mhcc
mental health coordinating council

Inquiry into Equity, Accessibility and Appropriate Delivery of Outpatient and Community Mental Health Care in NSW

14 November 2023

RESPONSES TO QUESTIONS ON-NOTICE

1	Workforce Survey Report	**Mental Health Coordinating Council (MHCC)** Please see attached. Please note this document is embargoed until Minister Jackson launches it on the 16 November 2023. https://mhcc.org.au/wp-content/uploads/2023/11/Mental-Health-Workforce-Profile_2023_WEB.pdf
2	YES-CMO Annual Report	**Mental Health Coordinating Council (MHCC)** Please note the report will be available early December and MHCC will forward a copy once available.
3	MHCC LD Training & Professional Development	**Mental Health Coordinating Council (MHCC LD)** Please see attachment concerning questions: 1. What the current arrangements are around the scholarships? How many we get, from whom and how much we receive? 2. The current cost we advertise for the program without a scholarship. 3. Future cost of delivering the program (reflecting ABC (Actual Based Costing))
3	Mental Health Carers Training	**Mental Health Carers NSW** https://www.mentalhealthcarersnsw.org/learn/training-and-education/ Courses Purposeful Storytelling Carers & Advocacy: Foundations Healthy Boundaries The Caring Journey Navigating Carer Support Systems Recovery Oriented Practice Inclusive Care Planning User's Guide to the NSW Mental Health System **Roses in the Ocean** Suicide prevention peer working training for carers https://rosesintheocean.com.au/co-designing-suicide-prevention-peer-working-training-for-carers/

		Living Works More generalised training for school counsellors and the community: Free suicide prevention training developed by LivingWorks | LivingWorks **Agency for Clinical Intervention** The suicide care pathway is meant to be for all and to cover support for people working in mental health services more generally: NSW Health suicide care pathway | Agency for Clinical Innovation
4	CTO Research Papers	Brophy, L, Edan, V Kisely, S Lawn, S, Light, E, Maylea, C Newton-Howes, G Ryan, C J Weller, PJ & Zirnsakegal T-M et al., 2021, *The Urgent Need to Review the use of CTOs and compliance with the UNCRPD across Australian Jurisdictions, [International Journal of Mental Health and Capacity Law.* Available: https://journals.northumbria.ac.uk/index.php/ijmhcl/article/download/1232 Te Hiringa Tiarnua: Mental Health Commission NZ, 2023, *Lived experience of compulsory treatment Orders Report*. https://www.mhwc.govt.nz/news-and-resources/lived-experiences-of-cctos-report/ Edwina M. Light A J, Michael D. Robertson A, Philip Boyce B, Terry Carney C, , Alan Rosen D E, Michelle Cleary F, Glenn E. Hunt G, Nick O'Connor H I, Christopher J. Ryan A B and Ian H. Kerridge A, 2016, *How shortcomings in the mental health system affect the use of involuntary community treatment orders*. https://www.publish.csiro.au/ah/Fulltext/ah16074 Robertson M, Light E, Boyce P, Carney T, Rosen A Cleary M, Hunt G, O'Connor N, Ryan C., 2013, *Community treatment orders: the lived experience of consumers and carers in NSW,* Centre for Values, Ethics and the Law in Medicine, University of Sydney. Funded by: Mental Health, Drug and Alcohol Office (MHDAO), NSW Health. https://ses.library.usyd.edu.au/bitstream/handle/2123/14913/report-community-treatment-orders-2013.pdf?sequence=1&isAllowed=y
4	Services that transitioned to the NDIS – The missing middle	Hancock, N., Gye, B., Digolis, C., Smith-Merry, J., Borilovic, J. & De Vries, J. (2019). *Commonwealth Mental Health Programs Monitoring Project: Tracking transitions of people from PIR, PHaMs and D2DL into the NDIS. Final report.* The University of Sydney & Community Mental Health Australia, Sydney. Microsoft Word - CMHA and University of Sydney NDIS Transitions Final Report September 2019 (apo.org.au) *Missing Middle: Research Reports, 2019, Identifying why people slip through the gaps or do not receive the mental health care they need,* Missing Middle Research Reports | Lived Experience Australia

5	Backfill issues whilst staff undergo training	Community Mental Health Workforce Project, 2021, Queensland Alliance https://www.qamh.org.au/wp-content/uploads/Community-Mental-Health-Workforce-Report.pdf
6	Step-Up / Step Down Service evaluation	*Prevention and Recovery Care Services (PARCS) evaluation* *NHMRC Partnership Project: Building the evidence base of Prevention and Recovery Care Services* https://www.neaminational.org.au/what-we-do/research-and-evaluation/projects/prevention-and-recovery-care-services-parcs/ Justine Fletcher, Brophy, L, Killaspy, H, Ennals, P, Hamilton B, Collister, L, Hall, L, Harvey C, 2019, *Prevention and Recovery Care Services in Australia: Describing the Role and Function of Sub-Acute Recovery-Based Residential Mental Health Services in Victoria.* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6824184/ John Farhall, Lisa Brophy, John Reece, Holly Tibble, Long Khanh Dao Le, Cathrine Mihalopoulos, Justine Fletcher, Carol Harvey, Emma Morrisroe, Richard Newton, Georgina Sutherland, Matthew J. Spittal, Graham Meadows, Ruth Vine, Jane Pirkis, 2021, *Outcomes of Victorian Prevention and Recovery Care Services: A matched pairs comparison.* https://research.monash.edu/en/publications/outcomes-of-victorian-prevention-and-recovery-care-services-a-mat See 2 attached documents from ICLA re Parc service in NSW

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Inquiry into the equity, accessibility and appropriate delivery of outpatient and community mental health care in New South Wales – Post-hearing responses – 16 October 2023

1. What the current arrangements are around the scholarships? How many we get, from whom and how much we receive?

MHCC receives the following scholarships for the CHC43515 Certificate IV in Mental Health Peer Work qualification:

- From 1 July 2020 – 30 June 2023, MHCC received 100 CHC43515 Certificate IV in Mental Health Peer Work scholarships from the NSW Ministry of Health - $4,000 per student (some students are still continuing their studies from these scholarship positions)
- 100 scholarships from the NSW Mental Health Commission (1 July 2020 – 31 December 2024) - $3,500 per student (MHCC used to charge a $500 co-contribution fee to students; however, this was discontinued from 1 March 2023 due to receiving $1000 supplementary funding per student from the Commission, bringing price per student to $4,500)
- 10 scholarships from the Commonwealth Department of Health and Aged Care via the NSW Mental Health Commission (2 February 2023 – 31 December 2024) - $5,000 per student
- Cap of $231,500 from the Department of Education - Training Services NSW's Smart and Skilled program to be used for Cert IV qualifications – amount per student varies based on individual student circumstances; ranges from $4,900 - $6,190 plus up to 25% loading (student's with disabilities, welfare recipient, Aboriginal and/or Torres Strait Islander, long term unemployed, rural and regional locations)
- Unlimited cap for Cert IV Traineeships through the Department of Education - Training Services NSW's Smart and Skilled program

2. The current cost we advertise for the program without a scholarship.

- Current fee for service cost per student for 12-month online delivery is $5,500 (GST inclusive)
- MHCC's fees are currently being reviewed in light of new course materials and updates to course structure being released in 2024

3. Future cost of delivering the program (reflecting ABC (Actual Based Costing))

- Depending on delivery mode, this will be between $5,500 - $6,100 + GST

Mental Health
Commission
of New South Wales

Insights Report: The role of Peer Navigators

Final Report

August 2023

Acknowledgement of Country

The Mental Health Commission of NSW acknowledges the Traditional Custodians of the lands where we work and live. We celebrate the diversity of Aboriginal peoples and their ongoing cultures and connections to the lands and waters of NSW.

We pay our respects to Elders past, present and emerging and acknowledge the Aboriginal and Torres Strait Islander people that contributed to the development of this report.

We advise this resource may contain images, or names of deceased persons in photographs or historical content.

Lived Experience Acknowledgement

The Mental Health Commission of NSW also acknowledge people who have lived experience of mental health issues and distress, and the lived experience of their carers, families and kinship groups. The Commission is committed to amplifying the voices of all those with lived experience. We value and respect their wisdom and expertise, and the bravery it can take to speak up. Together we will work to ensure people’s right to live meaningful, healthy lives, free from stigma and discrimination.

Insights Report: The role of Peer Navigators

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nswmentalhealthcommission.com.au

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1

Overview and purpose of report

1. Overview and purpose of report

The Mental Health Commission of NSW (the Commission) extends its thanks to members of the Peer Navigation Project Advisory Group for their valuable guidance. Importantly, the Commission also recognises and appreciates the contribution of those involved in the project pilot sites; peer navigators, consumers, carers, staff and service providers.

1.1 Background

Between 2021-2023 the Mental Health Commission of NSW (the Commission) undertook the Peer Navigation Project. The project developed from consultations for Action 14 of the *Living Well in Focus 2020-2024: A strategic plan for community recovery, wellbeing and mental health in NSW*, which identified the need to improve referral pathways to connect individuals with the right services and supports to improve their outcomes.

The purpose of this project was to examine the potential role of peer navigators, who can draw upon their personal lived experience of mental health issues and connection to communities and familiarity with local services, to help individuals access the right care and supports. To explore, test and evaluate the concept of peer navigation, the Commission collaborated with individuals who have personal lived experience of mental health issues, their families, carers and kin, as well as representatives from the mental health and human services sectors.

The primary objective of the first phase of the project was to explore the value of peer navigation to strengthen connection at the intersections between mental and physical health and other human services with a mix of informal, community, social service, cultural and clinical supports. An Insights Report, available on the Commission's website, documents the extensive discussions and workshops held with participants, and outlines the preliminary findings of the first phase of this project.

Exploring the value of peer navigation demonstrated its importance in:

- Building capacity to navigate service systems and advocate for coordinated and integrated care and supports for individuals
- Having a peer worker provide non-clinical support to people experiencing mental health issues and supporting them to navigate the service system
- Integrating social connection within mental health care
- Addressing the broader social determinants of health and factors that could contribute to mental ill health (such as homelessness or not having a regular general practitioner), and
- Supporting service systems where there is a workforce shortage and/or high workload of mental health clinical staff, such as regional and rural areas of NSW.

The main objective of the project's second phase was to examine the potential role of peer navigators and test the model with several communities and organisations across NSW. This report summarises the findings from the four pilot sites that trialled the peer navigation model between 2021-2023.

1.2 Overview of phase two

The core components of phase two of the Peer Navigation Project were to:

1. Develop and test peer navigation roles for priority population groups through four pilot sites (see table below), and
2. Develop specific training for peer workers around system navigation through the addition of a peer navigation unit for the Certificate IV in Mental Health Peer Work.

Table 1. The four peer navigation pilot sites.

Organisation/agency	Focus
Western NSW Local Health District (Western NSW LHD)	Individuals living in rural and isolated communities in NSW
Marathon Health	Young Aboriginal women in rural NSW
ACON	Transgender people in NSW
South Eastern Sydney Local Health District (SESLHD)	People experiencing complex mental health issues in tertiary hospital settings

Findings from the four pilot sites show the adaptability and effectiveness of the peer navigator model within the mental health and related service systems. They also highlight the value of lived experience as fundamental to the success of the model.

For consumers, key benefits of peer navigators included feeling supported and empowered to understand and navigate a complex system, increased engagement and willingness to reach out for help, timely access to services that reflect their diversity and needs, and improved mental health and recovery outcomes.

For staff and providers, the visibility of the peer navigators, who were embedded in services, was central to understanding and valuing the peer navigator model. Education and training, including for peer navigators, was also essential. Other findings show that staff improved their knowledge of mental health and related services, and that peer navigators filled a gap in support and service provision, particularly in areas with limited clinical staff.

A challenge for pilot implementation was the short pilot timeframes, which affected onboarding and upskilling of peer navigators, and their capacity to build rapport with consumers prior to engaging in navigation work. Timeframes were further impacted by prolonged flooding in some of the pilot areas.

Role delineation and scope of practice was also a challenge, including where the level of support required by a consumer surpassed the role and ability of the peer navigator. At times, lack of services and resources available for referral created a barrier, particularly when consumers required immediate assistance such as with housing.

This report also summarises the second core component of the project to develop a nationally recognised unit on peer navigation for the mental health peer workforce undertaken by the Mental Health Coordinating Council (MHCC).

2

Key outcomes of phase two

2. Key outcomes of phase two

Key outcomes of the four pilot sites are summarised below.

Table 2. Key outcomes of the project.

Improvement in referral pathways and consumers and staff knowing how to navigate the service system	— Consumers felt supported and empowered in navigating the often complicated mental health and related service system — Consumers were more likely to engage with services with a peer worker walking alongside them and offering warm handovers and active follow up — Timely access to support was improved — Unsuitable referrals and missed appointments were reduced, leading to shorter waiting lists
Improved mental health and recovery outcomes, reduction in distress and willingness to seek help	— Many consumers reported feeling less alone, better understood and listened to — Many consumers reported a reduction in distress and use of alcohol or other drugs — Others reported a beneficial change in their attitude toward the mental health system and willingness to reach out for help — Consumers felt more empowered to take steps towards their personal recovery and healing
Improvement to the system and staff practice	— Staff and providers improved their knowledge of mental health and related services, particularly non-mental health staff — Peer navigators filled a gap in support and service provision, particularly in areas where clinical staff are limited (e.g. rural communities)
Improved understanding of, and access to, peer workers	— Embedding peer navigators into settings that may not traditionally employ peer workers (e.g. Emergency Departments) improved access to peer-led support — Visibility of peer navigators improved understanding and valuing of peer work to staff and communities, particularly in non-traditional settings — Training and support for staff, including the peer navigator, was crucial to embedding the role
Consumers saw increased access to services that reflected their diversity and needs	— Lived experience is an essential component of the success of the programs — Knowing the peer navigators have lived experience is helpful for consumer engagement and provides a unique depth of understanding, particularly where peer navigators are a member of the community they are supporting — The peer navigator model is adaptable for different services and can incorporate diverse experiences and intersectionality

3

Peer Navigation Pilot Site Evaluation Summaries

3. Peer Navigation Pilot Site Evaluation Summaries

Each pilot program was evaluated to determine the outcomes, opportunities and challenges of program implementation. Overall, the pilot programs had positive outcomes for consumers, carers and staff (including the peer navigators and their colleagues). Importantly, the pilot sites showed that the peer navigator roles filled a gap in service provision, particularly regarding navigating and connecting people with services, advocacy, mental health education, and peer support and recovery planning.

This proved beneficial in busy settings like emergency departments in Sydney as well as isolated communities in rural NSW. Additionally, gaps in culturally responsive and trauma-informed care were filled through the employment of Aboriginal Peer Navigators and Trans and Gender Diverse Peer Navigators.

Several of the pilot sites have explored ongoing employment opportunities for the peer navigators or have embedded peer navigation into mental health peer work roles and new services. Embedding peer navigation into mental health peer work roles will be supported by the Peer Navigation Unit being developed by the MHCC (due for completion in 2024).

Evaluations of each pilot site are summarised below.

3.1 Western NSW Peer Navigation Pilot Project

The Western NSW Peer Navigation Pilot Project aimed to support equitable access to mental health treatment and care for people in isolated rural communities via a peer navigation model. The project supported navigation of, and access to, mental health services with a peer navigator position established in each town (Warren and Coonabarabran).

The peer navigators supported people to navigate referral processes for timely engagement, by establishing links and rapport with service providers. Moreover, the peer navigators' familiarity with local services and processes contributed to supporting access to services. For example, a person was assisted to visit a bulk billing general practitioner (GP) in a neighbouring town, providing a solution that had both a fiscal benefit and was more suited to the person's needs.

The peer navigators established strong links with Western NSW LHD Mental Health Drug and Alcohol Services, ambulatory and inpatient services, community services, non-government psychosocial service providers and humanitarian services such as Rotary and the Warren Health Action Group.

3.1.1 Scope of the program

The Peer Navigation Project was established and implemented using co-design methodology with both peer navigators establishing strong links and a visible presence in the community.

In Coonabarabran, the Peer Navigator was based in the community health team and worked closely with the visiting Mental Health Clinician, Drug and Alcohol Worker and Aboriginal Health Worker.

The Peer Navigator provided in-reach to the emergency department and the hospital as needed. In Warren, the Peer Navigator worked closely with the Aboriginal Health Worker, GPs and the Warren Youth Group. The Peer Navigator was based at the Multi-Purpose Service (MPS) and also worked out of the GP surgery, Warren Youth Centre and the Residential Aged Care Unit.

The strength and success of the pilot project was the co-design approach, with each peer navigator working within their role to respond to the unique needs of the community. The visibility of the peer navigators in their communities allowed for referral processes to occur informally. Peer navigators reported receiving referrals from all areas of the community, as well as from colleagues and service providers.

3.1.2 Evaluation overview

A formal evaluation (Beck, Coote, Raftery, Sng, & Kelly, 2022) was prepared by researchers at the University of Wollongong, Western NSW LHD and The Peregrine Centre and is expected to be published. The evaluation was funded as part of The Peregrine Centre's Rural Mental Health Partnership with NSW Health. The qualitative study was designed to explore consumer, provider and peer navigator experiences of the pilot program. A sample of consumers (n=11), providers (n=5) and peer navigators (n=2) were interviewed.

A summary of the evaluation from the formal evaluation report is included below.

3.1.3 Client demographics and sessions provided

A total of 96 peer navigation sessions were provided during the 3 month evaluation, with 61.5% of these being unique presentations. Approximately 44% of participants identified as Aboriginal or Torres Strait Islander and just under 60% of participants identified as female. Most participants were aged 26-40 years with the next most prevalent age groups being 41-65 years and 18-25 years.

The majority of support provided was 1:1 peer support, with just under 10% of sessions primarily focusing on advocacy. Participants were supported to access psychologists and social supports most frequently, with GPs, community mental health teams and drug and alcohol services also common.

3.1.4 What were the outcomes and challenges?

Service providers, consumers, carers and community members reported easier and more streamlined access to services with support from the peer navigators. Additionally, it was reported that the peer navigators were able to motivate and encourage people to link with services or provide assistance to manage anxiety when accessing, or planning to access, support.

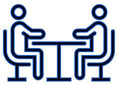
Participant feedback

Consumers, providers and peer navigators commonly reported that knowing the peer navigators had lived experience was helpful for consumer engagement and provided a unique depth of understanding (Beck, Coote, Raftery, Sng, & Kelly, 2022).

"I think she understands me a lot better."
- Tyler (20-29), Site 2

The evaluation found "this experience of 'mutual understanding' meant that consumers felt better able to share their experience without fear of being judged or dismissed. This was often contrasted

with the challenge of talking to providers who did not have lived experience" (Beck, Coote, Raftery, Sng, & Kelly, 2022, p. 9).



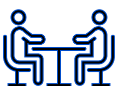
"They've been through it. They've lived it. And people warm to that. They seem to warm to that. And they know that they're not going to be judged."
- Vanessa, 50-59, Provider

The collaborative and flexible nature of the relationship was highlighted as a positive by providers and consumers alike, and consumers appreciated having the option of meeting in a more 'casual' setting like a café or at home (Beck, Coote, Raftery, Sng, & Kelly, 2022).

Consumers and providers both described how an active approach to contacting consumers helped overcome emotional and attitudinal barriers to accessing support. Consumers often contrasted the active follow-up demonstrated by the peer navigators with prior unhelpful experiences characterised by extended periods of waiting and uncertainty (Beck, Coote, Raftery, Sng, & Kelly, 2022, p. 11).

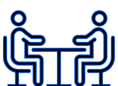
"It was a little bit difficult because even though I had gone to my GP and told them what was going on with myself, inside my own head, and stuff like that, they contacted and got referrals done for a counsellor. But then nothing really major happened. So, it took a while. And then when I got in contact with [navigator], yes, she speeded things along a lot quicker."
- Camila, 20-29, Site 2

The ease with which the peer navigators could be contacted was frequently raised by consumers and providers. Within the context of long wait lists, limited clinical services and time-poor clinicians, the availability of navigators meant that referrals could be made, and support offered sooner than would otherwise occur through traditional channels (Beck, Coote, Raftery, Sng, & Kelly, 2022, p. 12).



"It just might be that the community knows that [navigator] is at the library on a Tuesday at such-and-such. Do you know what I mean? It's easy. They're visible to the community."
- Maria, 50-59, Provider

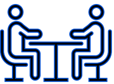
Providers also commented on how the number of inappropriate referrals had reduced, thereby reducing waitlists and administrative load (Beck, Coote, Raftery, Sng, & Kelly, 2022, p. 13).



"...been able to do referrals, have support with people that are linked with us. So that's stopped them reaching out through the triage, which means more paperwork, puts more of a load on us. It takes a load off us that way... It might not seem like it's much, but just the support that the people have been getting from them... They're taking a lot of the workload off us. And they're being a good support over there."
- Amanda, 40-49, Provider

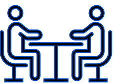
The evaluation found "many consumers also derived comfort from knowing that they could reach the peer navigators should they need to. Providers described how for some consumers, this brief contact with a navigator was enough to 'hold them over' to the next appointment, for others it afforded an opportunity to seek a referral or advice around appropriate services" (Beck, Coote, Raftery, Sng, & Kelly, 2022, p. 13).

"And if I want to talk, I can talk to her. It's just nice knowing that she's there when I need her."
- Kimberly, 40-49, Site 1



"...there's also this huge gap out here of psychologists and therapists, that are just either not available, long waiting lists, unaffordable. And sometimes all people need is just a bit of supportive therapeutic contact which people are able to get from a Peer Navigator."
- Amanda, 40-49, Provider

The emotional and practical support offered by peer navigators within the context of service utilisation was also raised. For example, some people found it helpful to have someone to talk to while waiting at the emergency department, while others appreciated having someone to walk them to and/or attend appointments with them (Beck, Coote, Raftery, Sng, & Kelly, 2022, p. 15). Providers noted a reduction in the number of missed appointments since the pilot began and benefits of having a peer navigator attend appointments with clients.



"...they're waiting for a mental health assessment from the video team in Orange, or whatever that is, they've been able to sit there with them and support them through that. That's invaluable..."
- Rachel, 20-29, Provider

Peer navigators played a crucial role in linking people to services, including mental health and other services like housing or employment. Many consumers did not know where to seek community-based mental health support while others had received referrals that had yet to be actioned or could not afford the providers and needed an alternative (Beck, Coote, Raftery, Sng, & Kelly, 2022). Similarly, providers appreciated having a local point of contact with extensive knowledge of the local service system to seek advice or make a referral.

All consumers reported that contact with the peer navigators contributed to improvements in their mental health and motivation to manage their mental health, with many reporting a reduction in distress and use of alcohol or other drugs. Others reported a beneficial change in their attitude toward the mental health system and willingness to reach out for help and talk about their experiences (Beck, Coote, Raftery, Sng, & Kelly, 2022).

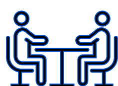
Peer Navigator experience

A structure of support was established to ensure the Peer Navigators were connected to clinical teams and supports although working remotely and often independently. Weekly check-in meetings were held with the Peer Workforce Coordinator, monthly review meetings with the Team Leader and regular clinical support from the Mental Health Drug and Alcohol Clinical team. The provision of a structure of professional development, support and supervision with the aim to grow the rural workforce was applied, with both peer navigators extending their contracts for another six months.

Both peer navigators described the importance of ensuring that the scope and boundaries of the role were made explicit to consumers and services. In some instances, uncertainty about the role scope led to consumers and providers making requests of the peer navigators that were 'out of scope'. Although both were comfortable and willing to assert their boundaries, this was often experienced as 'tricky' within the context of limited access to clinical support (Beck, Coote, Raftery, Sng, & Kelly, 2022, p. 21).

"It can be tricky at times, but I've just learnt that I don't overstep my boundaries, and I make it clear where my boundaries lie in that first initial meeting."
- Laura, Peer Navigator

The importance of ongoing training and support was raised, and some providers spoke of the potential to 'upskill' the peer navigators.



"I think making sure that they've got an opportunity to access education, and maybe then upskilling. I mean a lot of them have very valuable skills but just not had opportunity, maybe to sort of look for more training."
- Amanda, 40-49, Provider

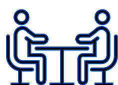
Opportunities and challenges with implementation

Local and prolonged flooding impacted on service provision in both towns, with Warren at times completely and repeatedly isolated. The presence of the Peer Navigator in the town supported ongoing connection to services who visit the town from major centres.

Rural communities cited the loss of services and supports and a reluctance or inability to travel to larger towns to seek support. The presence of the Peer Navigator regularly supported access to remote services, in particular mental health clinical services, when the clinician was prohibited from travelling due to environmental factors.

Challenges and considerations pertained to the positioning of the navigators within the broader health care system, their scope of practice, the impermanence of this valued source of support and suggestions for improvement (Beck, Coote, Raftery, Sng, & Kelly, 2022).

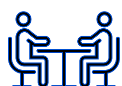
One consideration consistently raised by providers was the importance of embedding navigators within a service. This meant that peer navigators had access to the infrastructure and support required to perform their role. Embedding the peer navigators also increased their visibility to providers (Beck, Coote, Raftery, Sng, & Kelly, 2022).



"And they've got the clinical governance if they need it. They've got escalation pathways. They've got all that stuff in place."
- Eric, >60, Provider

Suggestions for improvement typically focused on expanding the service. Both consumers and providers wanted more promotion of the service and more peer navigators to be available. Some consumers suggested expanding the role to provide group programs or outings would improve community connection and opportunities for peer support.

“I think there need to be a lot more peer workers. I understand that job wouldn’t be easy, but they do help. And, like I said, it’s been one of the best things that’s helped me, is to have that extra support.”
- Camila, 20-29, Site 2



“I think it’s a resource we could use more of. I think it’d be good to have one in every town.”
- Eric, >60, Provider

The evaluation highlighted considerations for team-based implementation using a co-design approach: “Importantly, aligned with the flexible, needs-driven approach adopted in the current evaluation, the study sites differed in their approach to team-based implementation. For one navigator, this meant spending part of her time co-located within a clinical team. For another navigator, remote access to a clinical team and relationship building within the local community were more strongly emphasised. The co-design of peer navigator programs is central to ensuring alignment between the structure of the program and the needs and infrastructure of the local community. It does however complicate evaluation and dissemination” (Beck, Coote, Raftery, Sng, & Kelly, 2022, p. 26).

Similarly, concordance between central features of these roles with other peer worker positions was found, although clear role delineation was complicated by the flexible and co-designed nature of the pilot programs in each community.

The evaluation found peer navigators provided continuity of care between appointments with clinicians and could be utilised in lieu of clinical staff as the first point of contact within rural communities. This could partially address resourcing challenges experienced by remote communities and may help with the economic viability of the initiative (Beck, Coote, Raftery, Sng, & Kelly, 2022).

Training and ongoing professional development are essential to support implementation. Services that are considering employing a peer navigator need to ensure that policies and procedures support ongoing mentoring and development. Integration of the peer navigator into multidisciplinary teams is improved through preparing the organisation for the new role and staff training (Beck, Coote, Raftery, Sng, & Kelly, 2022).

Conclusion

The pilot has been successful in establishing peer navigator roles in two rural communities. In addition to identifying how peer navigators can contribute to the overall wellbeing of the community through navigating and supporting access to care, the Peer Navigation pilot has identified how a service gap of employing and retaining clinical staff can be ameliorated.

Feedback from consumers, providers and peer navigators highlighted the benefits of peer navigators for enhancing consumer engagement through an active approach, facilitating timely access to support and empowering consumers: “Peer navigators may offer a dynamic, engaging solution for helping to address the many health disparities faced by people living in rural communities.” (Beck, Coote, Raftery, Sng, & Kelly, 2022, p. 30).

The Peer Navigation Pilot Project in Western NSW was extended until June 2023 and Western NSW LHD has since funded the program permanently.

3.2 Marathon Health Peer Navigation Pilot Project

The program operated from March-December 2022 in Condobolin, NSW. Warrugarra (Wiradjuri language for *Home*) aimed to support disadvantaged girls and young First Nations women aged 16 to 35 to access mental health and wellbeing programs and community-based social supports. An Aboriginal Peer Navigator was employed to ensure culturally appropriate services and provide relatable support and mentoring – building people's self-confidence and knowledge and removing barriers hampering their recovery journey.

3.2.1 Scope of the program

The scope of Warrugarra was to support up to 20 women within the program's funded period. There was also a focus on determining the benefits of the peer navigation program and its ability to support the Aboriginal Peer Navigator to develop their leadership skills and confidence. For this program, the Aboriginal Peer Navigator was:

- A paid employee of Marathon Health
- Employed on a part-time contract at 53 hours per fortnight
- A local resident of Condobolin with no formal training prior to being employed in this position
- Identified as having a lived experience of mental health issues
- A past client of the Condobolin Wiradjuri Wellness Project.

This position and pilot program, although a stand-alone service, was embedded in the existing Condobolin Wiradjuri Wellness Project and co-located at the Condobolin Marathon Health office.

3.2.2 Evaluation overview

Support was provided to program staff to evaluate the program during and after delivery – with the aim to understand how Warrugarra impacted both participants and the Peer Navigator.

The evaluation used a mixed quantitative and qualitative design. Four outcome measures were used to collect data on participants' wellbeing, goal setting and progress towards goals, and overall satisfaction through the pilot period.

Measures included Goal Attainment Scaling (GAS), the Modified K5 for Aboriginal and Torres Strait Islander peoples, Personal Wellbeing index and consumer satisfaction surveying. These were applied at regular intervals, including initial and in three-month intervals or on exit from the program. Qualitative data was also obtained from the staff and participants through semi-structured interviews and staff reflective journaling.

3.2.3 Client demographics and sessions provided

There were 15 First Nations young women supported through the pilot period. The average age was 24.7 years which included six participants in the 16-18 aged cohort, and nine ranging from 20-29.

Six participants (40%) were supported through most of the pilot program, with a successful and planned transition to another service. Support included goal planning, engagement in service navigation and relevant referrals.

Four participants (27%) were supported with initial meetings with the Peer Navigator and guided with navigation to relevant services and education, before exiting to appropriate pathways.

Five participants (33%) accessed group-based events and education sessions. The Peer Navigator provided mental health and social and emotional wellbeing resources and information on available services.

Overall, there were 80 individual occasions of service with participants, including the facilitation of 30 referrals to external services. This translated to an average of 7.5 occasions of service, with an

average of 2.2 referrals for program participants. This reflects pleasing engagement and interest in the program.

3.2.4 What were the outcomes and challenges?

Participant feedback

Feedback surveys were provided to all participants and eight surveys were completed. Levels of satisfaction were high and 100% of respondents agreed with the following statements:

- I felt listened to and my needs were understood
- I was supported in making choices about the service I received
- I was helped with issues that were important to me
- I was helped to build my self-esteem and confidence
- I would be happy to recommend the service to others.

Participant improvements were high, with 100% agreeing or strongly agreeing that their ability to understand and better manage their mental health and wellbeing had improved.

Goal Attainment Scaling

Goal Attainment Scaling (GAS) was used throughout the program to measure success in achieving participants' identified goals. Goals were divided into the categories of:

- Vocation and education
- Linking to social and emotional wellbeing/mental health services
- Self-confidence and empowerment
- Social skill development
- Housing.

Six of the 15 program participants provided data on this measure on entering and review/exit of the program. All had links to relevant services included as a goal within their personal support plan with the Peer Navigator. Service linkages included connections to:

- Acute mental health services
- Community mental health services (both locally and outside of Condobolin)
- Local group-based cultural programs
- Services to support with birth certificates and license documents
- Generalist counselling
- Social and emotional wellbeing programs.

On average there was an improvement score across this data set meaning, on average, participants felt they had achieved their set goals at a rate 16.7% higher than they had expected.

Every participant who completed initial and exit GAS achieved their goals with higher-than-expected improvements to social isolation, their sense of community wellbeing, and overall self-confidence.

"This program helped me to build social skills."
- Participant

Modified K5 (MK-K5)

Six of 15 (40%) program participants completed initial and follow-up screenings with the modified K5 which measured for depression and anxiety. If a participant had a score which indicated they may be experiencing depression and anxiety, they were referred for further support from a clinician in addition to peer navigation.

Almost all participants (5 out of 6) who completed the MK-K5 required further mental health support from a clinician. On repeat application of the MK-K5, three participants self-reported improvements, two stayed the same, and one increased in need for further mental health investigation.

Personal Wellbeing Index

Six of 15 (40%) program participants completed an initial and final Personal Wellbeing Index (PWI) screening. The PWI measures seven core domains to assess participant satisfaction and wellbeing. Domains include relationships, achieving in life, standard of living, health, community connectedness, personal safety and future security.

There were no significant changes in wellbeing from initial to secondary screening. Overall, the mean of the initial and follow up values out of 100 was 50.48. This is considerably lower than the NSW average in 2021 of 75.10.

Peer Navigator experience and feedback

This pilot considered the support and professional development needs of the Peer Navigator. The Peer Navigator is a local Condobolin-based First Nations woman who had been a participant of the Condobolin Wiradjuri Wellness Project, and particularly the SHINE Women's Group.

The Peer Navigator experienced positive outcomes from their time in the role. There was a significant increase in confidence, leadership and understanding of the role as a Peer Navigator. This role was embedded with numerous support mechanisms including operational support, extensive training and mentoring from a peer leader (over 20 hours) that optimised opportunities for success.

More than 60 hours of training was provided, including training tailored for peer workers as well as organisational and governance training, DV Alert, De-Escalation, Safeguarding and Child Protection, Calm Care and Suicide Awareness training.

"My time started by learning the Marathon Health system and completing Peer Work training. I was lucky enough to meet fellow Peer Workers and develop a connection. Marathon Health offered ongoing professional development internally, which was awesome. I really took a lot out of all the training, and this played a massive part in my growth... Reflecting on these highlights along the journey has made me realise how much I have grown. From someone with lived experience in mental health and recovery, who had little to no confidence, I have grown immensely, learning the power of using your lived experience to support others who are on their own recovery journey has been so empowering for me... I will be forever grateful for the opportunity I was given by Marathon Health, as my time here has been life changing."
– Peer Navigator

Mentoring for the Peer Navigator was seen as an important component of the success of the program. The Peer Navigator stressed the importance of having someone external to the team to reflect with, and connect to, as they learned the role and built confidence. Mentorship also allowed

for access to a broader peer worker team and community. This was important to reduce isolation, especially for a Peer Navigator who was operating alone and was geographically disconnected to other peer workers.

Since completion of the pilot, the Peer Navigator has continued to study the Cert IV in Community Services with plans to continue employment in the local community. Ongoing employment options are being considered by Marathon Health.

Strengths and challenges of implementation

Timeframes were highlighted as a challenge for the program, particularly the short-term nature of the pilot (12 months). Marathon Health staff felt that increased time to connect and engage in culturally appropriate ways was essential before diving into outcome-based deliverable work. It was noted that the short pilot timeframe was detrimental to a community such as Condobolin, where services may be seen to "come and go".

"This program has helped me to express my feelings and to help me relax, I wish the program was for longer."
- Participant

Unfortunately, this was further impacted by the Condobolin community experiencing flooding during the pilot. This affected both service delivery and face-to-face mentoring sessions for the Peer Navigator.

Through the pilot, the cohort of participants that connected with the Peer Navigator were often determined to be in a state of crisis. The Peer Navigator highlighted that she felt mental health navigation was "not high on their list," and at times she felt that they needed help that was beyond "the scope of her role".

A clear theme within this cohort of participants was that the level of support required at times surpassed the role and ability of the Peer Navigator. As predicted, it was favourable that this role was embedded within existing services, as it allowed for successful referral pathways and escalation of support needs to other team members.

"The Peer Navigator helped me feel welcome and comfortable. I felt heard and listened to and I got regular check ins and phone calls, it felt relaxed. I was also supported by my case worker at Marathon Health and attended the women's group SHINE. I was referred to NewAccess, a phone service within Marathon Health, and they were great and really supportive. They allowed me to talk and listened to me which helped a lot. They also called regularly to check in on me, which really made me think they cared and listened to me."
- Participant

The team environment was seen as pivotal and played a large role in the Peer Navigator's experience. Therefore, key factors for success include a team with a willingness to learn and understand the role of the Peer Navigator, communication, compassion and strong leadership.

Given that the concept of a Peer Navigator was new in the community, opportunities for increased education and communication with the community about the role and function of peer navigation would have been advantageous. There was also a push for increased focus on group activities and

community engagement, and the ability to gain more organic referrals was highlighted as being connected to issues with the program timeframe.

"I would recommend this program to others, and I have already... There needs to be more programs like this, and it needs to be for longer."
- Participant

This approach would support a culturally appropriate pathway, and one that requires more time and resourcing. A peer navigation participant highlighted the importance of this approach being non-clinical:

"It supported me to make changes and was different than other services, more relaxed, not so clinical and more about me and my needs."
- Participant

As previously mentioned, mentoring and connecting with other peer workers was seen as an important component of this program. The mentor highlighted that based on the context of the position and the team, more mentoring (e.g. fortnightly) and more face-to-face contact with the Peer Navigator would have been favourable.

The Peer Navigator's lived experience was important in this model and their experiences and skills also benefitted from additional training. A staged approach to support the Peer Navigator to step into the role would be a consideration for future programs. Prior training or exposure to peer work would have been ideal, especially in pilot projects where there are limited timeframes for service delivery. There was extensive initial training, and this combined with starting a new role was at times overwhelming for the Peer Navigator.

A challenge with the program was engaging the 16-18yr old age group without withdrawing them from school and impacting their attendance. Through consultation with the high school, the Peer Navigator was able to deliver a wellbeing program inside the school with young girls who were identified by school staff as needing the support. This was a wonderful achievement for the program and was a creative and successful approach.

"I really like it; it has helped me both in and out of school. It would be good to have more of it." – Participant

Conclusion

The pilot successfully enabled access to needed ongoing support for young Aboriginal women, facilitating over 30 referrals to services such as acute mental health, psychosocial supports and mental health coaching. This program successfully allowed the delivery of integrated support with other service provisions within the Condobolin community.

The Peer Navigator was able to identify and resolve barriers to service access, and to improve health and help seeking behaviours. The Peer Navigator enabled participants to access support in navigating a highly complex mental health and community services system, in ways that were culturally safe and empowering.

Culture plays a crucial role in resilience and mental wellbeing, especially for First Nations communities. Timeframes that enable a deeper connection with community and an opportunity to build trust and rapport and support larger evaluation data sets are recommended.

3.3 P4T Trans Peer Navigator Pilot Program - ACON

P4T was a pilot trans peer navigation program designed to provide peer support to trans and gender diverse (henceforth trans) adults living in NSW. The program centred trans self-determination, autonomy, and agency.

ACON ran the pilot from May 2021 to October 2022. The service was peer-led and community co-designed over six months. This included extensive consultations and research by a team of three part-time trans staff. In December 2021, four additional staff were hired, bringing the team to six peer navigators and one project coordinator. All staff were peers, including trans women, trans men, and non-binary people, with two Aboriginal trans staff members.

3.3.1 What is a Trans Peer Navigator?

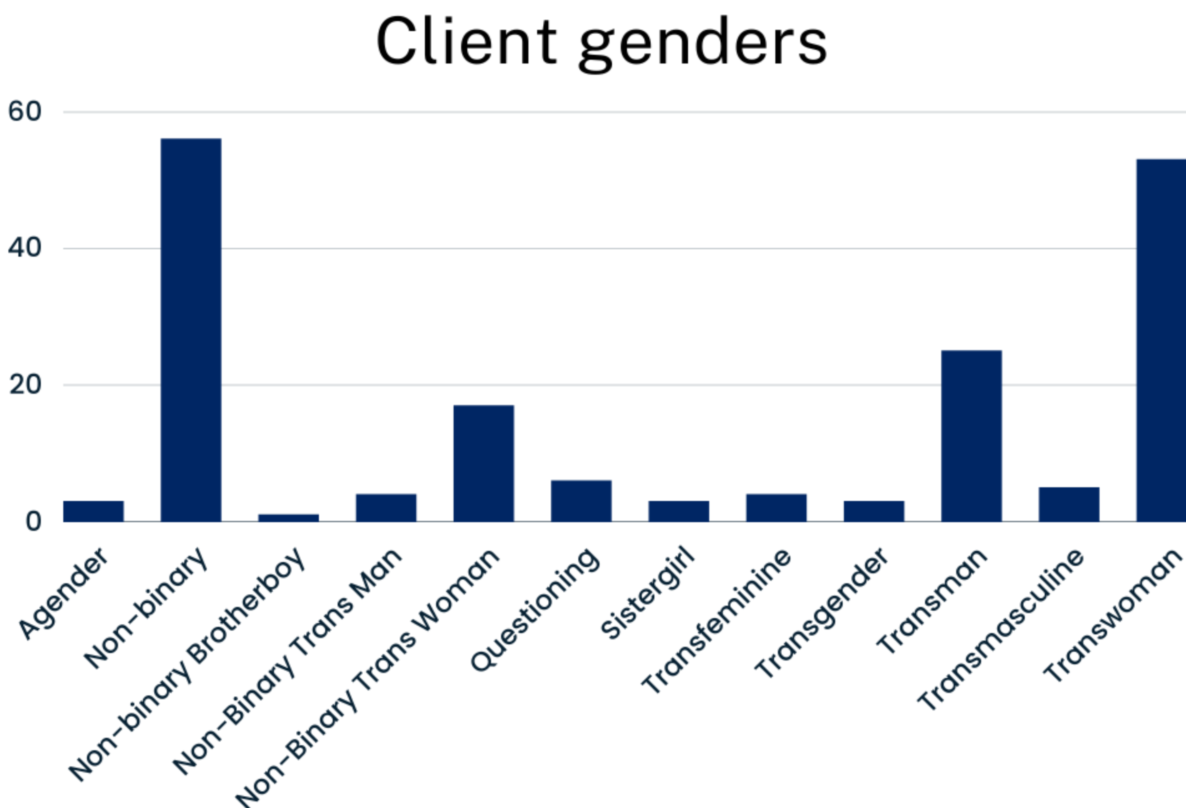
Trans peer navigation is a role bridging advocacy, referral and informal support between people with a trans lived experience. All of the peer navigators in this pilot also had a lived experience of mental health issues.

The role is focused on supporting trans people to improve access to resources and information for a wide range of health and personal needs including medical, legal and social gender affirmation support, and housing and employment. Trans peer navigation is person-centred and peer navigators provide support to trans people using their lived experience. This role builds on the success of peer work roles in mental health and HIV+ communities, in addition to research that shows peer support constitutes a significant protective factor for trans health and other aspects of trans life (ACON, 2022).

3.3.2 Client demographics and sessions provided

Clients of P4T (including those who applied but were referred on) ranged in age from 18 to 65, with over a third (40.2%) being 18-25 and another third (35.5%) aged 26-35. 9.8% of clients were of Aboriginal and/or Torres Strait Islander descent, and over a quarter (27.2%) were living regionally at the time they participated in the program. The program provided services to people across the gender spectrum, with trans women and non-binary people being the most prominent genders represented.

Figure 1. Client genders



*Clients who listed any non-binary gender categories (e.g. genderqueer) were all listed as non-binary for clarity. Clients who ticked both categories such as "man" or "woman" as well as non-binary categories are listed as non-binary man/woman respectively.

Across the evaluation period of January-September 2022, the service saw 99 unique clients, with nearly one-third utilising all four allotted hourly sessions and some requiring further support. The sessions were provided online with a peer navigator which further assisted regional and rural participation in the program.

The most common presenting issues were medical affirmation, identity, mental health and wellbeing, connecting with trans communities, social affirmation and relationships. Housing, legal gender affirmation and domestic and family violence were also areas of significant concern.

Referrals to other services was a key role of the peer navigators, often requiring multiple referrals to support each participant holistically. The most common services referred to were GPs, psychologists and counsellors, and other ACON services like care coordination or HIV+ Peer Support.

3.3.3 Workplace structures to support implementation

Fortnightly external professional supervision was provided as an essential component of professional development. The project coordinator was also available during the service operation hours for support or advice after a session. If a particular issue or difficulty arose, the peer navigators found time to meet and work out a solution together. It was noted by the peer navigators that having a coordinator who they could debrief with and seek advice from was an important aspect of the workday.

Complexity of presenting issues meant the peer navigators were required to develop competency across many fields. Although some of the peer navigators had previously worked in community services, many were new to the sector and therefore had to significantly upskill in order to best

support the clients. Peer navigators upskilled in a variety of ways, but several stated that their most important tool in upskilling was by consulting with the other peer navigators. Sharing skills and information played a pivotal role in P4T's success.

3.3.4 What were the outcomes and challenges?

Of the clients who completed the post-service evaluation, feedback was largely positive, and showed a strong increase in ability to access support and gender-affirming services. Of the clients who completed the post-service evaluation, 80% rated the service 5 stars (the highest rating).

"Incredibly good service, made me feel comfortable and heard, not judged which is very uncommon. Feels great to be heard and understood by some[one] else."
- Participant

The service also significantly improved clients' confidence around navigating the service system. In the pre-service survey, 50.6% of clients said they agreed or strongly agreed with the statement "I am confident that I can access services I need", compared to 89.7% of clients in the post-service survey.

"Great at creating a safe, welcoming, and affirming environment. My peer mentor actively listened to me and made me feel supported, I felt like I could be completely honest with who I am and what I need because they got it too. They did their best to provide me with links and resources."
- Participant

Some clients also had little to no contact with other trans people prior to attending P4T and named the lived experience aspect of the program as vital to the service. The clients interviewed stated that they found the peer navigators to be knowledgeable, hands-on and enthusiastic. The P4T's unique position as a peer-led service was both what attracted them to the service and what helped them to achieve their goals.

The peer navigators were required to share their lived experience in purposeful ways as part of their role. Though this was a complex position to uphold and maintain, several peer navigators stated that disclosing information at the right moment was a great way to build rapport, provide clients with new information or context, or to simply make a client feel like they are not alone in their experiences.

Some of the challenges and considerations identified in the evaluation included:

- A cap on available sessions per client meant that peer navigators commenced referral processes quite quickly when it may have been preferable for some clients to build more rapport first.
- Lack of services and resources available for referral, particularly long waiting lists. This was additionally challenging when clients required immediate assistance such as with housing.
- Peer navigators who worked remotely felt more isolated than peer navigators who worked alongside each other in an ACON office. This brought regional and rural perspectives to the peer team, however meant that some peer navigators had less opportunity to connect with fellow peer workers.

- Trans community members who have other intersectional or marginalised identities and experiences require further consideration before and during program implementation. The experience of peer workers from diverse backgrounds was integral to the success of the program with the organisation working to ensure appropriate structures were in place to support staff.

The lessons of this pilot were included in the development of ACON's new trans mental health service, comprising trans peer workers and trans care coordinator counsellors through ACON's Client Services. This service includes workers at ACON offices in the Hunter, Sydney and Lismore regions.

3.4 South Eastern Sydney Local Health District (SESLHD) Peer Navigator Pilot Program

This pilot involved recruiting a full-time mental health peer worker to provide support to consumers experiencing mental health concerns as they navigated the tertiary health system in SESLHD and discharge to primary health and community support services. The position was seen as a critical link for providing improved support navigating the system for consumers and their supporters at St George Hospital.

3.4.1 Scope of the program

The Peer Navigator worked alongside staff in the Emergency Department (ED), Psychiatric Emergency Care Centre (PECC) and Consultant Liaison Psychiatry (CLP) team, and on general wards, to provide information, education and support to people experiencing mental health concerns. The role also educated members of the multidisciplinary team about peer work, mental health and trauma-informed and recovery-oriented approaches to build their capacity to educate and support consumers.

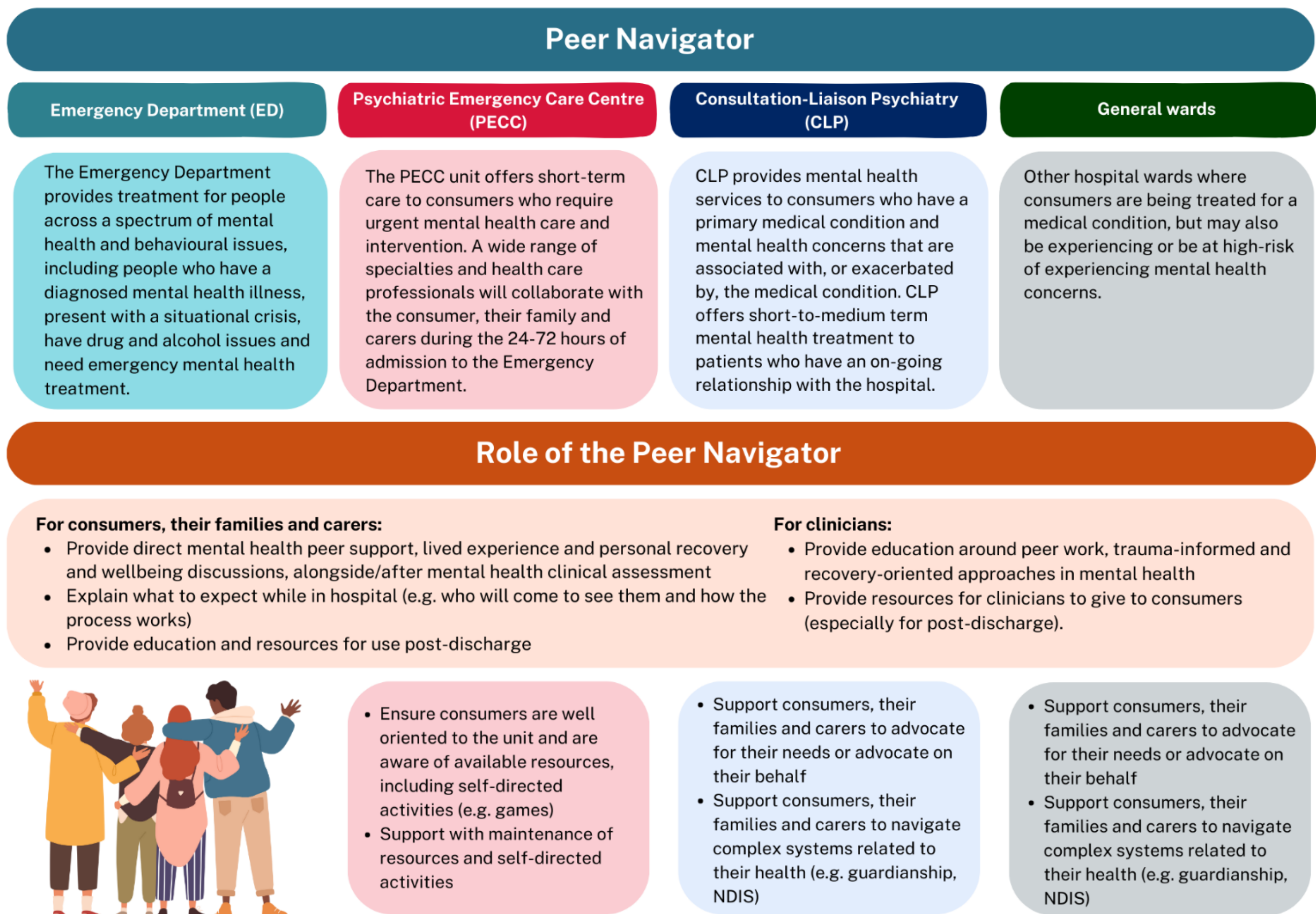
The Peer Navigator did this through direct mental health peer support and personal recovery and wellbeing discussions, support to orient people to the various hospital settings they were admitted to, and the provision of resources and education. The Peer Navigator also supported consumers to advocate for their needs or navigate complex systems related to their health (e.g. the NDIS). See Figure 3 below. Due to clinical governance structures, workload and large scope of the role, the Peer Navigator was unable to provide significant post discharge support.

The project aimed to create new insights into the viability and utility of a peer navigator role in settings where peer workers are less likely to be employed such as the ED, PECC and general wards of major tertiary hospitals.

The Peer Navigator interacted with the multi-disciplinary team in a variety of ways, including:

- providing resources
- updating other staff about the mental health status of consumers
- supporting staff to conduct initial assessments of consumers
- and clarifying and streamlining processes such as internal referrals.

Figure 1. Peer Navigator Model



3.4.2 Evaluation overview

The evaluation, conducted from February to December 2022 by ARTD Consultants, sought to:

- assess the implementation and reach of the Peer Navigator Pilot Project,
- understand the experiences of consumers and their support people accessing the Peer Navigator and the multidisciplinary team,
- and assess the extent to which the project was able to achieve its intended outcomes.

It draws on several data sources:

- administrative data about people supported by the service,
- a survey of, and interviews with, consumers supported by the Peer Navigator and members of the multidisciplinary team, and
- an interview with the Peer Navigator.

Overall, there was sufficient data to report on program implementation, reach, staff experiences, outcomes and key learnings. However, low response numbers from the consumer and carer survey mean findings should be seen as indicative rather than representative of people supported by the Peer Navigator. A summary of the evaluation from ARTD Consultants is provided below.

3.4.3 Client demographics and sessions provided

The Peer Navigator reached a total of 88 consumers experiencing mental health concerns through 207 sessions from 22 April to 31 October 2022. The Peer Navigator saw similar numbers of

consumers across the various settings in which they worked – 29 in the PECC unit, 26 in the ED and 34 on other wards.

The Peer Navigator supported a similar proportion of males (53%) and females (46%). Most (58%) ranged from 25 to 54 years of age, with the average consumer being 42 years of age. Consumers were predominantly born in Australia (73%).

3.4.4 What were the outcomes and challenges?

Consumer outcomes

Data suggests consumers and their support people who were connected to the Peer Navigator were highly satisfied with the information and support they received and had positive experiences. Almost all consumer survey respondents agreed that they were able to access the support in an easy and timely manner. Almost all were satisfied with the amount, accessibility and tailoring of the information and agreed they had received caring and compassionate support that made them feel respected, understood, listened to and like they could trust the Peer Navigator.

Data, while limited, suggests the Peer Navigator position is having positive outcomes for consumers and their support people. Most consumer survey respondents agreed that they:

- felt more empowered to take steps towards their personal recovery and healing
- had a better understanding of mental health services and supports and were more aware of how to access them
- felt less alone because of the support and information they received from the Peer Navigator.

Staff outcomes

Data suggests the Peer Navigator position achieved its intended outcomes and had positive impacts for the multidisciplinary team. Most staff survey respondents felt they:

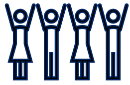
- were more knowledgeable about mental health services and supports in the community
- were better able to support people experiencing mental health concerns
- better understood the value and scope of mental health peer workers.

Most staff felt it was easy to work with the Peer Navigator, that they understood the Peer Navigator's role and how they're meant to work together, and that care was well coordinated for people. The role developed connections with, and raised awareness of, community supports and services and referred people to other programs such as the local Safe Haven.

According to all staff, the resources developed and distributed by the Peer Navigator, and time taken to talk through them, have been one of the most effective components of the project for both consumers and staff. The resources enabled consumers, their families and carers to understand supports and services that were available in the hospital and community, and were effective for educating non-mental health staff. In particular, they are:

- developed from a lived experience perspective
- accessible – simple information, structured logically, available in multiple formats (hard copy and electronic with QR codes linking to more information)
- categorised into topics so they can be tailored to individual needs
- developed in response to consumer needs.

Additional resources were developed as part of the program for use by staff to ensure the positive outcomes for staff and consumers continued if the role was not funded on an ongoing basis.

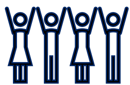


“I guess the focus [with peer workers], predominantly, it's been about how to support the consumer, which is 100% the right way to go. But what we found in this role, it's about empowering and educating and resourcing the clinicians, which I think [the Peer Navigator] has had such a strong focus because I guess when you work in a clinical environment for so long you almost get kind of like tunnel vision. You're not aware of what's outside your own space. [The role] has just brought so many resources, so much knowledge, so much awareness to everybody, and I guess everyone's been so grateful because it's really enhanced our capacity to give more to consumers, which is really important.”
- Staff interviewee

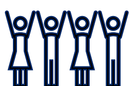
Improving knowledge of peer work and closing gaps in support

The Peer Navigator role was effective at filling key gaps in support:

- for people experiencing mental health concerns in fast-paced settings (e.g. the ED) where staff are time-poor
- for people who are experiencing mental health concerns on the wards, but haven’t been admitted for mental health issues
- from a peer lens in settings where this had previously not been available
- to understand and connect to community services post discharge.



“She's really been able to assist us in managing the person in the emergency department because obviously the emergency department's a busy place for somebody who's experiencing mental health distress. Having somebody that we can call on and say, “I really don't have the time to sit with this person. They're very distressed. I've done what I needed to do. Are you able to come and support them?” And she's always been able to come and do that.”
- Staff interviewee



“Because they’ve got lived experience with mental health conditions, and they have that extra training as well and know how to navigate that process, having them come in and do that work so that I’m not stepping outside the bounds of my role has been really useful.”
- Staff interviewee

Staff also saw the nature of the support provided by the Peer Navigator – that is, the lived experience, holistic approach to mental health and wellbeing – as unique and complementary to the clinical support they provided, and highly effective for consumers. They indicated that the peer lens allowed the Peer Navigator to build stronger connections with consumers through shared experience and overcome some consumers’ reservations with staff. Some also reported it enabled staff to better understand consumers’ needs and experiences.

According to staff, understanding of and connections to community mental health services is a big gap for many consumers once they leave hospital. The Peer Navigator played an important role in discharge planning by supporting consumers to understand and connect to community mental

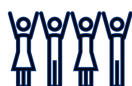
health supports, and by working with consumers to identify their goals and provide strategies for managing their mental health post discharge.

By proactively reaching out to key staff in the ED, PECC unit, CLP team and general wards, and sharing resources with departments at Sutherland Hospital, the Peer Navigator was able to build strong relationships and understanding of peer work and mental health throughout the hospital within a short timeframe. This was evidenced by all staff in relevant units knowing of the Peer Navigator, starting to embed the role in their teams and regularly calling on the Peer Navigator to support consumers they were caring for. According to staff, this was one of the most effective elements of the role and highlighted the lack of awareness of peer work and mental health among clinicians. As a consequence, their appetite to know more to better support consumers increased.

Implementation considerations and workplace supports

The embedding of the Peer Navigator was supported through the following practical strategies:

- daily handover meetings with other mental health staff
- providing the Peer Navigator with a pager so they could be notified if they were needed in the ED
- the Peer Navigator completing progress notes in the medical file to record support and resources provided to the consumer. This was critical to educating staff about resources and role-modelling recovery-oriented language, as well as increasing the visibility of the role to staff.



"When I've been providing support to people who are post ED or post admission, being able to read through the notes that the Peer Navigator has written about what resources have been provided and what the main issues were for that particular person is a really great snapshot for us knowing that somebody has already had those resources provided to them and we can then refer back to those and say, "Oh, you remember these resources that you were provided, how are you going with that stuff?"
– Staff interviewee

Challenges and learnings

Some of the challenges of the program included the short timeframe for the pilot which meant there was a limited amount of time to:

- scope the role and onboard the Peer Navigator
- establish relationships with the multidisciplinary team, and build their knowledge and awareness of peer work and mental health
- develop resources and determine referral pathways
- collect feedback from, and see outcomes for, consumers.

Being a new position in new clinical environments meant the Peer Navigator had to teach herself the clinical terminology (e.g. acronyms in progress notes) and processes for each hospital setting as the position rolled out. This proved to be a substantial amount of additional work on top of the role.

Supporting people post discharge was one of the more challenging components of the role. This is because a consumer must be connected to the Acute Care or Community Mental Health Teams (i.e. teams of clinicians whose remit is to provide post discharge support) for the Peer Navigator to support them post discharge in an effort to minimise the risk assumed by one person. This posed challenges because only consumers discharged from PECC or those who had a mental health

assessment in the ED are referred to the Acute Care Team. Implementation of this component of the peer navigator role is being further explored with the Acute Care Team.

Table 3: Enablers to Implementation

Enablers	
Qualities and qualifications of the Peer Navigator	The Peer Navigator was proactive, committed, had good communication skills and was resilient enough to cope if she was 'brushed off' by staff, which enabled her to reach key staff throughout the hospital and in community services to form relationships in the limited timeframe. She also had health-related qualifications, which meant she had existing knowledge and skills related to supporting people and was able to adapt faster to the hospital setting.
Mechanisms to coordinate care	Daily handover meetings, a pager for the Peer Navigator and case notes enabled the Peer Navigator to provide timely care that was well coordinated with consumers' clinical care. The case notes have also helped staff better understand what the person is experiencing, what they discussed with the Peer Navigator, and helped them provide recommendations for ongoing interactions with the consumer.
The resources	Enabled consumers and staff to learn about mental health and available supports and services both in the hospital and the community; assisted the Peer Navigator to empower staff to have conversations around mental health with consumers and provide consumers with resources – which was important for maximising reach and ensuring sustainability.
Staff attitudes	Staff embraced the role – they were open to working with the Peer Navigator and eager to learn more.
Support for the Peer Navigator	Management (some of whom had an existing relationship with the Peer Navigator) who were supportive of peer work and the role, and access to supervision, were essential for supporting the Peer Navigator in the role – particularly given it was a newly formed role. However, some staff indicated management needed to be more involved in introducing and explaining the role to the various units, wards and departments.
Filling gaps in support	By filling gaps in support, the role was widely embraced and seen as valuable.
Lived experience	The Peer Navigator was able to connect in a different way to consumers and provide support that complemented the clinical care they were receiving.

Table 4: Barriers to Implementation

Barriers	
Timeframe for pilot	Limited time to onboard the Peer Navigator, scope the role, build relationships and knowledge of the multidisciplinary team and develop resources. This potentially limits the sustainability of the role because more time is required to embed the knowledge and skills into the practice of clinicians.
Number of people in the role	Having only one person in the role limited its scope as it meant the Peer Navigator had to prioritise some settings and consumers over others.

Barriers	
Fast-paced nature of some settings	This can limit the amount and nature of support that can be provided because it limits the time available.
Lack of privacy in some settings	This can limit the nature of the support that can be provided because the Peer Navigator can only discuss what consumers are comfortable with others hearing.
Consumer readiness	Not all consumers who meet the criteria to be connected to the Peer Navigator are ready to talk about their mental health, therefore some are less likely to engage with the information and support provided by the Peer Navigator.
Clinical governance	Consumers must be connected to the Acute Care or Community Mental Health Teams (i.e. teams of clinicians whose remit is to provide post discharge support) for the Peer Navigator to connect with them post discharge in an effort to minimise the risk assumed by one person. This limits the number of consumers the Peer Navigator can connect with post discharge.

This evaluation identified several key learnings about the role of the Peer Navigator and other peer workers in mental health for SESLHD:

- The Peer Navigator is an important role that has positive outcomes for staff, and there is some evidence of its positive outcomes for consumers
- The role facilitates connections between staff within and between hospitals, consumers, families and carers, and community services
- There is a distinct lack of knowledge and awareness of peer work and approaches to supporting people experiencing mental health concerns among non-mental health hospital staff
- The role supports the development of the peer workforce
- The peer navigator role benefits from being filled by an experienced peer worker
- The ability to support people post discharge may strengthen outcomes for consumers experiencing mental health concerns and their support people
- Elements of the role could be embedded in the practice of clinicians and integrated into existing peer worker roles in a variety of settings.

4
Peer Navigation Unit Development

Peer Navigation Unit development

A Peer Navigation Unit of Competency is being developed by the Mental Health Coordinating Council (MHCC), in partnership with the Mental Health Commission of NSW, for inclusion in the CHC43515 Certificate IV in Mental Health Peer Work qualification.

The MHCC has worked closely with the NSW Community Services and Health Industry Training Advisory Body (CSH ITAB) and a range of stakeholders to gain a better understanding of peer navigation and the skills and knowledge that are required to perform this role. Key stakeholders included existing peer workers, peer navigators, peer managers and supervisors, community and public mental health services, and educators.

The information collected was used to form an initial outline of the skills and knowledge that exists, what role(s) are currently performed in peer navigation and by what types of workers. This helped to develop a focus group and advisory committee to further steer the unit development.

A Peer Navigation unit overview was developed between May 2022 and May 2023 and reviewed by the focus group and key stakeholders. The unit overview was finalised and submitted for approval to the Australian Skills Quality Authority (ASQA), with initial approval received. Final endorsement on the National Register of Vocational Education and Training (VET) is pending at time of publication.

The MHCC, in collaboration with the Mental Health Commission of NSW, will develop resources and training materials for Registered Training Organisations (RTOs) to rollout the nationally recognised Peer Navigation Unit in 2024.

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ICLA Independent Community Living Australia Everyday life changing

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REVIEW : THE PREVENTION AND RECOVERY CENTRE (PARC)

JULY 2022

CHLOE CLOGHER
PARC CNS

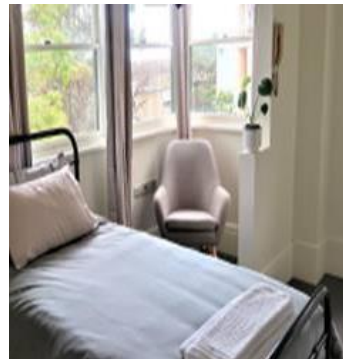
DANIELLA TAYLOR
SESLHD MHS, ACCESS AND PATHWAYS TO CARE LEAD

Bondi – Prevention and Recovery Centre (PARC)

The Bondi Prevention and Recovery Centre (PARC) Project is a partnership between SESLHD MHS and Independent Community Living Australia (ICLA)

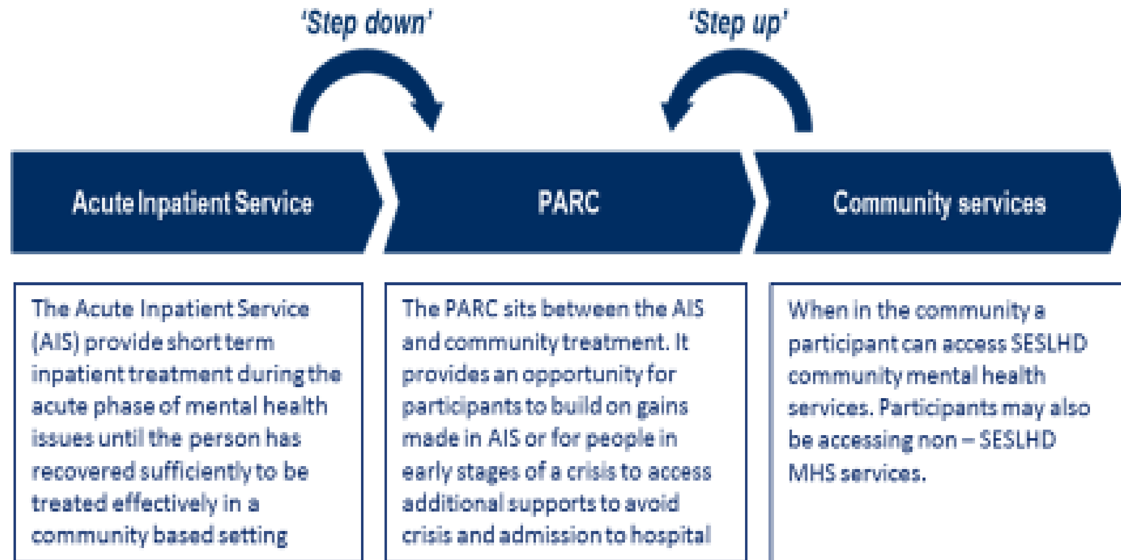
The model has 24 hour staffing 7 days per week and is based on a mixed staffing model with Support Workers, Peer Workers and Clinical staff. The site has had significant renovations in 2019, with 8 single bedrooms and is located in Bondi.

Website : ICLA - PARC



Safe - Person Centred Integrated Care

The program facilitates early intervention and recovery promotion to provide more intensive community support or avoid hospital admissions (step up), as well as providing residential support services following discharge from hospital (step down) under a least restrictive care and supportive environment arrangement



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Review Information:

- Time frame September 2020 to November 2021
- eMR data (Health)
- Salesforce (ICLA)
- Activity data included Emergency Department (ED) presentations and Mental Health (MH) admissions, pre PARC with post PARC over a 6 month period
- 60 occasions of service (across 45 Guests)
- 82% of people whom completed the program at PARC have had prior contact with either ED or MH Inpatient Units or both

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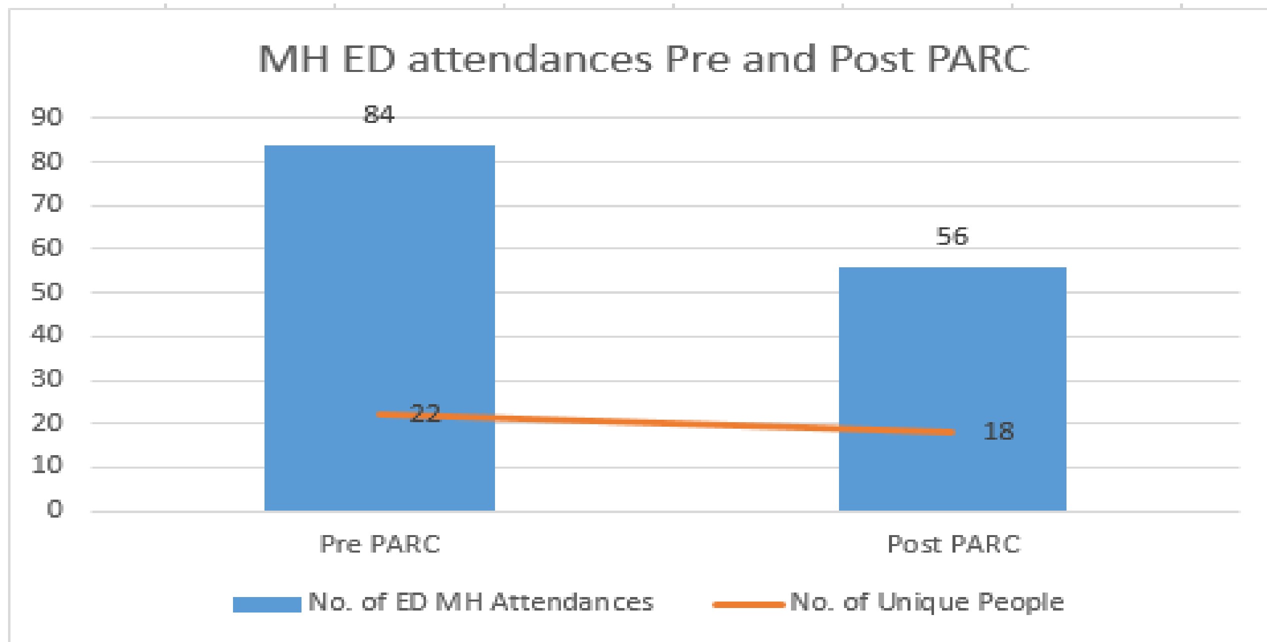
MH Emergency Data Analysis

Pre PARC ED visits = 84 ED MH attendances

Post PARC ED visits = 56 ED MH attendances



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MH ED attendances Pre and Post PARC

- **33% reduction in ED MH attendances (28 attendances)** when comparing pre and post PARC stay
- **38% (17 guests) have reduced the number of times they have presented to ED** when comparing pre and post PARC stay
- **80% (35 guests) presented to ED only x 1** or not at all post PARC stay
- **100% of the top 6 frequent presenters to ED** pre PARC reduced ED attendances post PARC

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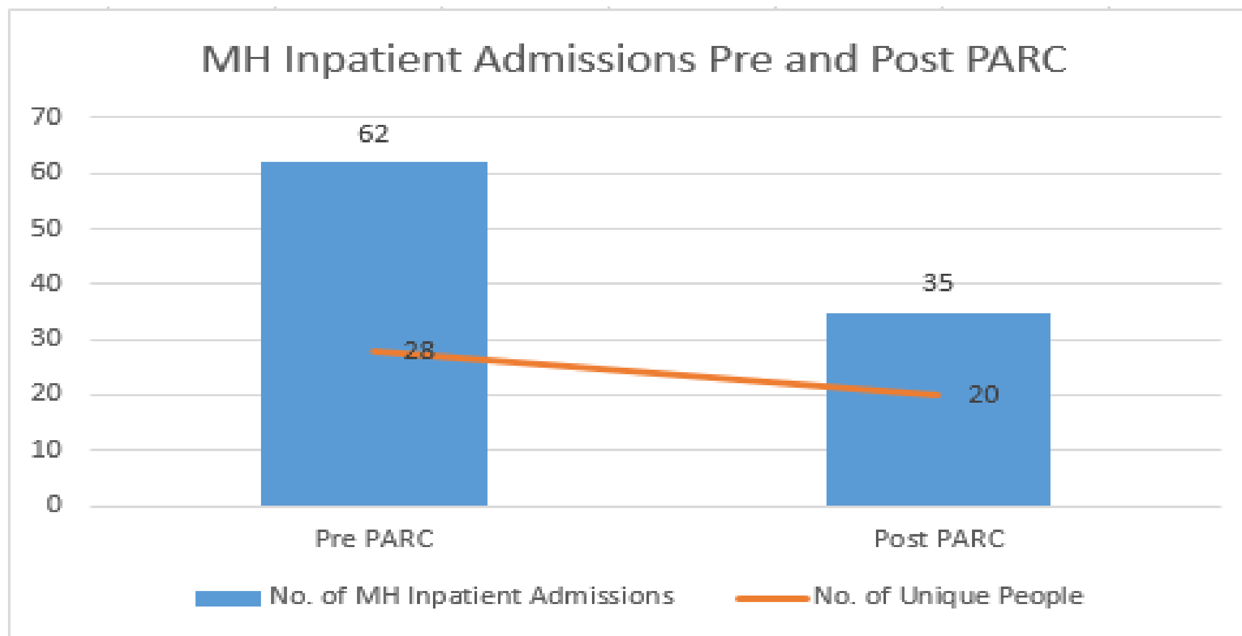
MH Admissions Data Analysis

Pre PARC MH admissions = 62 MH Admissions

Post PARC MH admissions = 35 MH Admissions



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MH Inpatient Admissions Pre and Post PARC

- **44% reduction in MH admissions** (27 admissions) when comparing pre and post PARC stay
- **29% (approximately 1 in 3 people)** of people whom had a MH admission prior to PARC did not have a MH admission at all post PARC

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Costings: PARC vs MH Inpatient stay

PARC Guest journey costings:

- 60 occasions of stays x 28 days = 1680 days
- 1680 days x $400 per day = **$672,000**

MH Inpatient Consumer journey costings:

- 60 occasions of stays x 28 days = 1680 days
- 1680 days x $1247 per day = **$2,094,960**

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Complex Needs Guests

2 - MH Inpatient Consumer journey's Pre PARC

- 412 days

2 - MH Inpatient Consumer journey's Post PARC

- 0 - both consumers have not returned

- Highlights PARC's ability support Guests with complex mental health issues
- Approximately 59% of Guests have a diagnosis of Schizophrenia or Schizoaffective Disorder

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Frequent Presenters to MH Units

1- MH Inpatient Consumer journey's Pre PARC

- 42 days (10 admissions)

1- MH Inpatient Consumer journey's Post PARC

- 7 days (2 admissions)

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Service Provision Highlights

- Finalization of a new consumer satisfaction survey
- Improvements to the consumer focused medication plan
- Updated intake assessment to include plans for each guest in the event of COVID-19 impacts during stay
- Commencement of work to create a sensory room
- Contracting of a videographer to produce a short “What to expect at PARC?” video for promotion and referral purposes
- 2021 Nomination for SESLHD ‘Collaborative Staff Member of the Year’ (PARC CNS2)
- 2021 SESLHD Highly Commended Award winner for ‘Integrated Value Based Care Team’
- 2022 Premiers Award submission for ‘Putting Citizens at the Centre’

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Guest / Carer Feedback

Family member of PARC Guest

- "My mother had a 4 week stay at PARC, receiving rehabilitative care after a couple of stints in the general psychiatric ward at Prince of Wales Hospital, Randwick, following a nervous breakdown. In the 25 years of trying to help my mum deal with mental illness and trying to guide her towards the most effective treatment and care, I have not come across anything of the standard of PARC, in fact before mum went there, I didn't think we would ever see anywhere like it. It is so reassuring to know that it is there and hopefully there will be more and more facilities like it."

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Guest / Carer Feedback

Family member of PARC Guest

- "Thank you so much Chloe, you are amazing ! I really appreciate all that you have done for XXXXX in his stay at Bondi, always being on top of all of his appointments and communicating with me regarding what's happening. It's been such an amazing opportunity for him to have stayed there helping him adjust back into the community after his hospital stay. He has really enjoyed his stay there. Thanks again"

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Guest / Carer Feedback

PARC Guests

- “PARC had a very dynamic team, each staff member brought something different to the team and this was very useful in my care. PARC focused on strengths and solutions. I was always supported to focus on my strengths and encouraged to come up with solutions to manage my distress and anxiety.”
- “Staff have been very helpful, kind, understanding and caring “
- Appreciated “Staff's strength and person focused approach.”

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Guest / Carer Feedback

PARC Guests

- "Amazing place with caring workers. Workers really care about guests wellbeing and are there if you need it. Great activities and safety planning. The best place I have been to help with Mental Health. Felt safe and supported in a great location. Would like to see more places like PARC open up in NSW, maybe more specific houses e.g. 18-25 year old's"
- " Felt very relieved that I had another option other than hospital when my mental health starts to deteriorate."

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Mental Health Prevention and Recovery Care

A clinical and community partnership model of sub-acute mental health care

VICTORIA
State Government

Health and Human Services

Mental Health Prevention and Recovery Care

A clinical and community partnership model of sub-acute mental health care

To receive this publication in an accessible format phone 03 9096 5606 or email Giuseppe.scollo@dhhs.vic.gov.au

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Where the term ‘Aboriginal’ is used it refers to both Aboriginal and Torres Strait Islander people. Indigenous is retained when it is part of the title of a report, program or quotation.

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Executive summary

Introduction

Victorian mental health Prevention and Recovery Care (PARC) services are sub-acute mental health services operating in community settings. PARC services treat people experiencing a severe and acute mental health episode, providing a mix of clinical and psychosocial support. They are short-term, residential treatment services with a recovery focus. PARC services supplement crisis intervention in Victoria and community-based ambulatory clinical care, with the aim of enabling better overall access to mental health services and stronger continuum of care for consumers.

There are a number of PARC service models. These are Adult PARC services which include a Women's and an Extended Stay, and Youth PARC services (for consumers aged between 16 and 25). PARC services seek to provide an average length of stay between seven and 14 days, with a maximum stay of 28 days. This exception to this is the Extended PARC service where the expected stay is up to six months.

The **aims** of PARC services are to:

- improve mental health outcomes of people with a severe mental illness, who become acutely unwell
- prevent avoidable admissions to acute units and avoidable re-admissions following an acute episode.

Objectives

This report analyses state mental health service data from 2009 to 2014 to evaluate whether PARC services are meeting their aims and objectives. This research also seeks an understanding of PARC services' roles in relation to hospital-based acute inpatient mental health care services and Community Care Units (CCUs).

The objectives of this research were to:

- describe PARC services in terms of their availability, clientele and context for access, health outcomes and care pathways
- compare PARC services to hospital-based acute inpatient mental health services and CCUs by consumer demographics, service delivery and outcomes
- assess whether PARC services are providing better access to mental health services in Victoria.

Findings

PARC consumers differ significantly to those people who access hospital-based acute inpatient mental health services, with a higher proportion of women entering PARC services (54%) compared to acute inpatient services (46%).

PARC services are less available than adult acute inpatient mental health services (0.46 compared to 1.74 beds per 10,000 population). However, PARC services are not operating to capacity, with an average of 72% of available beds occupied in the study period. While rates of use are lower than expected, use of PARC services has steadily increased from 64% in 2009/10 to 77% in 2013/14 as this service type is gradually embedded into the mental health care continuum.

The average length of stay at PARC services is 18 days, with discharge peaks at 14, 21 and 28 days (range 1-59 days).

Care pathways for PARC consumers typically involve transfer to PARC from community-based services (step up) or from acute psychiatric inpatient care to PARC (step down), with all PARC services operating successfully as step up and step down services. Nonetheless, there are some PARC services that provide a high level of step up referrals that could increase their capacity as a support and recovery service. This would perhaps decrease the burden on acute psychiatric inpatient care.

The primary diagnoses of people accessing Adult PARC services are schizophrenia, schizotypal and delusional disorders (48%). Mental health indicators show that:

- PARC consumers' mental health improves significantly during the treatment period, with better mental health at discharge than at admission
- compared to people entering inpatient mental health care, PARC service consumers have less severe mental health problems
- PARC service consumers appear to experience less improvement from intake to discharge compared to inpatient consumers. This may be an indication of the more intensive treatment practices undertaken in inpatient units and greater acuity at admission to these units.

Conclusion

This report finds that PARC services play a role in improving the mental health of PARC consumers. These services have been incorporated into Victoria's continuum of mental health care and operate successfully as step up and step down services.

However, our preliminary findings suggest that PARC services have not yet had a significant impact on preventing avoidable admissions to acute units and avoidable re-admissions.

Nonetheless, PARC services provide an important option for mental health care consumers in Victoria. Through delivery with a community focus, these services aim to ensure strong links with consumer communities and families, foster consumer participation in treatment and use least restrictive treatment practices.

Investigating the experiences of consumers and service providers' decision-making and referral practices in relation to PARC services will provide more information concerning the role of this service model in supporting and treating mental health consumers. In addition, longitudinal research would indicate the sustainability of the benefits of the PARC approach, and the potential for further expansion of the service.

Introduction

Victorian mental health Prevention and Recovery Care services are sub-acute mental health services operating in community settings. These services treat people experiencing a severe and acute mental health episode, providing a mix of clinical and psychosocial support. They are short-term treatment services with a recovery focus. The introduction of PARC services has enhanced mental health treatment options for consumers. These services aim to have high levels of consumer involvement, strong links to consumer's family and/or community and are committed to least restrictive practices.

Funded by the State Government, PARC services are generally delivered through a clinical and community partnership model, with both clinical mental health services and Mental Health Community Support Services collaborating to provide an accessible, supportive and therapeutic model of sub-acute care.

PARC services provide early intervention for people experiencing mental illness that is increasing in severity, acting as a 'step up' from community-based service provision. They also provide a supportive setting for those recovering from an acute psychiatric episode, acting as a 'step down' from hospital inpatient mental health services.

As step up/step down services, PARC services are an important addition to Victoria's continuum of mental health care. By providing an early-stage service option for people with an acute episode of mental illness, PARC services aim to reduce the need for admission to a hospital-based acute inpatient mental health service. By providing intensive support for people following a hospital inpatient treatment episode, these services aim to reduce re-admission rates and the length of stay in an acute setting.

This report gives an overview of PARC services in Victoria between 2009 and 2014. It provides a profile of people who access PARC services, their outcomes and care pathways; compares PARC services to hospital-based acute inpatient mental health services and Community Care Units; and assesses whether PARC services have delivered on their aims and objectives.

Background

PARC services are managed by Public Health Services within Area Mental Health Service catchments. As of January 2016 there are:

- 20 Adult PARC services offering 194 beds and 6 day places, including a Women's only service and an Extended Stay service
- 3 Youth PARC services offering 30 beds
- 2 new Adult services under construction in Mildura and Warrnambool to offer 18 beds and 2 day places (see Table 1).

Table 1: PARC service models

Service model	Age of consumers	Expected stay	No of services
Adult	16-64	7- 28 days	18
Extended	16-64	4 to 6 months	1
Women's	16-64	7- 28 days	1
Youth	16-25	7-28 days	3

Source: Client Management Interface/Operational Data Store

Young people aged between 16-24 years of age, who are eligible for adult mental health care services are able to access PARC services.

Admission to a PARC service is voluntary, however, people on a Community-Based Treatment Order (CBO)[1] are able to access the service. All admissions and discharges to Adult and Youth PARC services are facilitated through an authorised psychiatrist from the relevant Public Health Service.

Treatment practices at PARC services include:

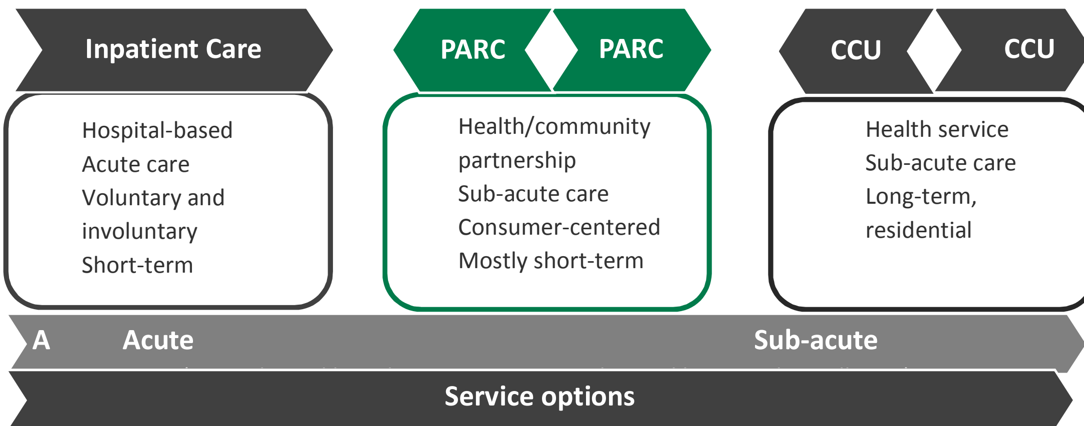
- intensive clinical intervention (including bio-psycho based treatment)
- support and practical assistance to foster independent living and social skills
- appropriate group-based activities and therapies.

In delivering treatment, PARC services aim to have a high level of consumer and carer participation in treatment practice and decision-making.

PARC services have been introduced within a continuum of mental health care in Victoria (see Figure 1) and it is important to look at these services in relation to acute and sub-acute mental health care treatment types. The following services are described and compared to PARC services in this report:

- **Community Care Units** (CCUs)– these units provide clinical care and rehabilitation services in a home-like environment. CCUs are sub-acute services that support the recovery of people seriously affected by mental illness to develop or re-learn skills in self-care, communication and social skills.
- **Inpatient care** – this is acute care and support for people who cannot be assessed and treated safely and effectively in the community. Inpatient care is provided through hospitals for people experiencing an acute mental illness who are unable to be treated in a community setting.

Figure 1: Acute and sub-acute mental health care services



PARC aims and objectives

The **aims** of PARC services are to:

- improve mental health outcomes of people with a severe mental illness, who become acutely unwell
- prevent avoidable admissions to acute units and avoidable re-admissions following an acute episode.

[1] A CBO means that a person has been mandated to receive mental health treatment. A person who has been given a CBO may receive treatment through a PARC service.

The **objectives** of PARC services are to:

- provide a service option for people with a severe mental illness, both in the inpatient setting and in the community, whose treatment and recovery is better suited to intensive, short-term treatment and support in a residential setting
- provide a mix of clinical, psychosocial and other support that enables gains from the period in the inpatient setting to be strengthened, community transition and treatment plans to be consolidated and minimises the trauma and disruption for consumers and carers that may arise from an episode of mental illness
- supplement crisis intervention and enhance access to inpatient services through the prevention of unnecessary inpatient admissions and the provision of an intensively-supported early discharge alternative (Department of Health, 2010).

Research objectives

This research aims to evaluate whether all models of Adult and Youth PARC services are meeting their aims and objectives. It also seeks an understanding of PARC services' roles in relation to inpatient mental health care services and CCUs.

The objectives of this research are to:

- describe PARC services in terms of their availability, who is accessing them, health outcomes and care pathways
- compare PARC services to hospital-based acute inpatient mental health services and CCUs by consumer demographics, service delivery and outcomes
- assess whether PARC services are providing better access to mental health services.

To achieve these objectives, state mental health service data between 2009 to 2014 have been analysed, looking at Adult[2] and Youth[3] PARC services compared to inpatient mental health services and CCUs.

Providing this analysis enables us to discuss implications in terms of state-wide mental health service provision policy and service delivery. It also gives insight into how PARC services are being incorporated into the spectrum of mental health care services in Victoria.

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[2] Adult PARC services refers to all Adult, Extended stay and Women's PARC services unless specified.

[3] Youth PARC services have only been available for since March 2013 so data are limited to 2013/14 for these services.

Findings

Availability of PARC services

Availability of PARC services has been assessed by measuring the rate of PARC beds per 10,000 population. Using this measure, there is an average of 0.46 Adult PARC services beds per 10,000 population. PARC services have similar availability in metropolitan (0.46 beds per 10,000 population) and rural areas (0.40 beds per 10,000 population).

Compared to acute inpatient mental health services (1.74 bed per 10,000 population), there are significantly fewer Adult PARC service beds available in Victoria.

Use of PARC services

While PARC services have lower levels of availability in comparison to inpatient mental health services, they are not currently operating at capacity. Guidelines stipulate that PARC services should maintain a bed occupancy rate of 85%, however, current occupancy rates are below this (see www.health.vic.gov.au/mentalhealthservices/parc.pdf).

On average, over the five year study period 72% of PARC beds were occupied, with no variation between metropolitan Melbourne services and rural services. This compares to 91% bed occupancy at inpatient mental health services.

While rates of use are lower than expected at PARC services, service use has increased, with average bed occupancy increasing by 13%, from 64% in 2009/10 to 77% in 2013/14.

As with Adult services, Youth PARC services have a lower than expected rate of use, with an average of 67% of beds occupied. This compares to 86% bed occupancy at Orygen Youth inpatient services.

It is possible that the comparatively low level of use of PARC services is a result of both mental health professionals and consumers having limited information concerning the treatment and support offered by PARC services as well as the embedding of the service type into the continuum over time. Increasing levels of use, however, are promising and suggest these services will reach their recommended occupancy level.

Who uses PARC services?

Gender

PARC consumers have a slightly different profile to that of people entering inpatient mental health care. Adult PARC services are being used by a higher proportion of women (54%) compared to the proportion of women at inpatient mental health services (46%). Youth PARC services also report a higher proportion of young women (61%) compared to young men (39%) accessing services. This is a significantly higher proportion when compared to youths accessing other mental health inpatient units (45% female compared to 55% male).

Age

While there is a clear difference between PARC consumers and consumers of inpatient mental health services in terms of gender, this difference is not apparent by age.

Adult PARC consumers have a similar age range to consumers of other mental health services, with 13% under 24 years of age, 40% between 25 and 39 years of age and 47% over 40 years of age.

Youth PARC services provide services to a large proportion of 18 to 24 year olds (77%) with 22% of consumers under 18 years.

Country of birth

PARC services are mostly accessed by people born in Australia, with 81% of Adult PARC services and 89% of Youth PARC services consumers in this group. This cultural profile is similar to that of other mental health care services.

Aboriginal Victorians

Almost two percent of all Adult PARC consumers and 1.5% of Youth PARC consumers identify as Aboriginal Australians. These proportions are similar to those of acute inpatient services and Community Care Units.

Why do people use PARC services?

While mental health disorders can be multifaceted, a consumer's primary diagnosis provides an indication of the severity and overall nature of their mental illness. In this sense, primary diagnosis is a useful measure with which to look at and compare consumer profiles at mental health services.

The primary diagnoses of people accessing Adult PARC services are schizophrenia, schizotypal and delusional disorders (48%) (see Table 2). Mood (depressive) disorders are the second most common primary diagnoses (19%), followed by personality disorders (13%) and mood (bipolar) disorders (12%). Adult acute inpatient services and PARC services differed significantly across all categories of primary diagnosis. Notably, PARC services provide treatment to a greater proportion of people diagnosed as having schizophrenia, schizotypal and delusional disorders (48% compared to 44%) and mood (depressive) disorders (19% compared to 15%).

There are also significant differences across all areas of primary diagnosis between CCUs and PARC services. For instance, 79% of consumers at CCUs have schizophrenia, schizotypal and delusional disorders as their primary diagnoses compared to 48% of PARC service consumers. As CCUs provide long term residential support, this finding may be indicative of the intensive support this group of consumers require to live in the community.

Primary diagnosis differs significantly at Youth PARC services compared to Adult PARC services, where young people are equally likely to access either service for treatment of schizophrenia, schizotypal and delusional disorders, mood disorders or personality disorders. Youth PARC services provide more services to young people diagnosed with mood (depressive) disorders than youth mental health inpatient services.

Table 2: Primary diagnosis of consumers accessing PARC and other mental services in a 5 year period 2009-2014

Diagnosis	%				
	Adult PARC	Adult Inpatient[1]	Youth PARC	Youth Inpatient[2]	CCU[3]
Schizophrenia, schizotypal and delusional disorders	48	44	25	26	79
Mood (Depressive) disorders	19	15	24	19	3
Personality disorders	13	15	23	24	7
Mood (Bipolar) disorders	12	11	11	6	5
Substance related disorders	2	6	2	7	1
Reaction to severe stress, and adjustment disorders	3	5	3	7	0
Unknown	1	2	6	1	3
Other	3	3	5	9	2

Source: Client Management Interface/Operational Data Store

[1]Refers to adult acute inpatient mental health services
[2]Refers to youth acute inpatient mental health services
[3]Community Care Units

Service delivery

Care pathways into PARC services

Care pathways in mental health are critical in supporting consumers at various stages of mental illness – from acute care to sub-acute treatment and then to ongoing support and recovery. Ensuring PARC services are appropriately accessed to support consumer care pathways is an important gauge of service efficacy. Care pathways for PARC consumers typically involve transfer into PARC from community-based services (step up) or from acute psychiatric inpatient care into PARC (step down). Our data show that all PARC services are operating as both step up and step down services thus achieving these programs aims and objectives in this regard.

Overall more consumers (57%) step up into Adult PARC services, with 43% stepping down from inpatient services, however, there are significant variations between individual PARC services (ranging from 43% to 80% stepping up). This suggests that some PARC services are acting primarily as early intervention services rather than in a support and recovery capacity for those discharged from a hospital setting. Given that PARC services operate within a network of mental health services this high rate of step up admissions may be influenced by hospital referral practices.

Two thirds of Youth PARC (67%) consumers step up, with significantly less stepping down (33%).

At the Extended PARC, significantly less consumers step up (34%) compared to those who step down from inpatient services (66%). This demonstrates this particular service’s role as step down care support and is perhaps indicative of the long term support required by some mental health care consumers.

How long do people stay in PARC services?

PARC services aim to provide an average length of stay between seven and 14 days, with a maximum stay of 28 days. The exception to this is the Extended PARC service where the expected stay is up to six months.

Overall, the length of stay is as expected for all PARC services, with the average length of stay across PARC services as follows (see Figure 2):

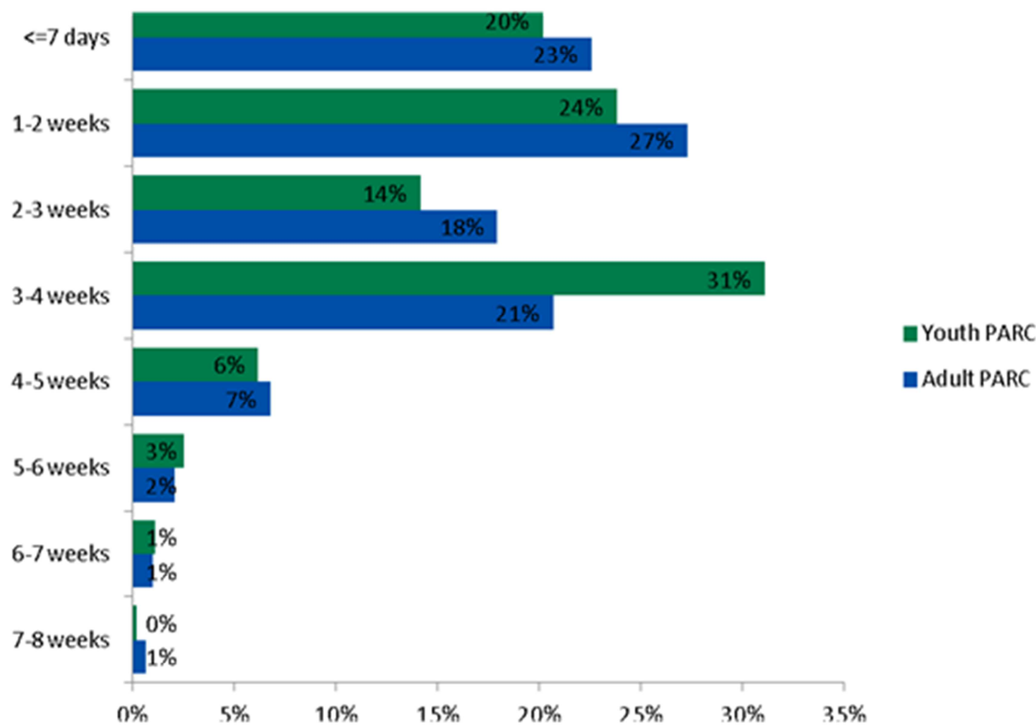
- Adult PARC 18 days
- Youth PARC 19 days
- Extended PARC 66 days.

For Adult PARC services, the average length of stay is 19 days in metropolitan services and 15 days in rural services.

Generally, stays at PARC services are within a 28 day period, and around half of PARC consumers stay for seven to 14 days (see Figure 2). Overall:

- 50% of PARC service consumers complete stays in a seven to 14 day period
- 88% of PARC service consumers complete stays within a 28 day period
- 23% of PARC consumers stay for less than seven days
- 12% of PARC consumers stay for more than 28 days.

Figure 2: Length of stay at Adult and Youth PARC services

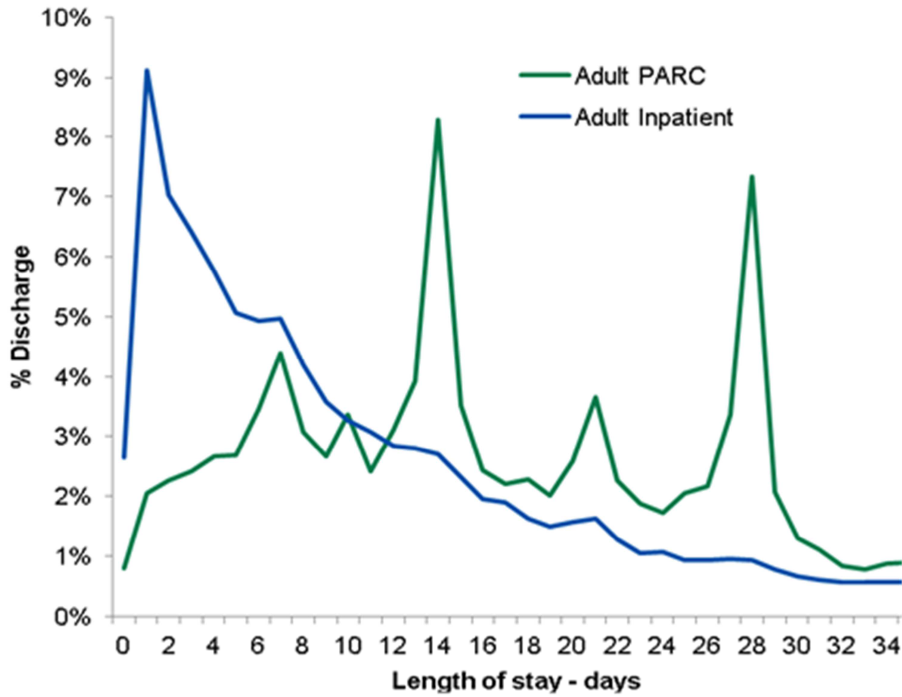


Source: Client Management Interface/Operational Data Store

Discharge from PARC services

Discharge from PARC services corresponds with consumers' length of stay and tends to be at 14, 21 and 28 days (see Figure 3). This contrasts with the high rate of discharge at one day after admission to hospital-based inpatient mental health services.

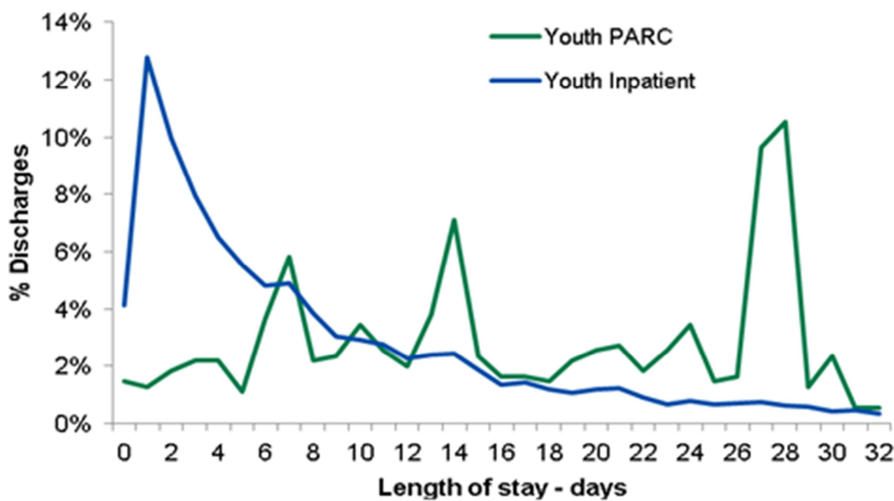
Figure 3: Discharge from Adult PARC and adult inpatient services



Source: Client Management Interface/Operational Data Store

Similar to the discharge patterns at Adult PARC services, Youth PARC services discharge peaks at 14, 21 and 28 days. This contrasts with other youth inpatient mental health services where discharge peaks at the second day after admission (see Figure 4).

Figure 4: Discharge from Youth PARC and youth inpatient services



Source: Client Management Interface/Operational Data Store

The early discharge from acute inpatient services (between 1-2 days) may be a result of legislation that is in place to minimise the use of compulsory treatment (see the Mental Health Act 2014 for further information). Inpatient units are the main sites for people on an Assessment Order, the first step in receiving compulsory treatment. People on an Assessment Order are typically assessed by an authorised psychiatrist within 24 hours. After this assessment, a number of people will be detained for compulsory in-patient treatment, whereas others will be eligible for community-based treatment—including that offered through PARC services—and leave the unit.

Mental health outcomes

One of the ways in which mental health outcomes are assessed in Victorian mental health services is by using the Health of the Nation Outcomes Score (HoNOS) results (Wing, Beevor, Curtis, Park, Hadden and Burns, 1999). The HoNOS is designed to measure the health and social functioning of people with mental health diagnosis across time. HoNOS results are calculated from a range of indicators that measure problems the consumer is experiencing. A higher overall HoNOS result indicates poorer mental health. Looking at changes in HoNOS outcomes can provide an indication of treatment efficacy.

Change in overall HoNOS results

Overall HoNOS results for both Adult and Youth PARC service models show improved health outcomes for consumers (see Table 3).

Table 3: HoNOS outcomes by Service Type

Service type	HoNOS Admission	HoNOS Discharge
Adult inpatient (n=39,228)	15.9	7.4
Adult PARC (n=5,915)	12.4	9.1
Community Care Units	13.8	13.9
Youth PARC (n=347)	12.3	7.8
Youth inpatient (n=10,890)	16.6	9.0

Source: Client Management Interface/Operational Data Store

Note: n = number of ended episodes where a valid admission and a valid discharge score were available.

HoNOS results in Adult PARC services show a significant drop from 12.4 at admittance to 9.1 at discharge. In the smaller Youth PARC sample (347 records) the average admission score reduced significantly from 12.3 at admittance to 7.8 at discharge. In both groups this change indicates that people had better mental health upon discharge from PARC services.

Compared to consumers at inpatient mental health services, PARC consumers had significantly lower HoNOS results at admission (12.4 compared to 15.9) and higher results at discharge (9.1 compared to 7.4). Further, adult inpatient consumers appear to show greater improvement at discharge compared to PARC consumers.

On average, Youth PARC services HoNOS scores (12.4) appear lower at admittance than youth inpatient services (16.6) and higher at discharge (7.8 compared to 9.0).

The different HoNOS results at admission for PARC consumers compared to inpatient services reflect the selection criteria of each particular service model. It is expected that people with more serious mental health disorders (and therefore higher HoNOs scores) would access the more intensive model of hospital-based acute inpatient treatment.

Likewise, the apparent greater rate of change in the mental health of people receiving treatment in an acute inpatient setting may be reflective of the more intensive treatment received and the greater acuity at admission. Further analysis and documentation of treatment practices by service type could provide a better understanding of these rates of change and their sustainability in the long term.

Change in individual HoNOS indicators

Individual HoNOS indicators provide a picture of the areas of concern for people at admission to mental health services. They also give an indication of the impact of treatment on these areas of concern. Table 4 shows the proportion of consumers by each HoNOS indicator at intake and at discharge.

For both Adult PARC services and adult acute inpatient services 'other mental and behavioural problems' was the most common area of concern for consumers at admission (69% and 67% respectively). This was followed by 'depression' (56% for both service types) and 'problems with relationships' (53% and 55% respectively).

However, at intake, there were a significantly higher proportion of consumers from inpatient services on various areas of concern including:

- overactive/aggressive/disruptive behaviour (53% of adult inpatient compared to 21% of Adult PARC services consumers compared)
- non accident self-injury (36% of adult inpatient consumers compared to 16% of Adult PARC services consumers)
- hallucinations and delusions (54% of adult inpatient consumers compared to 35% of Adult PARC services consumers)
- problem drinking or drug taking (44% of adult inpatient consumers compared to 23% of Adult PARC services consumers).

The above differences between PARC and inpatient mental health service consumers are reflective of the different role of the service types. People with more severe mental health disorders and resulting symptoms would not meet the selection criteria for treatment at a PARC service and would require admission to an inpatient service.

Treatment impact

Looking at changes in individual problem areas, HoNOS results for Adult PARC services show a significant drop in the proportion of people with each indicator at intake and then at discharge in a number of areas (see Table 4):

- other mental and behavioural problems (proportion of consumers decreased by 39%)
- problems with relationships (proportion of consumers decreased by 32%)
- depressed mood (proportion of consumers decreased by 28%)

These decreases suggest that PARC services have a positive impact on these particular problem areas measured by the HoNOS.

Table 4: Percentage of consumers with HoNOS indicators at admittance and discharge

HoNOS indicator	Adult PARC (%)		Inpatient (%)	
	intake	discharge	intake	discharge
Overactive/aggressive/disruptive behaviour	21	15	53	42
Non-accidental self-injury	16	11	36	29
Problem drinking or drug taking	23	11	44	23
Cognitive problems	20	10	30	22
Physical illness /disability problems	26	11	25	15
Hallucinations and delusions	35	15	54	37
Depressed mood	56	28	56	37
Other mental and behavioural problems	69	30	67	45
Problems with relationships	53	21	55	34
Problems with activities of daily living	38	21	37	29
Problems with living conditions	29	15	28	20
Problems with occupation and activities	44	23	41	28

Source: Client Management Interface/Operational Data Store

Have PARC services relieved the burden on acute mental health services?

Through providing intensive and accessible treatment, PARC services supplement acute community and bed based interventions in Victoria, with the aim of enabling better overall access to mental health services.

In order to determine whether PARC services are meeting this aim, we assessed whether they had reduced admission and re-admission to acute inpatient mental health services. As a preliminary exercise we looked at local rates of use and length of stay at inpatient services before and after the establishment of a PARC service in the same Area Mental Health Catchment.

Preliminary findings indicated that despite the introduction of PARC services there have been no significant changes in use of or length of stay at inpatient mental health services.

These findings suggest that the current balance of PARC services available have not reduced the burden on acute inpatient mental health services, however, further investigation is required into this matter that is not in the capacity of this study.

Enhanced consumer choice

While it is not currently evident that PARC services have had a significant impact on stay and admission rates in acute inpatient services, they provide an important option for consumers in terms of mental health treatment. Through delivery with a community focus, these services aim to ensure strong links with consumer communities and families, consumer participation in treatment and less restrictive practices.

PARC services have enhanced treatment options for certain consumer groups, for instance, providing services specific to women.

Conclusion

Implications for policy

PARC services are providing both early intervention and post-acute care through a unique partnership model and health services have incorporated them well in their continuum of care. There are, however, some services that operate primarily in a step up capacity. Greater support could be provided in order for these services to increase their support and recovery capacity.

PARC services aim to provide an alternative to hospital-based inpatient acute mental health care and/or post-acute support, and a step down service for consumers leaving inpatient care. However, initial analysis finds that use of hospital-based services has not decreased with the introduction of PARC services. Additionally, PARC services have a lower than expected rate of use – although this is steadily increasing. Better knowledge of service provider decision-making and referral practices, as well as consumer experiences might assist to understand the current levels of use of PARC services and improve and promote their role in the delivery of mental health treatment in Victoria.

The slightly different profile of PARC service consumers suggests that these services provide a treatment option for populations that have had lower rates of use of inpatient services, such as women. Further investigation is warranted in this area.

Future investment in both Adult and Youth PARC services should be considered on an individual catchment basis. This should take into account local use and availability of existing inpatient mental health services, as well as each catchment's ability to provide comprehensive services, to ensure there is a strong case for investment.

Implications for practice

Consumers, carers and mental health practitioners may require more comprehensive information concerning the role of PARC services and the support and treatment they provide. This could lead to improved referral practice to PARC services and ensure their operation as both a step up and step down service, relieving the burden on inpatient mental health care.

For those PARC services operating primarily as step up services, service providers are encouraged to consider their role as a support and recovery service for people discharged from a hospital-based service and, where appropriate, provide a higher volume of step down admissions.

Service providers are encouraged to consider assessment and admittance practices and ensure they are culturally sensitive and appropriate for people born in other countries than Australia.

To support reflective and informed practice, aggregated HoNOS results should be released to PARC health services.

Implications for research

Further investigation of consumer experiences and documentation of treatment practices at PARC services could provide insight into service strengths as well as areas for improvement.

References

Department of Health (2010). *Adult prevention and recovery care (PARC) services framework and operational guidelines*. State of Victoria, Department of Health. Accessed 13/01/16: http://www.health.vic.gov.au/mentalhealthservices/parc.pdf

Wing, J.K, Beevor, A.S, Curtis, R.H., Park, S.B., Hadden, S. and Burns, A. (1999). Health of Nation Outcome Scores (HoNOS). Research and development. *British Journal of Psychiatry*, 172, pp 11-18.

Appendix A: Adult PARC services in operation in Victoria

Table 5: Adult Prevention and Recovery Care Services Operating

Health Service	Campus	Beds
Alfred Health	Inner south	10
Austin Health	North east	0
Eastern Health (Box Hill)	Central east	8
Eastern Health (Maroondah)	Outer east	10
Melbourne Health (RMH)	Inner west	10
Melbourne Health (Sunshine)	Mid west	10
Melbourne Health (Northern)	Northern	10
Melbourne Health (Broadmeadows)	North West	10
Monash Health (Casey)	Casey	20
Monash Health (Dandenong)**	Dandenong	10
Monash Health (Monash MC)	Middle South	10
Peninsula Health	Peninsula	10
St Vincent's Hospital	Inner East	10
Werribee Mercy	South west	10
Ballarat Health	Grampians	0
Barwon Health	Barwon	6
Bendigo Health	Loddon Mallee	10
Goulburn Valley Health	Goulburn Valley	10
Latrobe Regional	Gippsland	10
Mildura Base Hospital	Northern Mallee	0
North East & Border	Hume	10
South West Health	Glenelg	0

Source: Client Management Interface/Operational Data Store

Appendix B: Methodology

This research has examined PARC services and compared them to other acute inpatient mental health service types and Community Care Units (CCUs) using Client Management Interface/Operational Data Store (CMI/ODS). The data are analysed over a five year period (1/05/2009 to 30/04/2014).

Our analysis investigated:

- PARC health outcomes, with a comparative analysis to mental health inpatient services and CCUs
- operational benchmarking against set parameters, including length of stay, bed use and occupancy, discharge patterns and 'step up' and 'step down' functioning.

To describe PARC services, demographic and diagnostic variables were analysed.

Length of stay and HoNOS analysis is based upon completed treatment episode, where the end date is the date of discharge.

All analysis is by treatment episode and therefore includes repeat consumers.

Episode type was either 'PARC' or 'inpatient'. These types were determined using a reference table which combines: subcentre type; ward/residential type; outcome measurement setting; program types attached; and department knowledge.

The 'Youth Inpatient' category was created with consumers aged between 16 to 25 years in Adolescent Units, Orygen and adult inpatient units. Young people admitted to adult inpatient units are also included in the 'Adult Inpatient' category. Approximately 14,000 records fall into this category.

In most instances, the Monash Health Extended Adult PARC located in Narre Warren was excluded from the analysis. This was because the model variation would distort the data analysis outcomes.

Frequencies have been reported and standard statistical tests have been applied to the results. These include t-tests and analysis of variance to compare means. Areas of statistical significance have been highlighted in the report.

Table 6: Number of records per episode type

Episode type	No. of records
Adult inpatient	75,833
Adult PARC	9,115
Extended PARC	35
Youth PARC	551
Youth inpatient*	**22,617**

Note: Youth consumers admitted to an Adult inpatient unit are included in the Adult inpatient and the Youth inpatient category.

Glossary of Acute and Sub-acute Mental Health Services

Community Care Units (CCUs)

Community care units (CCUs) provide clinical care and rehabilitation services in a home-like environment. CCUs are sub-acute services support the recovery of people seriously affected by mental illness to develop or re-learn skills in self-care, communication and social skills in a community-based residential facility.

CCUs provide medium to long-term clinical and rehabilitation support for people unable to live in other community residential options. Length of stay can be up to two years. During this time, consumers have access to 24-hour multidisciplinary clinical support and treatment, including regular medical psychiatric review.

In-patient care

Acute inpatient services support people who cannot be assessed and treated safely and effectively in the community. General hospitals commonly provide acute inpatient services.

These services provide a range of therapeutic interventions and programs to patients and their families to learn more about the impact of, and to better manage mental illness, improve coping strategies and move towards recovery.

Preventative and Recovery Care (PARC)

Mental health Prevention and Recovery Care (PARC) services are sub-acute mental health services operating in community settings. These services treat people experiencing a severe and acute mental health episode, providing a mix of clinical and psychosocial support. They are short-term, residential treatment services with a recovery focus.

From: Corinne Henderson
Sent: Wednesday, 29 November 2023 9:25 AM
To: Portfolio Committee 2
Cc: Evelyne Tadros
Subject: CM: Questions on Notice

Hi Holly

The YES-CMO, Your Experience of Service Community Managed Organisations: What consumers say about the services they receive from
community managed organisations in New South Wales 2022 - 2023 is the last remaining on notice item that MHCC was to forward to the committee. We are launching this report today.

The 2022 – 2023 YES-CMO survey findings reveal overwhelmingly positive results, highlighting considerable satisfaction among people accessing mental health services provided by HASI/CLS and Family and Carer community-managed organisations. Notably, a staggering 92% of respondents rate their experience of care as excellent or very good. This resounding endorsement echoes the dedication and efforts of people working in the community sector, supporting people with lived experience of mental health conditions. Another key highlight shows 95% of people believe they are shown respect and are valued as individuals, with the caring and supportive staff repeatedly cited as a cornerstone of their positive experiences. Further insights revealed particularly positive ratings from Aboriginal people, young people aged 25 – 35 years old and those engaged with the service for four to six months. This collective feedback underscores the impactful work being done within our sector and the positive contributions services make to the lives of those seeking support.

Best regards

Corinne

Corinne Henderson
Director, Policy & Systems Reform
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Mental Health Coordinating Council acknowledges the Traditional Owners of the lands on which we live, learn and work.
We value people with lived experience of mental health conditions and are informed by their insight and expertise in our work.