement for involvement with DHHS, it would be expected that several referrals to the Initiative would come from DHHS agencies. This does not appear to be the case. Departmental agencies and programs with the potential to refer included: Youth Justice, Out of Home Care, Disabilities and Support for Secure Tenancies. Youth Justice has a statutory obligation for case management of youth offenders on Community Orders, however referral at or near completion of an Order would provide transition to continuing support. Other DHHS agencies also had existing case management arrangements in place for their clients and similarly, transition pathways to community-based mental health support would have also been an option for these agencies to refer their clients. In early 2015, the Initiative developed a promotional strategy which included literature; visits to provider organisations and other stakeholders such as schools; presence at community activities and invitations to presentations on the Initiative. Representatives of DHHS agencies attended what was then SNAP offices, to discuss the structure of the program and what was possible in terms of referrals. There was no alert at this meeting, of possible conflict of roles between DHHS agencies' case management responsibilities and EGMHI's case coordination roles. The YICC received no referrals from DHHS agencies.

3. ***Communications/Promotion***

A number of stakeholders felt that the Initiative could have been promoted more vigorously. The YICC program was promoted through the networks of the Governance Group members. In addition, Initiative staff met with numerous agencies operating in the youth, health and community/social services sectors, to raise awareness of and promote the YICC and discuss referral pathways. Initiative staff participated in Youth Week activities and promoted the program through EG Shire's Youth Ambassadors and through membership of the East Gippsland Youth Alliance Forum. What was then SNAP was involved with the Services Connect network and the program was promoted in the governance group meeting of this network. A flyer was designed and distributed among service providers. As mentioned earlier, no referrals were recorded from any DHHS agencies or in fact, from any Consortium member agencies. Given the recorded effort of staff and management, it is difficult to know what other strategies might have been used.

4. ***Cultural Reluctance***

   Despite the increasing profile of mental health in the media and clearer government acknowledgement of the extent of mental health problems - particularly among young people - mental illness continues to carry a serious social stigma, which constrains sufferers in seeking assistance and treatment. Further, historical ignorance of different mental illnesses has meant that problems often go unrecognised by family and others, until a crisis. In both these situations early, community-based intervention, such as that offered by the EGMHI, may have been effective in dealing with the issue at the time. However, young people who were referred to the Initiative often proved to be reluctant to engage or to continue engagement.

5. ***Community-based nature of the Initiative***

   This factor proved to be an advantage and a disadvantage. Notwithstanding the general reluctance of young people to access mental health services, workers and other respondents reported that participation in a community-based program was less intimidating and more acceptable to young people than a clinical, hospital-oriented model of delivery.

   However, there was acknowledgement that many practitioners working within the clinical model tend to perceive community-based services as of a lower quality and are therefore reluctant to refer.

6. ***Staffing***

   The YICC program experienced considerable staff turnover during the twenty-eight months in which it has operated (to 31 March 2017). Lack of continuity can be problematic when working and supporting young clients. Further, within Australia found it difficult to recruit care coordination staff with a sufficiently solid working knowledge of the complexity of the mental health support service system. Numerous service providers operate in East Gippsland, under a plethora of funding streams. This fragmented situation exacerbated difficulties for each new worker - who did not have a mental health background - in securing referrals. The fragmented nature of this 'system' was acknowledged by DHHS in that the Department identified strengthened links and increased collaboration as a key element of the EGMHI. The dispersed nature of the EGMHI team was mentioned and although telephone support from the program coordinator (based in Orbost) was valued, closer proximity would have enabled more comprehensive support.

## B Aboriginal Intensive Care Coordination program (AYICC), for Aboriginal 16-21 year olds with DHHS, with a mental illness and co-existing complexities, in East Gippsland.

The underpinning objective of the program was to strengthen collaboration with Aboriginal Community Controlled Health Organisations (ACCHOs).

*"Aboriginal Community Controlled Health Organisations will partner…in the delivery of these services" (Departmental funding statement)*

The AYICC program commenced in mid-2015, with targets of 8 clients per year and a commitment to a part time worker (0.6EFT). From its commencement, the AYICC received more referrals than anticipated and continued to do so. In response, targets were extended to 12 per year and the YICC worker's employment expanded to full time.

Like the 'mainstream' YICC program, the AYICC relied on referrals from DHHS agencies and Aboriginal Community Controlled Health Organisations (ACCHOs). The participating ACCHOs are located in Bairnsdale, Lakes Entrance, Lake Tyers and Orbost. The AYICC worker visited these communities as often as time allowed and participated in several community activities and events.

### Outcomes of the AYICC Program

As with the YICC program, data collection and management arrangements provide detailed activity history but program outcomes are more difficult to extract. Table 2 sets out referral sources and Care Coordination outcomes. Referral destinations included ACCHOs, education support workers, community mental health, family, dental, drug and alcohol services, GPs and sports clubs. The AYICC program enjoyed moderate success in terms of completions of Coordinated Care plans (10 completions from 21 clients as at 31 March 2017).

The participating ACCHOs were very positive about the AYICC program, in terms of both intensive care coordination for young Aboriginal people and the resulting strengthened partnerships with Aboriginal organisations. The organisations that were more remote from Bairnsdale expressed a desire for more frequent visits from the AYICC worker (while understanding his time was stretched thin over a number of widespread locations.

Another concern was sustainability of mental health support beyond the funding of the program (30 June 2017). The AYICC worker's efforts have highlighted in some stakeholders' minds, the vulnerability of support for Aboriginal young people when the AYICC program comes to an end on 30 June, 2017.

*Table 2: Referral sources to AYICC program and outcomes*

| YEAR | REFERRAL SOURCE | Referral Nos | Outcomes |
|---|---|---|---|
| 2015 (three quarters) | • Koori Youth Justice<br>• LEAHA<br>• GEGAC<br>• Centrelink<br>• Education and Training sector<br>• Lake Tyers Aboriginal Trust | 9 | |
| 2016 | • LEAHA<br>• GEGAC<br>• Family<br>• Self<br>• AOD service provider | 19 | 6 completions<br>4 early exits |
| 2017 (first quarter) | • Self<br>• GEGAC<br>• within Australia<br>• Family | 13 | 4 completions |
| **TOTAL clients since program commenced** (at 31 March 2017) | | **21** | |

Factors affecting the outcomes of the AYICC program included:

**1. Relationships with the Aboriginal communities of East Gippsland**

Although not of Aboriginal heritage the AYICC worker was well known and respected among the Aboriginal community, having grown up in the district and established many long-term friendships. These strong links in the community served the program well in terms of referrals. In addition to referrals from Aboriginal organisations, the AYICC program also received numerous referrals from families and self-referrals, again an illustration of the standing of the AYICC worker among Indigenous communities. Further, notwithstanding shifting tensions and animosities between different groups within the Aboriginal community, overall, there is a degree of cohesion that allows communication about a range of developments, program offerings and activities. The wider Aboriginal community 'grapevine' is effective across a geographic spread and kinship groups. One ACCHO commented on the Initiative's influence in improving coordination and cooperation among Aboriginal organisations. Training opportunities provided by other elements of the Initiative were valued, such as ASIST (Applied Suicide Training) and the AYICC worker's participation in a Leadership camp.

2. **The acceptance by AYICC clients of the nature of the care coordination role.**

   It was argued by some respondents that, in general, many members of the Aboriginal community in East Gippsland are recipients of and therefore familiar with a variety of government support programs. As a result, there is less stigma attached to involvement in what could be viewed as yet another program. This compares with the non-Indigenous population, for whom, generally speaking, the stigma of mental illness and the formalised participation requirements of a mental health program present more of a barrier to engagement.

3. **Support from ACCHOs.**

   It is clear that the ACCHOs participating in AYICC[10] are very supportive of the program in general and the AYICC worker in particular. Referrals operated both ways, with ACCHOs referring to EGMHI for development of Care Coordination Plans, which in turn could involve young clients being referred back for specialist support. These organisations appear well set up to provide a range of health services to Aboriginal clients and have referred a number of clients. They are in periodic contact with the AYICC worker and, particularly those more remote from Bairnsdale, expressed a desire for more regular visits.

## C Building capacity around spiritual work and wellbeing in community mental health support service

In practice, this element was addressed by delivering a two-series workshop program. The first series comprised five one-off workshops entitled: 'Building Capacity for Spiritual Care and Wellbeing' and was delivered in various locations by Spiritual Health Victoria. The second series, comprising two workshops, was delivered by an independent facilitator, with experience in addressing the concept of spirituality beyond structured religious institutions. This presenter had developed a program entitled: *My Spiritual Path*. Both facilitators encouraged an approach to spirituality which embraced more than a religious perspective. In particular, they emphasised the significance of nature as a spiritual factor in many people's lives, especially those who live in the East Gippsland area.

Spiritual Health Victoria's five workshops specifically targeted those people whose work places them in contact with clients or patients, who have a lived experience of mental illness.

The *My Spiritual Path* workshops had the same broad aims as those delivered by Spiritual Health Victoria (to clarify and broaden people's understanding of spirituality and to give participants some techniques for how to approach their clients' needs in this area).

### Workshop Outcomes

*The Spiritual Health Victoria sessions* included a pre- and post- questionnaire, based on a tool developed by the Royal College of Nursing. A further survey was conducted at six

[10] Moogji in Orbost, Lake Tyers Trust, LEAHA in Lakes Entrance and GEGAC in Bairnsdale

months after the sessions.[11] More than 50 people attended the five workshops. It was notable that no clinical mental health practitioners attended and only one recognised spiritual leader in the community attended (in this case, a church minister).

Results of the surveys revealed that 90% of the participants found the workshops valuable because they had expanded their understanding of what spirituality can mean to different people and because they felt better equipped to deal with issues of spirituality in their interactions with clients.

> *"Most [participants] had no difficulty locating the place of spiritual care within a truly holistic framework that considers these needs alongside other health care needs in the model of person-centred care." (Spiritual Health Victoria facilitator)*

Eleven participants replied to the six-month survey with 80% of these indicating that the training continued *'to improve client/patient outcomes'*. This was most clearly expressed by the following comment from one respondent:

> *"Due to encouraging a chronically suicidal person to explore their spirituality, this person is now stating that they love life and is thanking me immensely for the guidance." (Participant)*

The two *My Spiritual Path* workshops drew a total of 22 people, most of whom were health-related professionals (including several nurses). Three participants were Indigenous, which was described as 'unusual'.

An evaluation was conducted on the day using questionnaires similar to those used by Spiritual Health Victoria. The responses indicated that people were satisfied with the workshops and had gained a good deal of value from them.

The facilitator, PhD candidate Simon Jones plans follow up contact with the participants and aims to develop a resource website, available to these participants and to the community at large.

Overall, the workshops were received positively by participants, who felt they had received a useful insight into an aspect of mental health which has previously been largely overlooked, as well as practical advice on how to handle this issue in their interactions with their clients. The responses to the six-month survey have shown that the training had a positive longer term impact on at least some of those attending.

**NOTE:** The workshops were also of value to the presenters who were both prepared to modify their approaches with the intention of making them more effective in the future. This improve capability could be also important for the East Gippsland area if ways are found to build on the promising aspects of this initial phase.

[11] Spiritual Health Victoria then conducted its own evaluation of the program, which has formed the basis for a paper delivered at two conferences on Mental Health.

## D Building mental health support community capacity which will provide mental health training and education prevention work with farmers and their families in East Gippsland

In early 2014, before the East Gippsland Mental Health Initiative was operational, some of the more remote East Gippsland communities were overrun by two damaging bushfires. One, to the north-west of Bairnsdale impacted Fingerboards, Glenaladale and Fernbank communities (hereafter called Glenaladale). The other, north of Orbost, affected Tubbut, Bendoc, Bonang, Deddick and Goongerah communities (hereafter called Mountain Rivers).

In response and to assist these communities in their recovery efforts, the East Gippsland Shire (also a member of the EGMH Initiative) rolled out a program: *Adaptation for Recovery (AfR).* This program aimed to support communities in the recovery process but also, through structured facilitation, to build individual and community resilience, based on strengthened community networks (social capital), infrastructure, improved preparedness and resource development. Personal growth and empowerment and sustained change underpinned these objectives.

At this time (during the initial implementation of the AfR), the EHMHI governance group took the decision to focus this element of the Initiative on those fire-affected communities, and to work collaboratively with the AfR.

It became clear very early, that these communities were resistant to a conventional approach by any mental health practitioner. The **Glenaladale** communities were focussed on practical steps to improve fire preparedness. The EGMHI program co-ordinator worked with the AfR facilitator, attended community meetings and interacted with some individuals but any kind of meaningful engagement with mental health as an issue was not forthcoming. It was felt that the communities needed to work through the most important practical tasks and processes as they perceived them[12].

Since the EGMHI program coordinator was based in Orbost, close to the workplace of the **Mountain Rivers** AfR facilitator, it was decided to co-locate the two workers. This proved to be a key factor in the success of this element of the Initiative. The EGMHI program coordinator took a *softly, softly* approach to penetrating the Mountain Rivers communities, who, like the Glenaladale communities, were also resistant. Rather than pursue the structured approach outlined in the Initiative's implementation plan, which was based on a series of one-off forums and workshops, she made a strategic decision to 'piggy-back' community activities organised by the AfR program until she was accepted as a valid player in the wider recovery process. The EGMHI program coordinator

[12] As it has eventuated, the Glenaladale communities are only now (in early 2017) expressing an interest in and willingness to address personal and social issues.

regularly attended local activities and supported the communities to develop and pursue their own priorities.

*"She has maintained a continuing and non-threatening presence."*

**Outcomes**

As she became accepted, the EGMHI program coordinator began facilitating a range of workshops and training sessions, often jointly with the Shire AfR program and supported by the local Neighbourhood House at Tubbut. These sessions were open to community members and practitioners and addressed a range of topics including personal skills development, community capacity building, mental health first aid, women's and men's health, and the Optimal Health and Wellbeing program.

Responses to these sessions were strongly positive:

*"A worthwhile day packed with information for time limited people"*

*"…getting valuable info in a good, calm manner"*

*"I learnt effective strategies for better functioning community groups"*

This approach has been endorsed by local community leaders and by providers delivering services to these remote districts, and has proved effective over time.

It has resulted, gradually, in an emerging openness among the Mountain Rivers communities to acknowledge mental health issues as an aspect of the impact of the fires, and a preparedness to address the issue on an individual basis. One result of this engagement has been an increase in requests for individual psychological counselling through the ATAPS[13] program. Orbost Regional Health has responded to this attitudinal shift and has committed one day of outreach delivery to the area. It should be noted here

that, although Orbost Regional Health has agreed to fund a day of outreach ATAPS delivery, it has not included travel costs in the quantum of funding. These (not inconsiderable) costs are being met by the delivering practitioner.

The Initiative's effectiveness at bringing these remote communities together, increasing cohesion, raising awareness of mental health and improving skills in recognising and addressing mental illness has been universally acknowledged.

*"…bringing people together who wouldn't have talked previously (or would have been antagonistic towards each other); building of relationships across community; willingness to be more constructive…" (Mountain Rivers community leader)*

Service providers were unanimous in attributing an increased collaboration among their local sector, to the work of the Initiative, in particular the EGMHI program coordinator.

[13] ATAPS: '*Access to Allied Psychological Services'*

*"Also, the Men's Health Nights have become much more successful. More men attending – and now they are a much more cohesive group… the idea of mental health has been 'normalised'".*

Providers and local community leaders expressed confidence that outcomes of the Initiative's work in the Mountain Rivers district are both impressive and sustainable.

*More men are seeking assistance. Men are recommending the service to others that they know in the community. This indicates that when the program has finished it will leave a lasting legacy"*

Factors affecting outcomes of this element of the Initiative:

- ***Co-location*** of EGMHI Program Coordinator with the Shire's *Adaptation for Recovery* program facilitator, which enabled mutual support and complementary effort such as secondary consultations and sharing of local knowledge.
- ***Flexibility*** of the EGMHI Program Coordinator to tailor strategies to the situational realities of the Mountain Rivers communities.

  *"She has been flexible in her approaches, which has proved to be successful in engaging previously reluctant residents."*
- ***Support*** from the local Neighbourhood House at Tubbut, which provided positive publicity and practical assistance to community members to attend meetings and forums.

## CONCLUSIONS

### Overall…

- The evolution of the EGMH Initiative was an iterative process, negotiated among a large network of stakeholders. This has had advantages and disadvantages. The extent of the network brought a breadth of expertise and connections, which was vital when delivering to such a dispersed population. Conversely, numerous interests needed to be addressed in the shaping of the program. There were also varying levels of commitment to delivery of the Initiative, from consortium members, which, at times, hampered the work of program staff.
- The mental health support service system – in East Gippsland at least – is characterised by a plethora of programs, funding streams, silos and poor coordination. It can present to 'lay' people as an impenetrable jungle. YICC staff did not appear to have the necessary skills to 'navigate' the system effectively.
- The disparate elements of the Initiative sought to address a range of needs for mental health support services in East Gippsland. However, the four elements were not necessarily complementary and so did not generate any synergy of effort towards achieving the overall objectives.
- The genesis of the Initiative was political, rather than strategic and the fact that the Initiative did not emerge directly from the then DH's own strategic planning processes, militated against sustainable outcomes, particularly for the YICC and AYICC components.
- Funding for the Initiative was brokered by the then Department of Health (DH). Following the amalgamation of this Department with the Department of Human Services (DHS) to form DHHS it appears possible that communication about the Initiative, to agencies formerly within DHS was not actively pursued. Further, as the Initiative rolled out and YICC referrals from DHHS agencies were not forthcoming, no action appeared to be taken by DHHS to promote the Initiative to potential Departmental agencies.
- Targets were set based on the funding available, rather than established Departmental data on the numbers of potential clients. This makes it difficult to determine what is the realistic need for the YICC program particularly given the narrow eligibility criteria, (more so than the AYICC).

### In the short term…

The outcomes of the Initiative's four elements were successful to varying degrees.

- The Youth Intensive Care Coordination Program has struggled to achieve its targets and the limited outcomes data available indicates it has not achieved successful outcomes. Based on the small number of referrals and engagements, and without further data on youth mental health needs in East Gippsland, the need for a youth intensive care coordination service is not clear.

- The Aboriginal Youth Intensive Care coordination has achieved its targets and the limited outcomes data available suggests that it was moderately successful (based on the number of successful closures).
- The Spirituality component of the Initiative represented an innovative approach to enhancing mental health support service delivery. It produced some encouraging results although these were rather limited, which was not surprising given the exploratory/experimental nature of its subject matter.
- The community capacity building component was partially successful. One group of communities – the Glenaladale group – did not engage, however this was more a reflection on those communities and their priorities at the time, than on the Initiative itself. The Initiative's impact on the second group of communities – the Mountain Rivers group – was largely successful.
- Overall, the impact of this component of the Initiative was positive among service providers and in one of the two targeted communities. It has resulted in:
  - Strengthened partnerships and collaboration among service providers
  - Increased community awareness of mental health as an important health issue
  - Improved community capacity to support people with a mental illness.
  - Some improvement in services

**In the medium term…**

- There are positive indications of:
  - ***Strengthened partnerships*** and improved collaboration among providers, including Aboriginal Community Controlled Health Organisations.
  - ***Increased flexibility of health providers*** to meet the needs of remote communities. This flexibility is based on a modest shift in organisational culture *in some providers.*
  - ***Increased community capability*** (in some of the targeted remote communities) to recognise and support people with mental health issues.
  - ***Increased community cohesion*** in some of the targeted remote communities, which have resulted in incidental integration of health and emergency services.

  These developments appear likely to continue beyond the life of the EGMHI.
  - ***There appears to be an emerging recognition of the efficacy of spirituality*** as an aid to mental health support services. Overall this component can probably best be considered as an interesting pilot program, which demonstrated that there is an interest in exploring the use of spirituality in the mental health area. Despite the lack of interest from institutional religious leaders, and rather limited exposure that people have had through the few workshops, this component of the EGMHI will have the best opportunity to leave a sustained impact if it encourages the approach to be included in programs in the future.

**In the long term…**

- To the extent that the Initiative has produced positive outcomes in its target areas, these will be given the best chance to have a lasting, sustainable impact if the experience gained is used to inform future programs in this area.

**RECOMMENDATIONS**

1. That future programs addressing psychological and mental health support are required to operate under a collaborative model. Such a model will require a formal commitment from partners - including Government Departments and agencies - and a structure which embeds monitoring and accountability of partners' contributions to delivery and outcomes. A recommended option is the Collective Impact model[14]. See Appendix C.
2. That program governance arrangements comprise senior management representatives of member organisations.
3. That future mental health programs are funded based on sound evidence of need, such as service mapping and gap analyses.
4. That future community resilience programs, which seek to address recovery following natural disaster, include a dedicated mental health support position.
5. That both clinical and community-managed mental health programs recognise the importance of a flexible approach, which takes account of the target communities' particular social circumstances and expressed needs.
6. That future mental health programs (in East Gippsland) recruit staff with strong background knowledge of the local mental health sector and the skills to negotiate the labyrinthine 'system'. Where this is not possible, appointed staff should be provided with comprehensive training and support.
7. That place-based services to remote communities are designed on a collaborative model, to include local organisations such as Neighbourhood Centres, schools and others and provide both mental health support services and self-management programs. They should be adequately funded to ensure sustainability. This would include the additional costs of outreach delivery and infrastructure support at sub-regional level.
8. That clinical mental health services provide professional development for their staff, which increases awareness and appreciation of community-managed mental health services.
9. That funding be sought to build on the work of Simon Jones and Spiritual Health Victoria to support continuing professional development on the use of spirituality as an aid to health practitioners in providing support to people with a mental illness.
10. That a process evaluation is commenced early in any project, in order to identify successes and opportunities for improvement. This then contributes to the continuous improvement cycle, so important in any project.

[14] https://collectiveimpactaustralia.com/about See also Appendix C

**APPENDIX A**

## Evaluation Respondents

Staff and managers in the following organisations were interviewed, either by telephone or face-to-face. In most instances, more than one person from each organisation was interviewed. In the interests of confidentiality, no names are provided.

- Moogji Aboriginal Community Controlled Health Organisation
- Lakes Entrance Aboriginal Health Association (LEAHA)
- Gippsland Lakes Community Health
- Orbost Regional Health
- Latrobe Community Health
- East Gippsland Shire Council
- Latrobe Regional Health Community Services
- Gippsland and East Gippsland Aboriginal Co-operative
- withinAustralia
- Spiritual Health Victoria
- Simon Jones
- Dave Munday
- Barrier Breakers
- Latrobe Regional Hospital Mental Health Service
- Tubbut Neighbourhood House
- Department of Health and Human Services

## APPENDIX B

## East Gippsland Mental Health Initiative Consortium Membership

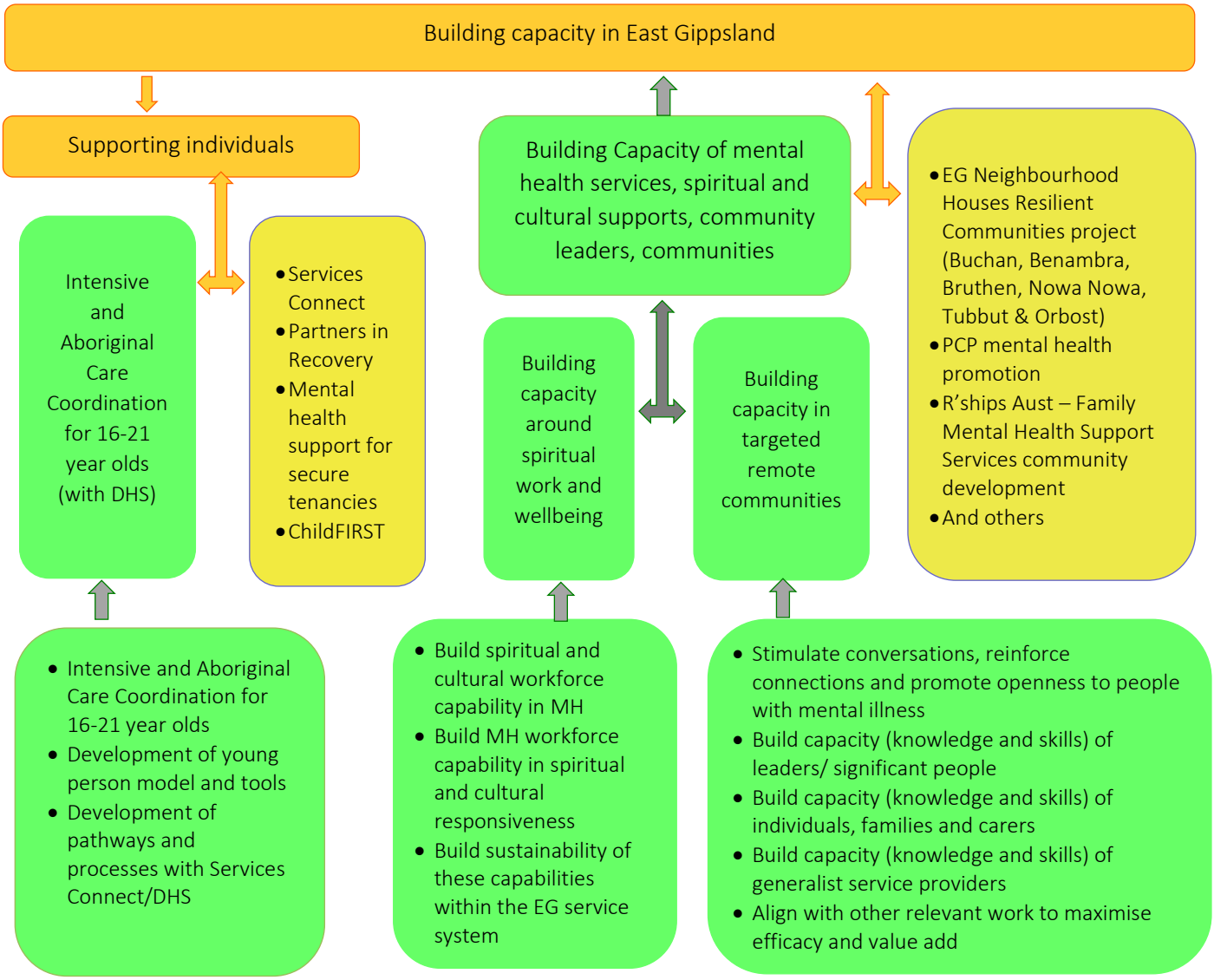
- Regional Department of Health and Human Services
- Latrobe Regional Hospital Mental Health Services,
- East Gippsland Shire Council
- Barrier Breakers
- within Australia
- Gippsland Lakes Community Health
- Bairnsdale Regional Health Service
- Orbost Regional Health

*Information only:*

- Consumer representation
- East Gippsland Primary Health Alliance
- Ramahyuck
- Gippsland and East Gippsland Aboriginal Co-operative
- Mental Illness Fellowship
- Carer Support Group

**APPENDIX C**

## PROGRAM LOGIC



## APPENDIX D

## COLLECTIVE IMPACT MODEL

Collective Impact is a framework for facilitating and achieving large scale social change. It is a structured and disciplined approach to bringing cross-sector organisations together to focus on a common agenda that results in long-lasting change.

Kania and Kramer (2011)* identified five key conditions:

1. All participants have a **common agenda** for change including a shared understanding of the problem and a joint approach to solving it through agreed upon actions.
2. Collecting data and **measuring results** consistently across all the participants ensures shared measurement for alignment and accountability.
3. A **plan of action** that outlines and coordinates mutually reinforcing activities for each participant.
4. Open and **continuous communication** is needed across the many players to build trust, assure mutual objectives, and create common motivation.
5. A **backbone organisation**(s) with staff and specific set of skills to serve the entire initiative and coordinate participating organisations and agencies. (Kania & Kramer, 2011)

*Kania, J &Kramer, M (2011): *Collective Impact* in *Stanford Social Innovation Review*. Leland Stanford Jr. University