Final Evaluation Report

# NSW Mental Health Literacy Initiative: Phase 3

Prepared by the Sax Institute and the Sydney Health Literacy Lab for the Mental Health Commission of NSW — October 2022

**Acknowledgments**

The authors and the Sax Institute acknowledge the Gadigal people of the Eora Nation as the traditional owners of the land where we work and pay our respects to Elders past, present and emerging. We also acknowledge and pay our respects to the traditional owners across the NSW locations where this initiative was implemented.

We acknowledge and very much appreciate the many people who contributed their time to help with organising, collecting and/or processing the various data presented in this report, and the many people who shared their time and honest reflections to provide feedback about the Mental Health Literacy Initiative.



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# NSW Mental Health Literacy Initiative: Phase 3 Evaluation Report

# Acronyms

| AH&MRC | Aboriginal Health & Medical Research Council of NSW |
|---|---|
| **CALD** | Culturally and linguistically diverse |
| **CoP** | Community of Practice |
| **CWG** | Collaborative Working Group |
| **GP** | General Practitioner |
| **LHD** | Local Health District |
| **MHAOD** | Mental Health, Alcohol and Other Drugs |
| **MHC** | Mental Health Commission |
| **MHLI** | Mental Health Literacy Initiative |
| **MHLR** | Mental Health Literacy Responsiveness |
| **NGO** | Non-government organisation |
| **PHN** | Primary Health Network |
| **PWLE** | People with lived experience of mental health challenges, their families and carers |
| **SUNNY Consortium** | Consortium of Swinburne University of Technology, University of New South Wales, and University of Newcastle |

# Contents

# Executive Summary

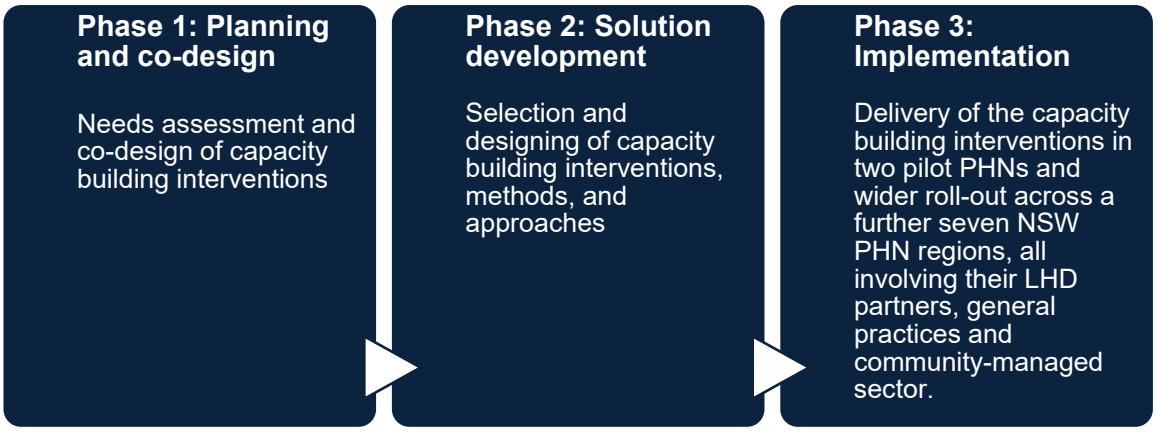
## Overview of the Mental Health Literacy Initiative (MHLI)

The MHLI aimed to improve organisational mental health literacy responsiveness (MHLR) by enabling health services, providers and community organisations to more responsively meet the needs of people with lived experience, in all their diversity. It involved the Mental Health Commission of NSW (MHC) commissioning a consortium of researchers (the SUNNY Consortium[1]) to co-design and deliver the MHLI, in partnership with nine Primary Health Networks (PHNs) and a range of key stakeholders, including people with a lived experience of mental health challenges, their families and carers (PWLE).

The main objectives of the MHLI were:

- To engage PWLE in all their diversity, and healthcare and other frontline workers with extensive experiential knowledge, in the co-design of capacity building interventions to increase the health literacy responsiveness of organisations that provide services to PWLE, not only as individual organisations but as an integrated system
- To implement a local planning process and a package of capacity building interventions initially in two Primary Health Networks (PHNs) and then in seven additional NSW PHNs
- To evaluate the package of capacity building interventions in terms of the capacities developed within organisations and across the system and the feasibility of the model for transfer to other jurisdictions.

- The MHLI was a three-year initiative conducted over three phases from July 2019 to June 2022:




1 The SUNNY Consortium included researchers from Swinburne University of Technology, University of New South Wales and University of Newcastle.

The MHLI was overseen by a cross-sector Steering Committee and managed by an internal project team of MHC staff. In addition, the MHC created a Collaborative Working Group (CWG) to support implementation and bring together all key MHLI stakeholders. A PHN Community of Practice was also established to support the MHLI's implementation and the SUNNY Consortium offered a buddy system to further support PHN coordinators with implementing the MHLI.

## Evaluation overview

This report presents the findings from Phase 3 of the MHLI (from July 2021 to June 2022) and aimed to explore the following high-level evaluation questions, which have been framed in relation to relevant domains from the Community Capitals Framework:

1. How has Phase 3 of the MHLI been implemented, who has been reached and what **built capital** (infrastructure and resources to support MHLR) has been created?
2. To what extent have activities implemented during Phase 3 of the MHLI contributed to improving the following for PHNs and their commissioned services?
    a. **Social capital** – the connections, relationships and collaboration between services
    b. **Human capital** – individual stakeholder capacity in relation to MHLR (including awareness, understanding and skills)
    c. **Cultural capital** – organisations' awareness of and readiness to be MHLR.

The Phase 3 MHLI evaluation data sources (which are each described in more detail in the body of the report) included:

- Quarterly progress reports submitted by all nine PHNs throughout the implementation period
- A Ripple Effects Mapping workshop with PHN coordinators to explore the impacts of the MHLI (conducted in July 2022)
- In-depth qualitative interviews with 12 PHN staff (coordinators and line managers) from seven of the participating PHNs, 11 CWG members and one MHLI Steering Committee member (conducted between June and September 2022) – resulting in a total of 11 interviews with 24 MHLI stakeholders (see Table 1 for further details).
- PHN data analytics and local evaluation data provided for some of their implemented activities.

## Key findings

1. **Implementation of the MHLI was challenging** – the MHLI began as the COVID-19 pandemic was unfolding and was further challenged by major natural disasters affecting many of the participating PHNs, which resulted in considerably increased pressures and competing priorities for all stakeholders. In addition, while the flexibility in funding and the related

autonomy were valued by many PHN coordinators, others reported feeling confused and uncertain, especially during the early stages of implementation.

2. **The MHLI supported the development and implementation of a range of MHLR-promoting activities** – in the form of training, resources, service navigation tools and organisational processes. It facilitated the implementation of new activities, as well as supporting existing activities that required additional resourcing to be fully achieved. The MHLI also led to increased conversations about mental health literacy at all levels within most PHNs (including at the leadership level) and the filtering of a health literacy framework/lens into "business as usual".

3. **The MHLI contributed to enhancing MHLR** – in PHNs, general practices and commissioned services across NSW in a number of ways, including:
   - Developing and/or enhancing MHLR **infrastructure and resources** (Built capital)
   - Enhancing the **connections, relationships and collaboration** between services in working towards MHLR (Social capital)
   - Enhancing **individual stakeholder awareness, understanding and skills** in relation to MHLR (Human capital)
   - Enhancing **organisations' awareness of and readiness** in relation to MHLR (Cultural capital).

4. **The improvements in MHLR have the potential to be sustained at least in the short-term** – although the sustainability and strengthening of these improvements is likely to vary considerably between PHNs, depending on the availability of local champions and the progress achieved during the MHLI.

5. **The success of the MHLI's implementation was facilitated by a number of factors**, including:
   - The commitment, flexibility, agility and collaborative nature of the MHC and participating PHNs, with both the statewide and local coordination roles seen as critical to "making things happen"
   - The flexible funding, which provided PHNs an opportunity to capitalise on and progress pre-existing activities related to mental health literacy or to "kick-start" activities that would have otherwise been delayed or forfeited because of a lack of funding
   - Its co-design approach, which enabled value-adding contributions from a wide range of stakeholders, including LHDs, general practices, interagency groups, non-government organisations and PWLE (although this was made more challenging by the COVID-19 pandemic) – at both the statewide and PHN levels

- Its collaborative nature, which created an environment that supported relationships across PHNs, innovative ideas generation, enhanced trouble shooting and sharing of ideas and resources
- Some PHN's pre-existing capacity in relation to MHLR, with greater implementation progress seen in PHNs who had previously been working on improving their health literacy responsiveness.

Given the MHLI's relatively short post co-design implementation timeframe, this evaluation focussed on the perceived short-term impacts of the MHLI, and was not able to explore any longer-term impacts on stakeholder and organisational MHLR capacity or any potential improvements in service access and experience for PWLE.

## Learnings for the future

The evaluation of the MHLI also generated a range of learnings that may be useful for future similar initiatives to consider:

1. **Definitions and scope**
In flexibly-applied initiatives with multiple stakeholders, ongoing reinforcement and support is needed to define focus and scope, including what activities are permissable. This is particularly important for initiatives focused on complex, new or evolving concepts (e.g. mental health literacy responsiveness) for which stakeholders are likely to bring pre-concieved and alternative definitions and understandings.

2. **Project phasing and availability of resources**
Clear expectation-setting about the availability of resources at different Phases, and transparent discussions about what to do if delays occur, are necessary to support informed implementation planning.

3. **Co-design**
All stakeholders need to feel a sense of ownership of resources developed through the co-design process. This can be achieved through earlier engagement of all stakeholders and involvement in all co-design phases. A combination of 'system' and 'place-based' levels of co-design may also be valuable.

4. **Implementation period**
Longer-term funded implementation and evaluation periods would allow for more thorough exploration of a broader range of outcomes, including longer-term impacts on stakeholder and organisational capacity and service access, experience and outcomes for PWLE.

## Conclusion

In summary, the MHLI has contributed to progressing organisational MHLR in the nine participating PHN regions, resulting in a considerable amount of enhanced MHLR capital that could be useful in other regions, although some local co-design and tailoring would be required. However, ensuring this enhanced built, social, human and cultural capital translates into improved service access, experience and outcomes for PWLE remains a work in progress that will require ongoing support and championing from the MHC and the nine participating PHNs.

# Introduction

## Background

In NSW, approximately 1.3 million people experience mental illness each year. People with a lived experience of mental illness have higher morbidity and mortality rates and those with severe and complex mental illness die an average of 13 to 24 years earlier than those without, largely as a result of physical health conditions. In 2014, the National Health Literacy Statement was published, identifying health literacy as a national priority [1]. Sixty percent of Australians have low health literacy, which has been associated with less participation in preventive health activities, less effective communication with healthcare professionals, poorer health outcomes, and higher healthcare costs.

The Australian Commission on Safety and Quality in Health Care describes health literacy as having two main components: individual health literacy and the health literacy environment [1][2]. Overtime, health literacy has evolved from focusing on individuals reading and numeracy skills to include broader social and cultural contexts [3] [4]. Improving organisational health literacy responsiveness is one of the most direct ways to improve health and equity outcomes for communities and individuals. Whole populations can be supported to get timely and appropriate information and optimal access to care through organizations and services that understand the health literacy strengths, needs, and preferences of the communities they serve.

## About the Mental Health Literacy Initiative

The Mental Health Commission of NSW (MHC) was established in July 2012. Its purpose is to monitor, review and improve the mental health and wellbeing of the community by undertaking strategic planning, systemic reviews and advocacy, with the guidance of the lived experience of people with mental health challenges, their families and carers (PWLE).

In acknowledgement of the need for improved organisational responsiveness to the health needs of PWLE, the MHC sought Commonwealth funding and commissioned a consortium of researchers (hereafter referred to as the SUNNY Consortium) from Swinburne University of Technology, University of New South Wales and University of Newcastle to co-design and deliver a Mental Health Literacy Initiative (the MHLI), in partnership with two pilot PHNs, North Coast and Western Sydney PHN, and a range of key stakeholders, including PWLE. The **aim of the MHLI** was to improve

organisational mental health literacy responsiveness (MHLR) by enabling health services, providers and community organisations to more responsively meet the needs of PWLE, in all their diversity.

This MHLI defined MHLR as:

> *"The provision of services, programs, support and information in ways that promote equitable access and engagement for all people in the community, that meet the diverse mental health literacy strengths, limitations and preferences of all people, and that support individuals with lived experience, their caring families and kinship groups and communities to participate in decisions regarding their health and wellbeing."* (Adapted from Trezona et al, 2017 ).

The SUNNY Consortium, in partnership with the MHC and the two pilot PHNs, aimed to achieve this by:

- Better understanding the way that PWLE experience health and health care; and
- Working together with service providers and PWLE, to develop education and training resources to improve organisational MHLR to be implemented across NSW PHNs in partnership with their Local Health Districts (LHDs) and community-managed sector.

The main objectives of the MHLI were:

- To engage PWLE in all their diversity and health care, and other frontline workers with extensive experiential knowledge in co-design of capacity building interventions to increase the health literacy responsiveness of organisations that provide services to people with lived experience, not only as individual organisations but as an integrated system
- To implement a local planning process and a package of capacity building interventions initially in two Primary Health Networks (PHNs) and then in seven additional PHNs across NSW
- To evaluate the package of capacity building interventions in terms of the capacities developed within organisations and across the system and the feasibility of the model for transfer to other jurisdictions.

The MHLI was a three-year initiative conducted over three phases from July 2019 to June 2022:

- **Phase 1: Planning and co-design**: Needs assessment and co-design of capacity building interventions
- **Phase 2: Solution development**: Selection and designing of capacity building interventions, methods, and approaches (potential Action Areas)
- **Phase 3: Implementation**: Delivery of the agreed capacity building interventions in two pilot PHNs and wider roll-out across a further seven NSW PHN regions, all involving their LHD partners, general practices and community-managed sector.

During Phases 1 and 2 (which have been evaluated previously), two Statewide Forums were held for all NSW PHNs and LHDs, and key NSW-based agencies. These forums were an opportunity for the SUNNY Consortium to present the evidence and ideas for how to improve organisational MHLR and to start the process of prioritisation of potential action areas that could be relevant for all NSW PHNs. The SUNNY Consortium also conducted an environmental scan and gap analysis to identify relevant existing PHN resources and activities, and to highlight any potential gaps and opportunities for the MHLI. They also conducted a series of Ideas Generation Workshops (with 39 people from MHLI

priority groups and 13 service providers) to gather ideas and strategies for improving health practitioner and organisational MHLR.

Ultimately, eleven key Action Areas were identified, grouped into three themes based on the previous data analysis and consultation processes: 1) Connections between health services and the community; 2) Accessing help at the right time in easy and friendly ways; and 3) Training and capacity building in health and community services (see Appendix A for further details).

The SUNNY Consortium then developed a suite of resources aimed at addressing the 11 MHLI Action Areas and improving organisational MHLR (see Appendix B). The resources covered four main categories and included vignettes, training support and a patient experience journey toolkit[2]:

- **The Case for Action** – Document to help organisations advocate for change
- **Let's learn from research** – Five video/audio stories that can be used by organisations, managers and frontline staff, to generate ideas for quality improvement
- **Take actions to respond to communities** – Factsheets for the 11 Action areas
- **Resources for Action** – Evidence-informed actions that can be practically applied by organisations and health workers to improve the access, experience and satisfaction of people using services.

## MHLI governance and support structures

As detailed in Figure 1, the MHLI was overseen by a cross-sector MHLI Steering Committee and managed by an internal project team of MHC staff. In addition, the MHC created a Collaborative Working Group (CWG) to support implementation and bring together all key MHLI stakeholders, including PWLE.

In December 2020, the MHC also established a PHN Community of Practice (CoP) to further support the MHLI's implementation. The CoP met on a six-weekly basis, with its management transitioning to Western Sydney PHN and the coordination and chairing of each meeting rotating among the PHNs.

During Phase 3, the SUNNY Consortium also implemented a buddy system to further support PHN coordinators with implementing the MHLI. This involved PHN coordinators being paired with a member of the SUNNY Consortium, who they could seek advice and support from.

**Figure 1:** Overview of the MHLI governance and support structures

[2] The SUNNY consortium also developed a quality improvement tool but this was not available by June 2022.

| | |
|---|---|
| **MHLI Steering Committee** | The Steering Committee consisted of representatives from the MHC, Ministry of Health, PHNs, and peak bodies. Their purpose was to provide **strategic advice and oversight across the design, evaluation and implementation** of the initiative. |
| **Collaborative Working Group (CWG)** | The CWG was established to **support implementation and bring together all key stakeholders**. It included all funded stakeholders such as members from the SUNNY Consortium, the Evaluation Team, pilot PHN coordinators, as well as unfunded stakeholders such as representatives from ACI and peak bodies. |
| **PHN Community of Practice (CoP)** | The PHN CoP was initiated by the MHC for all PHN coordinators and was chaired by one of the pilot PHN coordinators. The purpose of the CoP was to **support implementation** at the PHN level and to **encourage collaboration** across PHNs. |
| **SUNNY Buddy model** | Members of SUNNY consortium paired up with PHNs coordinators to provide one-on-one **implementation support** and to **ensure effective facilitation.** This also enabled SUNNY members to become familiar with action areas prioritised at each PHN and to facilitate data collection for research and evaluation purposes. |

# Evaluation Approach

## About this Evaluation Report

This Evaluation Report explores the implementation and early impacts of Phase 3 of the MHLI (July 2021 – June 2022), with Phases 1 and 2 having already been evaluated and reported in our Interim Evaluation Report .

## Key evaluation questions

This evaluation of Phase 3 of the MHLI aimed to explore the following high-level evaluation questions, which have been framed in relation to relevant domains from the Community Capitals Framework :

1. How has Phase 3 of the MHLI been implemented, who has been reached and what **built capital** (infrastructure and resources to support MHLR) has been created?
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    c. **Cultural capital** – organisations' awareness of and readiness to be MHLR.

## Data collection and analysis

The Phase 3 MHLI evaluation incorporated analyses of data collected from PHNs' quarterly progress reports, a Ripple Effects Mapping workshop and in-depth qualitative interviews with 24 MHLI stakeholders. Some PHNs also provided data analytics and local evaluation data for some of their implemented activities.

### Quarterly progress reports

As part of their project management, all participating PHNs completed quarterly progress reports, using a template designed to capture consistent and comprehensive data in relation to all key aspects of the MHLI implementation (see Appendix C), including:

- The nature, reach and perceived usefulness of activities implemented (or planned for implementation)
- How the MHLI was staffed in their PHN
- Partner organisations and individuals involved in developing, governing and/or implementing their MHLI activities
- Implementation highlights, challenges and potential risks.

In their final progress reports, PHNs also provided information about how the MHLI had been resourced in their site and how they were working towards sustainability, as well as being invited to share any local evaluation data or reports collected throughout their MHLI implementation.

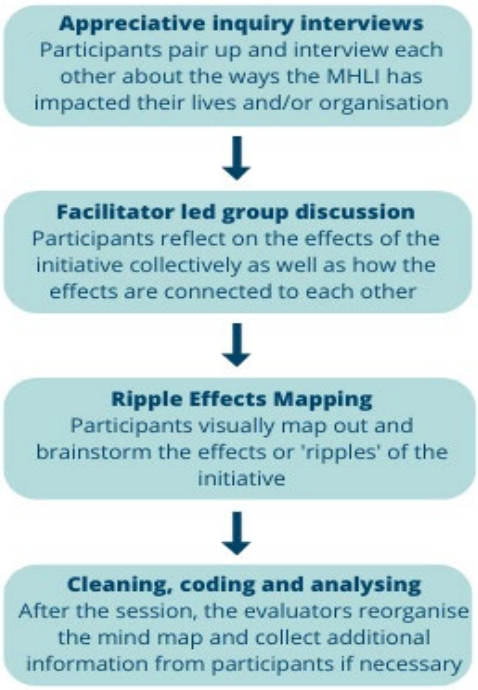
### Ripple Effects Mapping

Ripple Effects Mapping is a participatory data collection method designed to capture the impact of complex programs and collaborative processes. Participants were invited to reflect upon and visually map intended and unintended changes that have resulted from their involvement with the MHLI. For this evaluation, participants were encouraged to think about the different type of impacts using the Community Capitals Framework (see Figure 2). The Ripple Effects Mapping process consists of four stages which are outlined in Figure 3.

All PHN coordinators and any other relevant PHN staff (e.g., managers or executive sponsors) were invited to participate in a one-hour group Ripple Effects Mapping workshop via Zoom in July 2022. With the exception of the appreciative inquiry interviews, the workshop was audio-recorded with participants' consent. The final Ripple Effects Map was circulated to the PHN coordinators to ensure that it was representative of their experiences and captured all their perceived impacts of the MHLI.

**Figure 2:** Types of impacts described in the Community Capitals Framework

**Figure 3:** Stages involved in Ripple Effects Mapping




## Qualitative interviews

In-depth qualitative interviews with 12 PHN staff (coordinators sometimes accompanied by their line managers) from seven of the participating PHNs, 11 CWG members and one MHLI Steering Committee member were conducted between June and September 2022, resulting in a total of 11 interviews with 24 MHLI stakeholders (see Table 1 for further details).

A semi-structured interview guide was developed by the Evaluation Team based on the evaluation framework (see Appendix D). The interview guide was revised iteratively based on preliminary analyses and adapted depending on how the interviewee was involved in the project (e.g., part of the CWG, MHC project team or a PHN Coordinator).

The 45-60 minute interviews were conducted via Zoom, audio recorded (with participants' consent) and transcribed verbatim. All participants gave their informed consent. The interviews were analysed thematically to enable recognition of commonly occurring patterns and relationships to answer the research questions. The steps involved in thematic analysis are outlined in Figure 4. We used a hybrid inductive (data-driven) and deductive (theory-driven) approach in our data analysis.

**Figure 4:** Steps involved in thematic analysis

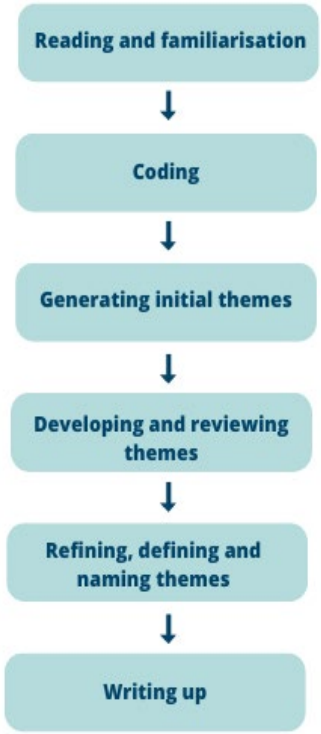



**Table 1:** MHLI stakeholders invited and participating in the in-depth interviews

| Stakeholder Type | Number invited | Number interviewed |
|---|---|---|
| Members of the Collaborative Working Group, including: | | |
| • MHC project team members | 2 | 1 |
| • Members of the SUNNY Consortium (including lived experience representatives) | 11 | 8 |
| • Representatives from lived experience advocacy groups | 2 | 2 |
| • Other key stakeholder | 1 | 0 |
| Steering Committee Members | 5 | 1 |
| PHN staff # | 16 | 12 (across 7 PHNs) |
| **Total** | **37** | **24** |

# One PHN coordinator declined to participate due to lack of capacity and one did not respond to our invitation. Two of the interviewed PHN coordinators were also members of the CWG.

### PHNs' local evaluation data

In their final quarterly progress reports, PHNs were invited to share any resource dissemination, website analytics and/or training evaluation reports for consideration and inclusion in this MHLI final Evaluation Report. Where available, a summary of their reach, acceptability and impact findings have been incorporated in the relevant sections of this report.

## Ethics

This evaluation was approved by the University of Sydney Human Research Ethics Committee. Protocol number 2021/945. Ethical guidelines related to consent and privacy were followed (National Statement on Ethical Conduct in Human Research (2007) updated 2015; Australian Code for the Responsible Conduct for Research (2007); Australian Privacy Principles Guidelines Privacy Act (1988) and the Aboriginal Health & Medical Research Council of NSW (AH&MRC) Guidelines for Research into Aboriginal Health Key Principles (updated September 2016)).

# Evaluation Findings

The MHLI evaluation findings are divided into two main sections, with each section bringing together all the relevant evidence from the various data sources to address the key evaluation questions:

1. How the MHLI was implemented, who was reached and what **built capital** was created (infrastructure and resources to support MHLR);
2. How the MHLI contributed to improving the following for PHNs and their commissioned services:
    a. **Social capital** – the connections and relationships between services
    b. **Human capital** – individual stakeholder capacity in relation to being more MHLR (including awareness, understanding and skills)
    c. **Cultural capital** – organisations' readiness to be MHLR.

The following results include direct quotes from the in-depth qualitative interviews, with the quotes presented selected as those best illustrating the dominant themes from the thematic analyses.

## MHLI implementation findings

### The challenging external context

Phase 3 of the MHLI was implemented between July 2021 and June 2022. During this time, the COVID-19 pandemic significantly impacted implementation activities as a result of stay-at-home orders and the need for general practices to prioritise vaccine delivery and the pandemic response. Primary care practices and commissioned services within each PHN also experienced increased COVID-related workloads, staff shortages and "fatigue", which ultimately limited their ability to engage with the MHLI, implement training and utilise resources.

> *I think the challenge was that we were delivering these around the time that there was COVID and vaccination and all of that as well. So, I think that was part of why practice managers were too busy because they were trying to organise vaccinations at their practices. (PHN)*

> *I think there's a whole bunch of stuff that was just completely beyond everyone's control and that all related around COVID. And that was the capacity internally, and of all of our external stakeholders, to be able to deliver, participate, engage, recruit. (PHN)*

Concurrently, different geographical regions across NSW experienced various natural disasters over the course of the MHLI, including major bushfire events between June 2019 and May 2020 and major flooding in February and July 2022. These events compounded the existing implementation delays and challenges associated with the COVID-19 pandemic.

> *The floods had such a significant impact on our implementation phase … just even being able to try to touch base with the PHNs to see how they were going with their activities … the common message was "look we're just trying to work with our providers and our communities to deal with this, we've actually put it on hold". (MHC)*

> *The combination of bushfires overlaid with the floods and the pandemic, and then the COVID vaccine rollout … last year practices just said "look, we really would love to be involved, but we literally couldn't wait to get to Christmas and have a day or two off" if they could get that … so just this fatigue of the practices, that's quite frustrating. (PHN)*

> *There was also a lot of demand on the community sector at that time because they had staff off sick. They had less people trying to deal with more things because there was so much distress and you know logistical needs in the communities, in terms of difficulties with food security and all the other things that they deal with, so, they got a bit extra stressed out at that point as well. (PHN)*

### MHLI staffing, governance and collaboration approaches

Eight of the nine participating PHNs appointed dedicated MHLI coordinator positions (usually 0.6 FTE) to lead the MHLI implementation in their region. These coordinators were usually supported by one or more PHN senior program managers and some received support from part-time project officers. All PHNs established MHLI working groups and/or steering committees to guide and oversee the activity development and implementation, with one PHN hiring consultants to assist with this phase. The regional MHLI working groups and steering committees usually involved PHN, Local Health District (LHD), community and PWLE representatives (often including groups of PWLE, with one PHN also reporting Aboriginal Community Controlled Health Organisation staff engagement.

Beyond these working groups and steering committees, a wide range of stakeholders acted as MHLI Key Influencers (involved in overall governance and/or decision-making) or MHLI Collaborators (involved in developing and/or implementing activities). The MHLI Key Influencers and Collaborators included:

- A wide range of PHN teams (eg: Mental Health, Alcohol & Other Drugs, Primary Care, GP Liaison, Stakeholder Engagement, Strategy & Planning, Data Governance, Practice Development, Health Coordination, Commissioning, etc)

- A range of LHD teams (eg: Mental Health, Alcohol & Other Drugs, Domestic & Family Violence, Communications, Information Technology, Stakeholder Relations, Aboriginal Health, Health Literacy)
- A range of pre-existing advisory bodies (including Local Health Advisory Committees, Community Advisory Committees, Mental Health & Suicide Prevention Advisory Groups, Clinical Advisory Committees, Consumer Advisory Committees, Aboriginal Health Advisory Councils, Population Health Committees, MHAOD Advisory Committees, Health Pathways Advisory Board, Clinical Councils, Community Councils, MHAOD Interagencies)
- External consultants, usually to assist with activity implementation (eg: AGORA Connect, Australian College of Nurses, Beacon Strategies, Black Dog Institute, Bright Agency, Dokotela Consultant Psychiatry, Embrace Multicultural Mental Health, Health Literacy Solutions, Healthy Digital, Mental Health Coordinating Council, Neami, Social Ventures Australia, This Way Up).

### MHLR-promoting activity implementation

Despite the pandemic and natural disaster challenges outlined above, PHNs implemented a range of MHLR-promoting activities during Phase 3 of the MHLI. While some activities originated because of the MHLI, others were progressions or updates to existing activities that PHNs had been previously working on. The activities implemented included a wide range of MHLR-related training events and resources, service navigation enhancements and some infrastructural improvements and therapeutic activities.

As shown in Figure 5, there was a heavy emphasis on capacity building training and resources (relating to Action Areas 4, 6, 8 and 10) and infrastructural activities, such as enhancing service navigation tools, (relating to Action Areas 2, 9 and 11). A few PHNs implemented more therapeutically-focussed activities, providing direct support to PWLE, (relating to Action Areas 1 and 5) but no PHNs implemented activities relating to Action Areas 3 and 7.

Figure 4: How the activities implemented related to the 11 MHLI Action Areas


**Note:** The above graph excludes initial planning and co-design activities and most activities mapped to multiple Action Areas.

The amount and combination of MHLR-promoting activities implemented varied considerably across the nine PHNs, with the Figure 6 and Figure 7 case studies providing overviews of how the MHLI was implemented in two PHNs (see Appendix E[3] for the remaining PHN case studies). The sections following the case studies provide a summary across the nine participating PHNs of each of the main types of MHLI activities implemented.

3 Implementation case studies were developed for the seven PHNs participating in the in-depth interviews.

**Figure 5:** Implementation Case Study: South Western Sydney PHN

## CONTEXT

South Western Sydney PHN covers south western suburbs of metro Sydney and extends to the Southern Highlands.

Activities implemented as part of the initiative were mainly targeted towards PHN staff, commissioned services and general practice staff.

## KEY IMPLEMENTATION ACTIVITIES

**NO WRONG DOOR FRAMEWORK**
Guides local organisations in implementing the principles of MHLR. It offers training, self-assessment modules and targeted resources, including some of the SUNNY resources.

*The reason for the framework was around implementing some of those mental health literacy responsiveness as well as other kind of things around the wrong door recovery-oriented practice...It's...kind of like interactive modules, so we've got for example, we have principle one: There's an indicator related to principle one and then we've got some resources and then a self assessment so they can assess themselves against the indicator and then develop actions for improving.*

**EMBRACE FRAMEWORK**
Framework to improve cultural responsiveness aimed at PHNs and commissioned services. It includes a self-assessment tool and supporting resources.

*So, we did Embrace and we did the modules and everything completed a framework. There were some actions that came out of the framework which we started implementing...we had a committee that that did the Embrace framework, and now we've created a committee from that which is for the general organisation around CALD engagement.*

## OTHER IMPLEMENTATION ACTIVITIES

**SERVICE NAVIGATION**
- HeadStart App: Online service directory to assist consumers, carers and service providers to navigate local mental health services.

**TRAINING**
- State-wide MHLR training
- Mental Health First Aid training
- GP-focussed basic mental health skills

*We had the combined training which we hosted, but it was a collaboration between the PHNs. That one went really well. I think we had like 23 different people attend. That was more focussed specifically on mental health literacy responsiveness.*

## IMPLEMENTATION HIGHLIGHTS

- Successful implementation of the Embrace and No Wrong Door frameworks
- Collaborative work across PHNs to deliver state-wide MHLR training
- Successful GP and practice nurse training sessions

*We all saw that [the combined state-wide MHLR training] is really valuable and now we're wanting to do more of that stuff.*

**Figure 6:** Implementation Case Study: Western Sydney PHN

## CONTEXT

Western Sydney PHN Western Sydney PHN covers the following Local Government Areas: Blacktown, Cumberland, Parramatta and The Hills Shire.

Activities implemented as part of the initiative were primarily focussed on general practices, but also included focus on PHN staff, commissioned services and other mental health service providers. Service navigation was a key area of focus.

## KEY IMPLEMENTATION ACTIVITIES

**DIGITAL QUALITY IMPROVEMENT HEALTH LITERACY TOOLKIT**
Online toolkit incorporating SUNNY and other resources to improve service responsiveness. Targeted towards all staff in general practices.

*[The toolkit] is a compilation of all of the resources that have kind of been developed by SUNNY...completely repackaged and a link into a whole raft of different support networks, resources, training guides, anything that could help a GP to be more service responsive and it's designed to allow any member of of a general practice, so say, nurse, receptionist or GP and allied health worker to look at that and work through it. And it's...a reflection tool so they can watch a snippet from a patient experience video reflect on some questions about their own practice, identify areas to improve and then there are resources to coach them through those improvements.*

**EMBRACE FRAMEWORK**
Framework to improve cultural responsiveness aimed at PHNs and commissioned services. It includes a self-assessment tool and supporting resources.

*Embrace was through the CoP. We had conversations hearing about others engaging in that framework thinking we have a really large CALD population in Western Sydney. This is something that we should really look at and so got a team together from commissioning our project management team and our refugee multicultural health facilitators on board and engaged that that process.*

**SPOTLIGHT VIDEOS**
Brief videos for GPs to provide an overview of mental health services, eligible recipients and referral pathways available within the PHN.

*So there was certainly a need identified that we needed to get information out to enable GPs to not go to their one and only approach to mental health...So we've categorised the videos into sections from low, moderate and high intensity services, their youth, digital services and and then some overarching ones like Head to Health, our PMHC program, the GP Psychiatry support line. So, it's just a way of getting information out there.*

## OTHER IMPLEMENTATION ACTIVITIES

**SERVICE NAVIGATION**

- HeadStart: Online service directory to assist consumers, carers and service providers to navigate local mental health services
- Update to HealthPathways website: Website to support GPs, practice nurses and other clinicians with service navigation, condition management and referral
- AGORA Connect: Online social prescribing platform referring people to psychosocial programs and activities. Funded prototype but abandoned due to lack of funding

*HeadStart happened coincidentally. Like it was would this work under you know, under this banner to me and I said yes it would and then it just happened.*

*A psychiatrist came up with a concept around and on a digital social prescribing tool that could be accessed by patients and GPs and. We certainly saw a lot of potential in it to the extent where we funded a proof of concept phase.*

**TRAINING**

- State-wide MHLR training
- Mental health training for practice nurses

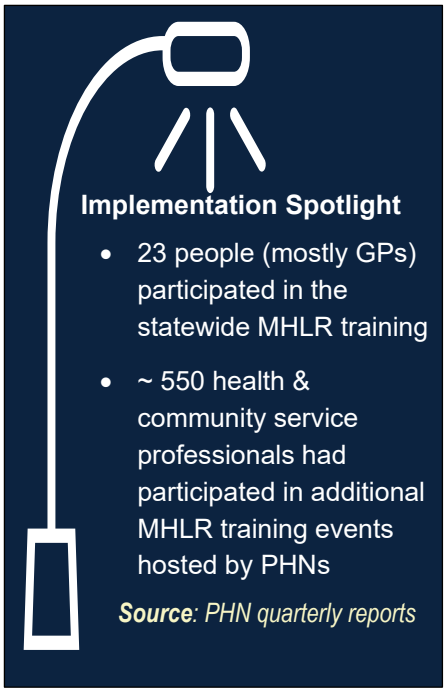
## IMPLEMENTATION HIGHLIGHTS

- Collaborative partnerships through the CoP which provided a foundation for implementing activities to improve MHLR
- Learnings gained from the AGORA social prescribing proof of concept phase

*I really, genuinely valued the kind of that communities of practice, conversation and I think that's probably where all of us and the PHNs got the most. I want to say momentum, but encouragement I guess, and affirmation in what we were doing and that support of one another.*

### *Capacity building training*

All PHNs participated in the statewide MHLR training delivered in March 2022. This training event was a collaboration between PHNs and the SUNNY Consortium and was delivered as a Continuing Professional Development activity for general practitioners. The training covered mental health literacy, MHLR, quality improvement approaches, barriers and enablers to MHLR and communication and engagement in the GP consultation.




In addition to the statewide MHLR training, seven PHNs implemented (or planned to implement) additional training events relating to MHLR or mental health more broadly. These trainings were often delivered by external training providers. The most common trainings were Mental Health First Aid, Australian College of Mental Health Nurses' online mental health training for practice nurses, Stepped mental health care, e-mental health supports and GP-focussed basic mental health skills training. Some PHNs had plans to deliver additional training events beyond June 2022, mostly due to COVID-19-related delays and cancellations.

### *Capacity building resources*

*SUNNY-developed resources*

While use and adaptation of the SUNNY-developed resources varied, most PHNs included some form of mental health literacy-promoting resources as part of implementing this MHLI.

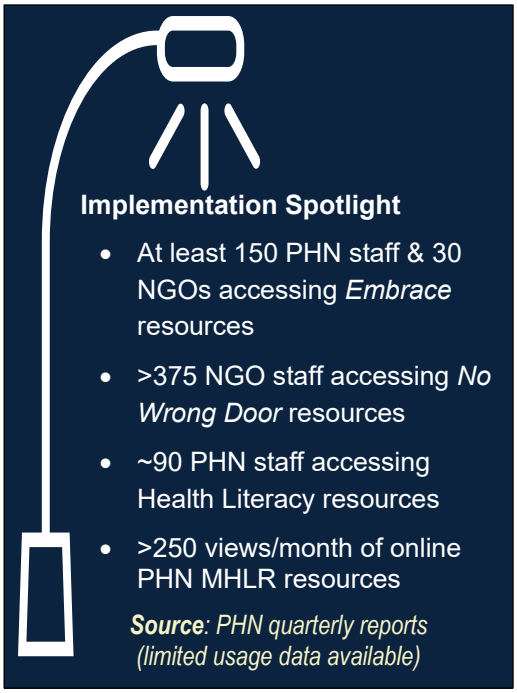
The SUNNY-developed resources were used by about half the participating PHNs in a variety of ways:

- Some PHNs promoted the use of SUNNY-developed resources to GPs and commissioned services through newsletters and webinars linking directly to the NSW Mental Health Commission webpage.
- Other PHNs selected the resources most relevant for their region and adapted or repackaged them.
- In other cases, SUNNY-developed resources were integrated into existing tools or other implementation activities. For example, South Western Sydney PHN incorporated resources into their No Wrong Door Framework online platform. Similarly, Western Sydney PHN incorporated SUNNY resources, along with other resources, into a digital health literacy quality improvement

toolkit. Both of these adaptations are described in more detail in the corresponding case studies in Appendix E.

*Pre-existing resources*

All nine PHNs implemented (or planned to implement) other existing MHLR-related resources. Several PHNs implemented MHLR tools and resources specifically for culturally and linguistically diverse populations, including the *Embrace Framework for Mental Health in Multicultural Australia*, developed by Embrace Multicultural Mental Health, to improve cultural responsiveness. Some PHNs also translated and adapted existing resources for culturally and linguistically diverse communities. Other resources included a *Physical Health Conversation Guide* for people with mental health issues, the *No Wrong Door Framework* which guides local organisations in implementing MHLR and a *Primary Care Impact* webpage, which provides a range of quality improvement resources.




*PHN-developed resources*

Some PHNs also developed their own MHLR-related resources as part of the MHLI. For example, North Coast PHN are developing locally relevant resources co-designed with an external consultancy company and a lived experience panel. These resources are targeted toward the broader community to act early and inform them of available mental health services and supports. Central Eastern Sydney PHN developed *While You Wait*, a conversation guide to help GPs and patients create a plan for their first specialist mental health appointment.

### *Infrastructural activities*

*Service navigation enhancements*

Most PHNs implemented one or more activity aimed at improving the ease with which health professionals and/or community members could identify and/or access relevant services.


Most PHNs reviewed and upgraded their service directories and online platforms. For some PHNs this involved updating the information on HealthPathways, a website designed to support health professionals with service navigation and referral to other services. Western Sydney PHN also developed a series of brief 'Spotlight' videos for GPs with information about different mental health services and their referral pathways.

Several PHNs implemented (or planned to implement) the HeadStart app, an online consumer-facing mental health service directory connecting community members with local service providers. While some PHNs had planned to implement HeadStart prior to the MHLI, the MHLI enabled the implementation to be 'kickstarted'. Nepean Blue Mountains PHN implemented another Mental Health Navigation Tool, an online platform to direct people with lived experience and their carers to locally available mental health services.

*PHN administrative processes*

Five PHNs incorporated (or planned to incorporate) MHLR considerations within their regional mental health and suicide prevention planning and at least three PHNs had incorporated MHLR considerations within their service commissioning processes.

*Other*

Other infrastructural activities reported by 1-2 PHNs included: a centralised phone contact point for mental health, drug and alcohol and NDIS support; redesigning mental health, drug and alcohol and suicide prevention service models; integrating their phone & web-based fact sheets/ support services with their updated online service directory; and a MHLI Communications strategy.

### *Therapeutically-focussed activities*

Three PHNs also implemented therapeutically-focussed activities:

- Northern Sydney PHN implemented a Better Off With You media campaign aimed at reducing the stigma associated with mental ill-health, estimated to have been seen by thousands of people
- Central Eastern Sydney PHN promoted a range of e-mental health tools and self-help resources to GPs and non-government organisations (NGOs) but no data were available about the extent to which these resources were being accessed or promoted to clients
- Western Sydney PHN worked with consultants to develop a proof of concept for an online social prescribing platform, however additional funding could not be secured to fully develop and implement the platform.

## Feedback about MHLR-promoting activities

While participant evaluation data were limited for most MHLI activities, the PHN quarterly progress reports provided generally positive reflections about how trainings and resources were received.

The following sections provide a summary of the acceptability data from the statewide MHLR training evaluation and other evaluation reports for MHLR-related training implemented by PHNs.

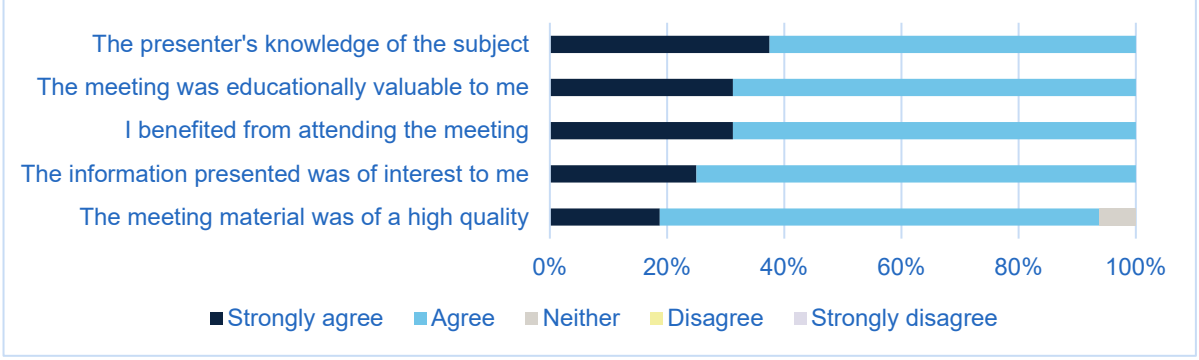
### *Acceptability of MHLR capacity building training*

*Statewide MHLR training*

- Delivered to 23 people (mostly GPs) in March 2022, with evaluation forms received from 16 participants
- Respondents provided positive feedback about the nature of the training (as detailed in Figure 8)

**Figure 7**: Participant acceptability feedback about the statewide MHLR training (n=16)

| Item | Min | Max | Mean | Responses |
|---|---|---|---|---|
| The relevance of this training to your work/role | 8 | 10 | 9.44 | 16 |
| How the content was organised | 6 | 10 | 8.75 | 16 |
| The usefulness of the resources provided | 6 | 10 | 8.31 | 16 |
| How well your learning needs were met | 7 | 10 | 8.19 | 16 |



*Understanding Mental Health: Trauma and recovery-informed practice*

- Delivered to 31 GPs and practice nurses in April and May 2022 for South Western Sydney PHN, with evaluation forms received from 27 participants, who provided very positive feedback.
- 75% considered the training was at the right level and 88% felt it was delivered at the right pace
- Most rated the overall facilitation and the trainer's understanding and explanation of the topic as 'Excellent' (74%, 85% and 74% respectively), with others rating them as 'good' or 'very good'
- 65% rated the training resources as very helpful, with others rating them as helpful or fairly helpful.

*[Trainer] is warm, knowledgeable and her delivery was impeccable. (Training participant)*

*Loved this training. It was wonderful. So engaging. So raw. So real & insightful. Love the respectful & safe space that you created for us all! (Training participant)*

*Psychological Distress in Primary Health Care*

- Delivered to approximately 30 practice nurses in February 2022 for South Western Sydney PHN, with evaluation forms received from 16 participants.
- 68% rated the training as 'excellent', with the remainder rating it as 'good'
- 63% considered the training as relevant or very relevant to their work, with only one participant considering it not relevant.

*Managing Common Mental Health Challenges in General Practice*

- Delivered to approximately 23 GPs in February 2022 for South Western Sydney PHN, with evaluation forms received from 13 participants.
- 63% rated the training as 'excellent', with a further 31% rating it as 'good'
- 92% considered the training as relevant or very relevant to their work, with only one participant considering it somewhat relevant.

*This Way Up (online Cognitive Behavioural Therapy)*

- Delivered to 31 GPs and 11 practice nurses in April 2022 for Central and Eastern Sydney PHN, with evaluation forms received from 32 participants
- 94% agreed the content was clearly and effectively presented and 97% would recommend the training to a colleague
- 84% considered the training entirely relevant to their work, with the remainder considering it partially relevant.

*Training in MHLR and Culturally-appropriate Practice*

- Delivered to approximately 55 NGO staff working with culturally and linguistically diverse (CALD) communities between March and June 2022 for Central and Eastern Sydney PHN, with evaluation forms received from 51 participants

- Participants provided positive feedback about the nature of the training (as detailed in Table 2).

**Table 2:** Participant acceptability of CALD-focussed MHLR training (n=51)

| | n | Min | Max | Mean |
|---|---|---|---|---|
| a) How clearly the content was presented | 51 | 5 | 10 | 8.8 |
| b) The usefulness of the resources provided | 50 | 5 | 10 | 8.8 |
| c) How the content was organised | 48 | 5 | 10 | 8.7 |
| d) How well your learning needs were met | 50 | 4 | 10 | 8.0 |
| e) The relevance of this training to your work/role | 51 | 3 | 10 | 7.7 |

**Note**: Rating scale – 0 = Extremely poor, 5 = OK/Varied, 10 = Excellent.

## MHLI enablers and challenges

### *MHLI funding and flexibility*

A unique feature of the MHLI was the flexibility in funding provided to the PHNs, as noted by most interviewees. The flexibility about how the MHLI funds were spent allowed a more tailored, locally-responsive and pragmatic approach to MHLI implementation and governance. For many PHNs, this provided an opportunity to capitalise on and progress pre-existing activities related to MHLR in their PHN or "kick-start" activities that would have otherwise been delayed or forfeited because of a lack of funding. For all but one PHN, this was operationalised by hiring a coordinator to oversee MHLR activities for their region.

> *We were so excited about the flexibility and what that could afford in terms of being able to do some really interesting, creative stuff 'cause we're so hamstrung. (PHN)*

> *What the health literacy project did was help to kind of really kick start that activity so we're able to implement that a lot quicker than we would have been able to otherwise because we had resourcing there to help. (PHN)*

> *I'm surprised they've got to implement as much as they did amongst all the challenges … and I think one of the solutions was that they were looking for things they were doing already … so the MHLI was not seen as an extra piece of work, but enhancing what they were doing and so, in some ways we were really lucky to have such strong champions and advocates for this work. (MHC)*

> *I felt like there was an appropriate level of oversight that allowed flexibility which is good because different PHNs, different organisations, they all have their own problems and issues and it's good not to be too top down in the way you do stuff. (CWG)*

Although the flexibility in funding and related autonomy were valued by many PHN coordinators, some also reported feeling confused and uncertain, especially during the early stages of implementation. While one PHN attributed this simply to having to adapt to a different model of working, for others it was related to the broad scope of the MHLI and uncertainty about what activities constituted MHLR.

> *Initially, I was really confused about what my role was, then like what the funding was about, … but in hindsight, it was probably a good way to do things, because it just gave us a bit more autonomy … they trusted that we were the subject matter experts for our region and so rather than dictating what we need to do, we had the option to design things that were suitable for our regions. (PHN)*

> *At the start, I found it very confusing and didn't know what the parameters or the scope of what we were doing because it was so flexible, when we're used to much more prescriptive funding … on reflection it might have helped if there had been a bit more of a framework, a bit more structure around that. (PHN)*

### *Achieving co-design and local relevance in a multi-staged, statewide initiative*

Co-design was a fundamental component of Phases 1 and 2 of the MHLI, with only two pilot PHNs engaged during this time. In these early phases, participants felt that the co-design process "*was done quite well*", with acknowledgement that the MHC "*tried really hard and they did well in including people with lived experience*" while also highlighting the challenges associated with *"transitioning from the slightly amorphous, messy stage where we're doing lots of talking with people and hearing their opinions and views and then moving to actual projects"*.

However, for some PHNs involved in only the Phase 3 rollout, the outcomes of the early co-design were at times not perceived to be locally relevant as they did not specifically involve community members or specific priority population groups from each PHN. These PHN coordinators expressed feeling disconnected from the co-design phases of the project and felt they did not achieve *"meaningful engagement with consumers in a way that we would have liked to or felt that we should".* A desire to have had a greater role in co-producing resources with and for their local stakeholders and communities prompted some PHNs to undertake their own local co-design processes, coordinated either internally or with commissioned consultants. Other PHN coordinators spoke about ways in which they tried to engage PWLE in later stages of the project, but this was often acknowledged as falling short of true co-design.

> *They went through the process of working with two PHNs around co-design but bringing those other PHNs in at an earlier stage to make sure that actually applied across all regions probably would have been a good step. (PHN)*

> *Initially, we thought we would have a larger role in terms of co-producing the resources and then it was kind of "here are the resources, they're done and up on our website". (PHN)*

*We wanted to understand what the mental health literacy needs were for our region and then what we wanted to prioritise … it was related to the mental literacy initiative but it was a broader activity around understanding the needs in our region as well. (PHN)*

*I always think there's room for improvement there … as I went through this project I began to better appreciate the contribution of and the need for that voice in what we were doing … so towards the end of the project we've worked with our Relationships & Partnerships team, who look after our consumer base, and we started having conversations about how do we actually get people with lived experience or the consumer voice integrated again into business as usual. (PHN)*

Despite these challenges, it is worth noting that the engagement of key stakeholders in PHNs' co-design processes was the most commonly-mentioned implementation highlight in their quarterly progress reports.

### *Delayed delivery of the SUNNY-developed MHLR resources*

The MHLI's initial co-design process was seriously hampered by the onset of the COVID-19 pandemic, resulting in a considerable delay in the development and delivery of the SUNNY-developed MHLR resources to PHNs. Many PHN coordinator interviewees reported that the delayed delivery of the SUNNY-developed resources had made it difficult for them to fully grasp the scope of the MHLI and to plan their implementation activities. In the in-depth interviews, PHN coordinators expressed a desire for clearer delineation and communication regarding who was responsible for the development of resources and the degree to which PHN activities should be driven by the SUNNY-developed resources and/or their locally-developed resources. Aside from the COVID-19 pandemic, these delays were the most commonly mentioned challenge in the PHN progress reports.

*We needed clearer communication and understanding of who was responsible for the different aspects of what was being produced right from the beginning … who has responsibility around producing those resources, whether it's PHNs or the Commission or the SUNNY collaborative. (PHN)*

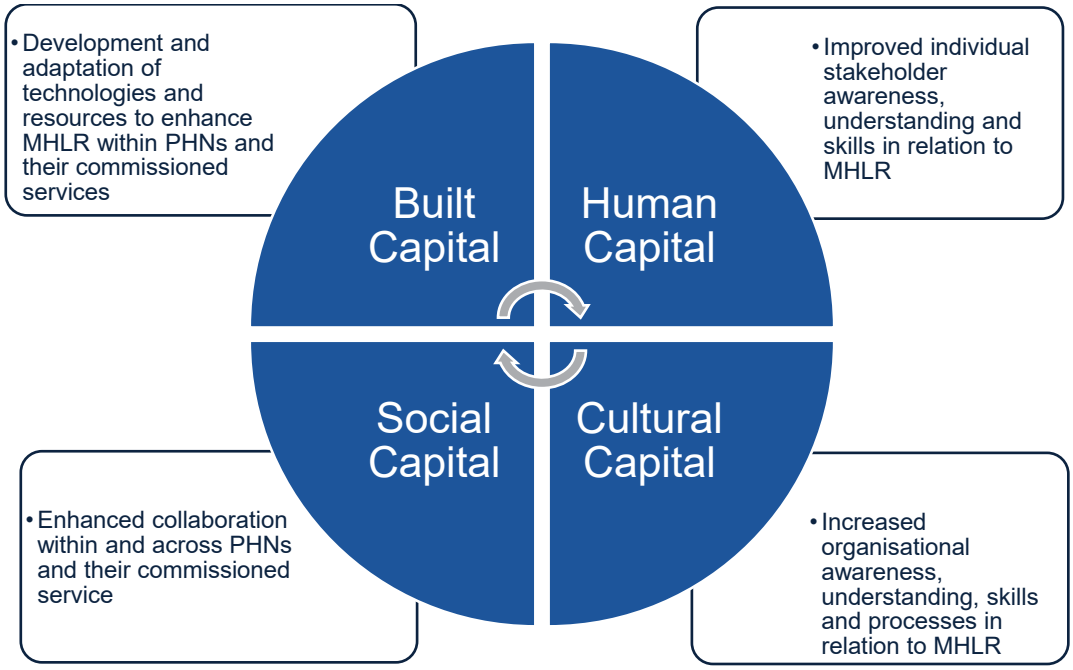
*Had the resources been ready sooner then that would have provided a little bit more structure … it could still have been super flexible but we would have worked around the resources we got. (PHN)*

*How can we use these resources and these activities if we're not really sure what they'll look like and how they will end up?... Sort of challenging and I'm still getting my head around those action areas and how they would then link with what we could do. (PHN)*

## MHLI impact findings

Given the MHLI's relatively short post co-design implementation timeframe, this evaluation focussed on the perceived short-term impacts of the MHLI, as well as exploring perceptions about how these impacts might be sustained and/or enhanced in the future. The qualitative interviews and Ripple Effects Mapping identified several short-term outcomes for PHNs, general practices and commissioned services which are summarised in Figure 9. As discussed earlier, these changes have been mapped to the following domains of the Community Capitals Framework, as outlined in Figure 9 and discussed in further detail throughout this section of the report: built capital, human capital, social capital and cultural capital.

**Figure 8:** Short-term outcomes of the MHLI identified through the Ripple Effects Mapping




The MHLI impacts were also identified in a recent external review of the MHC which found that "*Health literacy development is one of the key pieces of work commonly referenced by key stakeholders as being influential and delivering value to people with lived experience in NSW*". However, many evaluation interviewees commented that it was too early to see any improvements in outcomes for PWLE, especially given the ongoing impacts of COVID-19 and natural disasters which delayed many implementation activities.

Another positive outcome was that the MHLI was recognised as a World Health Organization National Health Literacy Demonstration Project, which are local case studies that measure and improve health literacy in a local or regional context, and which have the potential and intention to be scaled up to improve health literacy at a national level. Participation was endorsed by The Hon. Brad Hazzard,

Minister for Health, The Hon. Bronnie Taylor MHLC, Minister for Women, Regional Health and Mental Health.

> *The initiative got noticed by the World Health Organization … so it's put mental health literacy on the global map, which is pretty amazing, that's a very big, big picture thing. (CWG)*

### MHLI impact on built capital – the infrastructure and resources to support MHLR

As illustrated in Figure 10 and discussed in more detail in the *Implementation Findings* section, the MHLI supported the development, adaptation and implementation of technologies and resources to improve MHLR within and across PHNs, general practices and commissioned services. While detailed reach data were limited, there was evidence that the trainings and resources have been accessed by many different professional groups and, in some cases, by the broader community, including mental health service consumers, their families and carers.

**Figure 9**: A snapshot of some of the built capital resulting from the MHLI


The MHLI also provided grant funding to Macarthur Disability Services, South West Sydney Recovery College and Northern Sydney Primary Health Network to develop and pilot MHLR resources for services working with Aboriginal people. This work was led by an Aboriginal Leadership group.

## MHLI impact on human capital – individual stakeholder capacity in relation to MHLR (including awareness, understanding and skills)

While participant evaluation data were limited for most MHLI activities, the PHN quarterly progress reports provided generally positive reflections about how the trainings and resources were received, as well as perceptions that training participants had benefited from their attendance.

The following sections provide a summary of the MHLR capacity-related data from the available training evaluation reports from the statewide MHLR training and other MHLR-related training implemented by PHNs.

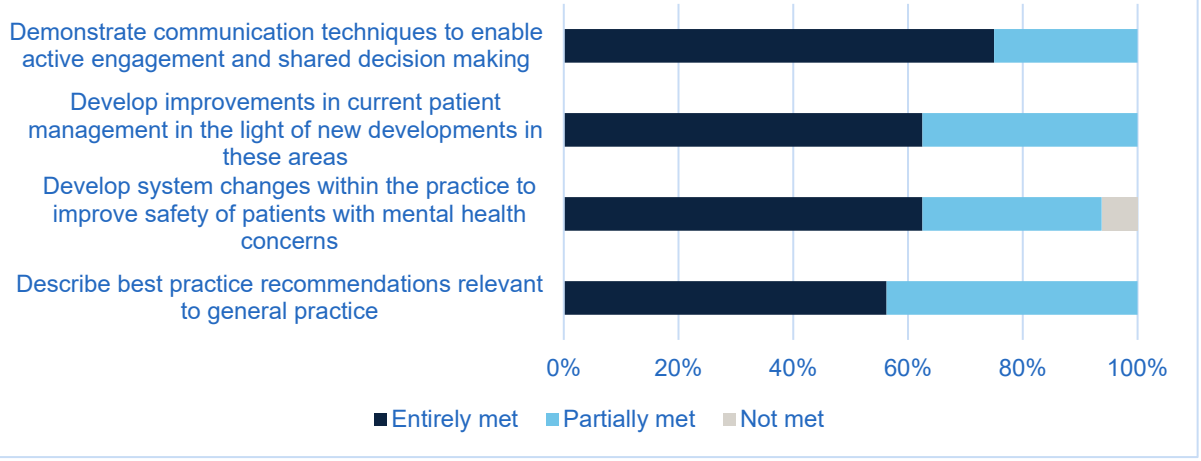
### *Statewide MHLR training*

- Delivered to 23 people (mostly GPs) in March 2022, with evaluation forms received from 16 participants
- Participants felt the training helped with improving their understanding about various aspects of MHLR, with almost all feeling the learning outcomes were met (as detailed in Figure 11) and all 16 considering the training was relevant to their practice.

**Figure 10:** Participant learning outcome feedback about the statewide MHLR training (n=16)

| Extent the training helped with improving their understanding of …: | Min | Max | Mean | Responses |
|---|---|---|---|---|
| How communication with GPs can support client outcomes | 6 | 10 | 8.75 | 16 |
| How people's health literacy needs can impact their experience with your service | 3 | 10 | 8.25 | 16 |
| How different communication techniques can help people | 3 | 10 | 8.25 | 16 |
| How you can improve their experience of accessing your service | 5 | 10 | 8.06 | 16 |
| Barriers people with mental health issues experience when accessing services | 2 | 10 | 8.13 | 16 |

| Extent the training helped with improving their understanding of …: | Min | Max | Mean | Responses |
|---|---|---|---|---|
| Different types of information clients may need to make informed decisions about their care | 5 | 10 | 8.00 | 16 |




- All 16 participants commented about their main learning from the training and felt motivated to change systems and/or processes in their practice to improve patient safety, with 12 indicating specific planned changes and 14 commenting about things they planned to do differently.

*Dedicate more time to patient interviewing, improve interaction with support worker and give more "room" for patient "expression" as our/mine focus is the patient's individual mental health improvement. (Training participant)*

*Provide quiet space for those who need it. Inform reception staff on best practice for mental health patient care. Reinforce importance of being present and not distracted during visits. (Training participant)*

*Talk to reception and nursing staff about providing a welcoming and inclusive environment. During consultations include peer support or family members. Also, reinforced importance of being engaged and present during consult. (Training participant)*

### *Training in MHLR and culturally-appropriate practice*

- Delivered to approximately 55 NGO staff working with CALD communities between March and June 2022 for Central and Eastern Sydney PHN, with evaluation forms received from 51 participants
- Participants reported high levels of improvement in relation to the key learning objectives (as detailed in Table 3).

**Table 3:** Participant feedback about the impact of CALD-focussed MHLR training (n=51)

| | n | Min | Max | Mean |
|---|---|---|---|---|
| a) How you can improve their experience of accessing your service | 50 | 5 | 10 | 8.3 |
| b) How people's health literacy needs can impact their experience with your service | 50 | 5 | 10 | 8.2 |
| c) How different communication techniques can help people | 49 | 2 | 10 | 8.2 |
| d) Different types of information clients may need, to make informed decisions about their care | 49 | 2 | 10 | 8.2 |
| e) Barriers with mental health issues experience when accessing services | 50 | 4 | 10 | 8.0 |
| f) How communication with GPs can support client outcomes* | 40 | 0 | 10 | 7.9 |

Note: Rating scale – Extent to which the training helped with improving understanding about the items:
0 = Not at all, 5 = Somewhat, 10 = Very much so.

### *Psychological Distress in Primary Health Care*

- Delivered to approximately 30 practice nurses in February 2022 for South Western Sydney PHN, with evaluation forms received from 16 participants
- Participants reported increased understanding and confidence levels across 12 key learning objectives – the proportion of participants rating themselves as 'very good' or 'excellent' increased on all items from 25-50% before the training to 62-81% after the training; similarly, while 19-38% rated themselves as 'fair' or 'poor' on each item before the training, only one participant rated themselves as such on a single item after the training.

> *I believe I am more confident in dealing with distressful situations after this meeting. If I am unsure I can use the teach-back checklist to help reflect my actions in the practice setting.*
> *(Training participant)*

- Participants nominated a range of next steps they would take to progress their learnings in the workplace.

*Discuss with team, plan for patient assessment and incorporate into practice. (Training participant)*

*Shadow GP's in their mental health consults with patient's consent and debriefing after mental health consultations. (Training participant)*

***Understanding Mental Health: Trauma and recovery-informed practice***

- Delivered to 31 GPs and practice nurses in April and May 2022 for South Western Sydney PHN, with evaluation forms received from 27 participants
- 65% reported feeling confident putting the learned skills into practice after the training, compared with only 15% before the training.

*I learnt a great deal not just for my profession but also personally. (Training participant)*

*Great Course, great learning experience surely gonna recommend to others. (Training participant)*

- 85% provided examples of ways their understanding and/or skills had improved:

*How to navigate towards the right information and putting it into practice. (Training participant)*

*Identify & recognise signs of trauma. To respond in a kind & present way, & to hold space for the person experiencing distress. (Training participant)*

*Engage meaningfully with consumers who struggle with mental health … I have refreshed my knowledge on the impact of trauma & grounding techniques. (Training participant)*

***Managing Common Mental Health Challenges in General Practice***

- Delivered to approximately 23 GPs in February 2022 for South Western Sydney PHN, with evaluation forms received from 13 participants
- All participants felt three key learning outcomes were partially or entirely met (77-85% entirely)
- Participants reported increased understanding and confidence levels across 12 key learning objectives – the proportion of participants rating themselves as ‘very good’ or ‘excellent’ increased on all items from 23-54% before the training to 69-85% after the training; similarly, while 15-31% rated themselves as ‘fair’ or ‘poor’ on each item before the training, only one participant rated themselves as such on two of the items after the training
- Participants nominated a range of next steps they would take to progress their learnings in the workplace.

*Work with patients to help formulate treatment plans and what they would like to achieve. (Training participant)*

*Review all the resources provided, prepare a list of resources that are useful for patients and practice more by with patients who require mental health care plans. (Training participant)*

*Spend more time to listen. Provide more information to patient. Work along psychologist and psychiatrist. (Training participant)*

- 46% felt motivated to change the systems or processes in their practice to improve patient safety.

***This Way Up (online Cognitive Behavioural Therapy)***

- Delivered to 31 GPs and 11 practice nurses in April 2022 for Central and Eastern Sydney PHN, with evaluation forms received from 32 participants
- All participants felt six key learning outcomes were partially or entirely met (66-88% entirely)
- Participants nominated a range of ways that their learnings could contribute to a systems-based patient safety outcome for their practice.

*Integrate this way up as a therapeutic tool to guide and manage patients with anxiety/depression. (Training participant)*

*Introduce to more patients iCBT. Look into referring patients so I can track progress. I have known of the program previously but was not entirely sure how to use it. (Training participant)*

*Screen patients with assessment tool, identify major distress issue and prescribe this way up blended with face to face or while awaiting other therapy. (Training participant)*

- 47 participants nominated a main learning, mostly in relation to having learned about available resources and services (62%) or about communication and empathy (23%)

*To be able to use the various websites - Headstart, Head to Health, This Way Up - to help people to refer to where they need to go to need help. (Training participant)*

*Communication tools that we could adopt to better assess and serve clients. (Training participant)*

- 41 participants nominated things they anticipated doing differently as a result of the training, mostly in relation to accessing and/or recommending services and resources; and being more MHLR and open-minded.

*Recommend our clients to the 3 websites, e.g., headstart, head to health. (Training participant)*

*Improve communication and responses when working alongside people with complex needs. (Training participant)*

## MHLI impact on social capital – the connections, relationships and collaboration between services

Many interviewees perceived new and enhanced linkages between PHNs to be a significant and valued outcome of the MHLI, which they felt rarely happened with most funding initiatives. PHN coordinators valued the opportunity to connect and learn from one another, especially through the Community of Practice, and were able to build strong relationships and ties as a result.

> *I've developed relationships with people in the PHNs that I didn't have before and haven't had the opportunity to before. (PHN)*

> *It was an opportunity for us to come together and work on something collaboratively based … we all had a similar need that we all wanted to do some kind of training and being able to pool our resources to do that together. (PHN)*

The PHN coordinators' readiness and enhanced capacity for inter-PHN communication, cooperation, and collaboration were seen as a valuable sustained outcome of the MHLI. Many PHN coordinator participants noted that they were eager to sustain these new linkages after the MHLI ended.

> *One of the biggest changes I've seen is the dialogue and sharing around resources and joint planning of programs … when we first started this three years ago and were canvasing PHNs to be part of the MHLI, they were saying "we are independent organisations we have our own population needs and programs, we don't know how this is gonna work, together in a collaborative" … now the dialogue that I hear from them is "we've developed this training program and this PHN and this PHN is joining". (MHC)*

> *We got to the last official CoP a couple of months ago and started the dialogue about "what do we want to do now?" … and everyone has indicated they would like to continue meeting and having these conversations, because we're all in roles that still have a position of influence in the mental health literacy space. (PHN)*

The PHN quarterly progress reports reinforced these findings, with both inter-PHN and intra-PHN collaboration commonly nominated as implementation highlights of the MHLI.

## MHLI impact on cultural capital – organisations' awareness of and readiness to be MHLR

Many interviewees commented about a growing cultural shift characterised by an increased awareness of the importance of MHLR within PHNs, general practices and commissioned services. Most regarded the major impact of the MHLI to be increased conversations about MHLR at all levels of the PHN (including at the leadership level) and the filtering of a health literacy framework/lens into "*business as usual*".

*It's being built into conversations now as BAU, which is something you wouldn't have heard of in PHNs three years ago … so I think that's the true win (PHN)*

*We've changed our way of working since participating in this project, but it's probably not something that's formalised, so here's a good example: we have a flyer that's going out next week about practice managers and medical practice assistance and it was just so full of jargon and acronyms and now we're just keeping it simple and not over-complicating things. (PHN)*

Some PHN interviewees also spoke about changes to procurement and contracting processes as a result of the MHLI. This included, for example, embedding health literacy requirements, standards and deliverables through which they would be able to "hold people to account" in terms of optimising the responsiveness of their commissioned services.

*We've changed the way that we write procurements too so we can consider improving the way that services are delivered to the community by factoring in those action areas and also evidence around how to improve health literacy in general. (PHN)*

*We're asking questions like "how will your organisation be responsive to the health literacy needs of the community?" … we put a question in the schedules, they responded about how they will do it at a consumer level and also how they will do it at an organisational level … and now we're putting a contract together based on that. (PHN)*

Some PHN interviewees also commented about how MHLR was now being considered in PHN organisational planning, especially in relation to their regional mental health and suicide prevention planning.

## MHLI Sustainability and Scalability

While interviewees had varying views about the extent to which MHLR would remain a priority beyond the MHLI implementation period, the MHLI resulted in considerable MHLR capital which has the potential to be sustained beyond the life of the MHLI, at least in the short term:

- The built MHLR capital created includes many resources that will remain available to organisations and communities (and some that are yet to be delivered), although concerns were also raised about who would update these.

*In terms of sustainability, we've got educational resources there that people can use beyond the project, but they are gonna date. (MHC)*

- The human MHLR capital created has the potential to be applied by the impacted stakeholders, with some PHN coordinators commenting that they will able to spread their new MHLR knowledge

to different teams within the PHN and that they remain committed to MHLR even after the MHLI funding period

*We'll be keeping the PHN Coordinator beyond the project so that we have that additional resource to support not only future health literacy activities, but broader implementation of our regional plan. (PHN)*

*It's a conversation now that is probably just starting purely because my role has shifted and as a program manager for mental health I get to sit in on all of our mental health contracts and procurement processes. (PHN)*

- The social MHLR capital created has the potential to continue in future collaborations and sharing of ideas, solutions and interest between PHNs, primarily through the commitment to continue the MHLR Community of Practice

*The ongoing community of practice will sustain opportunities for people who are interested in health literacy between different PHNs to keep sharing with each other … sharing what they have done or even bringing the question "hey, we have this issue – does anyone else have an idea about how to address this?" I think those are really powerful strategies. (CWG)*

- The cultural MHLR capital created has the potential to help shape how PHNs and their commissioned services optimise the MHLR of their activities.

*The whole process of Ophelia is to develop a scalable model, building ownership within the PHNs, putting in place sustainable things so at the end of it, there isn't something to implement because it already has become embedded. (SUNNY)*

However, the extent to which the newly-created MHLR capital can be sustained in the longer term, without dedicated PHN coordinators and the MHC statewide coordination role, is less certain – as voiced by a number of interviewees:

*We're lucky 'cause I am continuing on but for the PHNs that don't have people staying on, it could fizzle out or not remain as a key issue or in the forefront of their minds. (PHN)*

*I remember having lots of discussions about "how are we going to keep the resources up to date and where are they going to be hosted?" … these are very practical questions and can be quite significant barriers. (CWG)*

Some interviewees, while feeling that the MHLI had raised the profile of MHLR within PHNs and even at state and global levels, also acknowledged the need to build and sustain commitment with senior management across different organisations in order to achieve sustainability.

*It's just making sure that the organisation as a whole is committed to it and you've got some buy in from upper-level people, that they see value in it – so you're not just relying on one person. (PHN)*

*That just seems to be the way organisations work – if you've got a CEO or someone who's run it right at the very top, who says "gosh, this really vitally important for us", it'll move ahead … so it would be good if the project outcomes were shared at a more senior level. (CWG)*

While acknowledging the achievements of the MHLI, many interviewees were cautious about the extent to which it could be further scaled up without additional investment to facilitate local co-design processes in the new communities.

*While the resources are there for others to pick up and use, it took money, support and time to get each of the NSW PHNs to engage with the MHLI … it's not like you can just say to other PHNs in other states "here's the resources, off you go" … it's not going to happen, I don't think. (SUNNY)*

However, one SUNNY consortium interviewee felt that the MHLI's scalability could be enhanced by its ongoing inclusion of a broad range of stakeholders throughout the life of the project – resulting in a number of "*invested parties*" beyond PHNs who could maintain the created resources and assist with scaling up the MHLI.

*Over the last 2 1/2 years, we've been talking with many interest groups, outside the PHNs, that want to see the content, the material, the resources, sustainable and scalable – as the materials have been developed for a much broader, bigger, diverse audience. … So, how will it all stay current? I think that is happening through other interest groups and other bodies that have been part of this process and perhaps we need to see how these two can come together. So that both making the material current and keeping it current is one, but scaling it as a resource beyond the boundaries of NSW starts to happen by interested parties.(SUNNY)*

# Discussion

The findings presented throughout this report demonstrate that, despite a very challenging external environment (including the COVID-19 pandemic and a number of major natural disasters that resulted in considerably increased pressures and competing priorities for all stakeholders), **the MHLI has contributed to enhancing MHLR capacity** in PHNs, general practices and commissioned services across NSW in a number of ways, including:

- Developing and/or enhancing **infrastructure and resources** to support organisations to be more MHLR (Built capital)
- Enhancing the **connections, relationships and collaboration between services** in working towards MHLR (Social capital)
- Enhancing **individual stakeholder awareness, understanding and skills** in relation to MHLR (Human capital)
- Enhancing **organisations' awareness of and readiness** to be MHLR (Cultural capital).

The MHLI supported the development and implementation of a range of MHLR-promoting activities in the form of training, resources, service navigation tools and organisational processes. It facilitated the implementation of new ideas, as well as supporting existing activities that required additional resourcing to be fully achieved. An example of this is how one PHN used the MHLI as an avenue to progress their implementation of the *Embrace Framework for Mental Health in Multicultural Australia*, with two additional PHNs subsequently adopting this as part of their MHLI activities too. A similar synergistic effect was also seen with additional PHNs adopting the *No Wrong Door Framework*.

PHN coordinators frequently commented about increased conversations about mental health literacy at all levels within most PHNs (including at the leadership level) and the filtering of a health literacy framework/lens into "business as usual". For example, some PHNs spoke about changes to procurement and contracting processes as a result of the MHLI, including embedding health literacy requirements, standards and deliverables into new contracts with commissioned services, from which they would be able to "hold people to account" in terms of optimising service responsiveness.

Given the MHLR-related capital nature of the above-mentioned impacts, they have the potential to continue contributing to improvements in MHLR beyond the MHLI funding period. However, the sustainability and strengthening of these impacts is likely to vary considerably between PHNs, depending on the availability of local champions and the amount of progress achieved during the MHLI.

Given the MHLI's relatively short post co-design implementation timeframe, this evaluation focussed on the perceived short-term impacts of the MHLI, and was not able to explore any longer-term impacts on stakeholder and organisational MHLR capacity or any potential improvements in service access and experience for PWLE

The success of **the MHLI's implementation was facilitated by a number of factors**, including:

- The commitment, flexibility, agility and collaborative nature of the MHC and participating PHNs, with both the statewide and local coordination roles seen as critical to "making things happen"
- The flexible funding, which provided PHNs an opportunity to capitalise on and progress pre-existing activities related to mental health literacy or to "kick-start" activities that would have otherwise been delayed or forfeited because of a lack of funding
- Its co-design approach, which enabled value-adding contributions from a wide range of stakeholders, including LHDs, general practices, interagency groups, NGOs and PWLE (although this was made more challenging by the COVID-19 pandemic) – at both the statewide and PHN levels
- Its collaborative nature, which created an environment that supported relationships across PHNs, innovative ideas generation, enhanced trouble shooting and sharing of ideas and resources
- Some PHN's pre-existing capacity in relation to MHLR, with greater implementation progress seen in PHNs who had previously been working on improving their health literacy responsiveness.

However, the MHLI also **generated a range of learnings** that may be useful for future similar initiatives to consider:

- Starting with a blank canvas and no clear definition of MHLR created some confusion and was even somewhat overwhelming for some PHNs and their stakeholders, with many evaluation participants commenting that they would have benefited from clearer early definitions about what was in and out of scope
- Not having a core set of resources available early in Phase 3 of the MHLI created some confusion and implementation delays, with many evaluation participants commenting about this
- Conducting the initial co-design phase with only two of the nine participating PHNs resulted in some PHNs feeling a need to conduct their own co-design processes and further tailor the SUNNY-developed resources to better fit their communities' needs
- Given the time needed for meaningful co-design of this type of complex and multi-faceted intervention, having a longer funded implementation and evaluation period would have allowed more thorough exploration of a broader range of outcomes, including the longer-term impacts on stakeholder and organisational MHLR capacity and any potential improvements in service access, experience and outcomes for PWLE.

In summary, the MHLI has contributed to progressing organisational MHLR in the nine participating PHN regions, resulting in a considerable amount of enhanced MHLR capital that could be useful in

other regions, although some local co-design and tailoring would be required. However, ensuring this enhanced built, social, human and cultural capital translates into improved service access, experience and outcomes for PWLE remains a work in progress that will require ongoing support and championing from the MHC and the nine participating PHNs.

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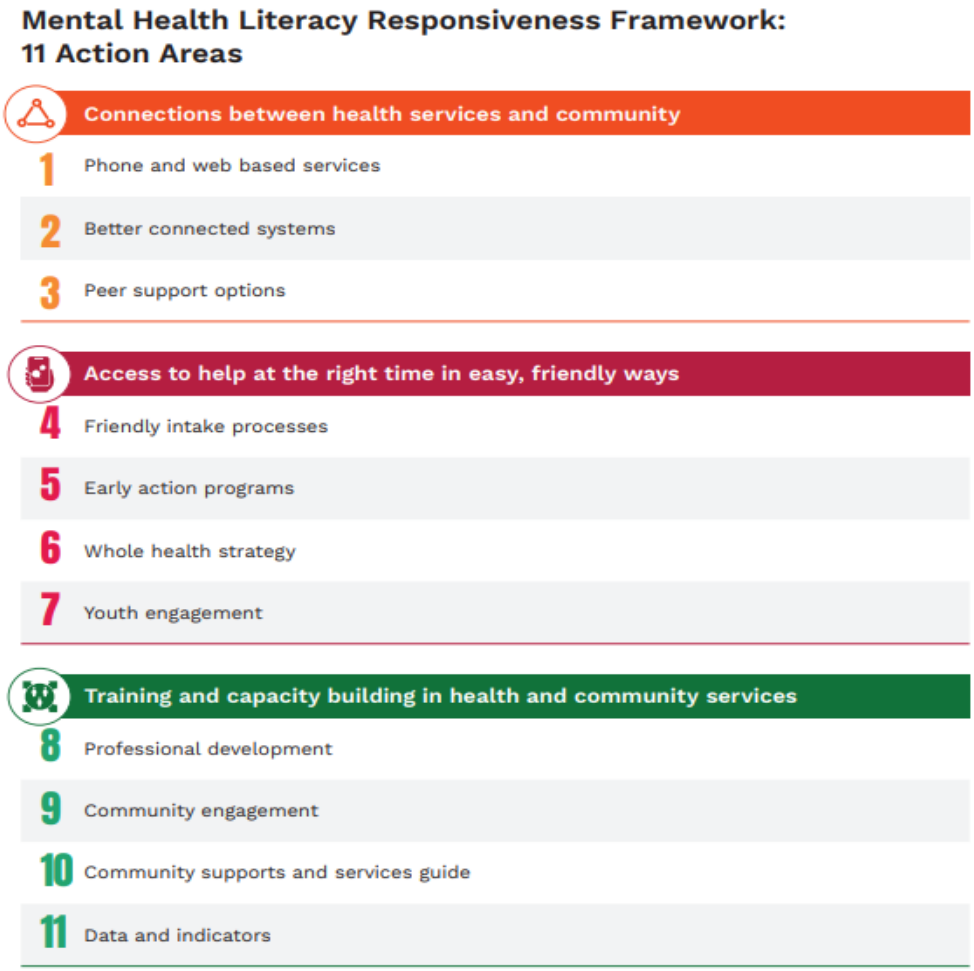
# Appendices

## Appendix A: The 11 MHLI Key Action Areas



# Appendix B: Summary of resources developed by the SUNNY consortium

The following table is adapted from the MHLI Final Report and outlines the resources developed by the SUNNY consortium across the three phases of the MHLI.

| Resource (with MHC hyperlinks) | Aim | Format | Purpose | Audience |
|---|---|---|---|---|
| **Health literacy development overview** | Overview of the resources & their development using the Ophelia co-design process | Webpage including video on the MHLI & PDFs of Ophelia manual & resources | For understanding why & how the resources were created. Ophelia manual can be used for planning local co-design | PHNs & other health organisations |
| **Case for action** | To provide the case for action on health literacy responsiveness | Written document | For advocating for resources to be allocated to organisational change | PHNs & other health organisations |
| **Vignettes** | To represent the lived experience of people with mental health issues | Short videos with discussions questions (<4 minutes) | To generate ideas for health literacy activities | Organisations (managers & frontline staff), general public |
| **Fact Sheets** | To provide a set of resources about each of the 11 action areas & questions to prompt discussion | Written document (2 pages, n=11) | For quick reference & prompting discussion during workshops | PHNs & other health organisations |
| **Examples of service responses** | To provide practical examples of mental health literacy responsiveness | Videos: Interviews with service providers (7–11 minutes) | For prompting discussion in a workshop; for individual viewing | PHNs & other health organisations |
| **Toolkit to improve the Service Experience Journey** | To improve the experience of people with lived experience booking or attending a general practice or other health service | • Workshop facilitator guide<br>• Presentation slides<br>• Videos<br>• Guide for consumers<br>• Service checklists<br>• Fact sheet | For use in a workshop. Guides & checklists can be used with general practices during site visits | PHNs & other health organisations training general practice staff & peer support workers |
| **Training support** | To assist organisations to plan how they will address the 11 action areas | Workshop facilitator guides for 2-hour & half-day workshops | For use in planning workshops | PHNs and other health organisations—can be adapted for a variety of audiences |
| **Training on sharing** | To train GPs, mental health clinicians | Video (29 mins) Presentation slides | For use in a workshop Video can | PHNs, mental health |

| | | | | |
|---|---|---|---|---|
| **consumer information** | & support/peer workers to facilitate sharing consumer information to improve integrated care | | also be viewed by individual GPs, mental health clinicians & support workers | services, general practices, CMOs, support workers & peer workers |
| **Quality Improvement (QI) Tool** | To guide organisations in planning & reviewing strategies to improve the experience of people with mental health issues | Interactive organisational assessment | For guiding organisational planning & review | PHNs & other health organisations |
| **Mapping to policy and regulation** | To support organisations to understand their responsibilities under the existing standards for mental health services, general practice, disability services & accreditation & quality improvement. | Fact sheets (n=2) | For reference during training or planning, reporting, or advocating for the need for change | PHNs & other health organisations |

## Appendix C: Final PHN progress report template

# Mental Health Literacy Initiative (MHLI) – PHN Progress Update

This template is a living document which aims to capture key information about **how the MHLI was implemented in your PHN over the life of the initiative**.
It **includes our understanding of your progress and plans to date**, based on your previous progress reports and interviews conducted during our interim evaluation.
**Please review and edit the unshaded information as needed** and **update any relevant yellow-highlighted sections**.

## REGION(S) COVERED – *where your MHLI is being implemented*

X Across the whole PHN

☐ In specific communities ➔ *please specify the communities:*

## ACTIVITIES – *please include ALL your MHLI-related activities (planned, underway & completed)*

ACTION AREAS:
1. Phone and web-based services
2. Better connection to community supports
3. Peer support options
4. Friendly intake processes
5. Early action/ intervention programs
6. 'Whole health' strategy
7. Youth engagement
8. Professional development
9. Community engagement
10. Community supports & services guides
11. Data and indicators (planning/ evaluation)

| Brief Description of Activity | Relevant Action Area(s) *Legend above* | Service Delivery Partner *(PHN or commissioned agency)* | Activity Implementation Timeframe *(from MMM/YY to MMM/YY)* | MHLI Contribution *Minor (advisory only) / Moderate (enhanced existing activity) / Major (MHLI-initiated)* | Lived Experience role in delivery / development *None / Minor (consulted only) / Moderate (advised/ helped) / Major (LE-led or partnered)* | Activity Status *Planning / Implementing / On hold (please say why)/ Abandoned (please say why)/ Completed* | Target Audience(s) | Number(s) Reached – by participant type *(egg: GPs, LHD staff, NGO staff, consumers) Estimates are OK* | Perceived contribution to improving local MHLR *Rating: 0= None …. 5= Moderate … 10= Immense AND please add a brief comment* |
|---|---|---|---|---|---|---|---|---|---|
| 1. | | | | | | | | | ***Rating***: ____ *Comment ↓* |
| 2. | | | | | | | | | ***Rating***: ____ *Comment ↓* |
| 3. | | | | | | | | | ***Rating***: ____ *Comment ↓* |
| 4. | | | | | | | | | ***Rating***: ____ *Comment ↓* |

## **STAFFING** – *please include only those people PAID (even if only partly) through MHLI funds*

| As reported in July 2021 Progress Report | | | | Any changes as at May 2022 |
|---|---|---|---|---|
| Position (Organisation) | Role | FTE on MHLI / Timeframe | New or Pre-existing | |
| | | | | |
| | | | | |
| | | | | |
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| | | | | |
| | | | | |

## **MHLI PARTNERSHIPS** – *please include any individuals or organisations involved in the following ways*

| | KI Partner Names | New or pre-existing group/ partner | KI Partner Roles | Engagement Timeframes *(from MMM/YY to MMM/YY)* |
|---|---|---|---|---|
| KEY INFLUENCERS (KIs) – involved in overall initiative governance / decision-making<br><br>(eg: advisory groups / steering committee) | | | - | |
| | | | - | |
| | | | | |
| | | | | |

| ANY OTHER COLLABORATORS – not previously mentioned as KIs or in ACTIVITIES section (eg: people consulted to develop trainings or resources) *Please record people delivering activities in earlier ACTIVITIES section* | Collaborator Names | Collaborator Roles/ Contribution |
|---|---|---|
| | | - |
| | | - |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

## IMPLEMENTATION HIGHLIGHTS – *including how the MHLI, and any other factors, contributed to achieving them*

| Implementation Highlights | MHLI Contribution | Any Other Contributing Factors |
|---|---|---|
| | | |
| | | |
| | | |

## IMPLEMENTATION CHALLENGES – *including any actions taken to address them*

| Challenges Encountered | Mitigation Strategies |
|---|---|
| | |
| | |
| | |

## IMPLEMENTATION RISKS – *any last updates about any of these*

| Potential Risks | Mitigation Strategies | February 2022 Update | May 2022 Update (IF ANY) |
|---|---|---|---|
| • | • | • | • |
| • | • | • | • |

## **RESOURCING** – *to give an estimation of what it has taken to get the MHLI up & going*

As part of the evaluation, we're interested to try and get some idea of what it has taken to get the MHLI up and going (assuming the PHNs will have contributed much in-kind support beyond the funding received from the MHC. So we're hoping you could estimate the inputs in relation to the following aspects:

| Component | MHLI funding $ used | Nature of any PHN &/or Partner in-kind contribution | Estimated $ value of any PHN/Partner in-kind contribution *(if possible)* |
|---|---|---|---|
| **Staffing – Project Lead** | | | |
| **Staffing – Other** | | | |
| **Project Governance** | | | |
| **Consultants** | | | |
| **Activity Implementation** *(excluding consultants)* | | | |
| **Other aspects – *please specify*:** _____ | | | |

## **LOCAL EVALUATION INFORMATION** – *to enrich what we're collecting statewide*

Could you please note below any evaluation data or reports you have about any of your key activities … and would be great if you could attach copies of any you're willing and able to share.

| **Key Activity** *Please indicate the Activity Number (from first table)* | **Nature of any evaluation data collected** (eg: web-page views or downloads, pre-post training surveys, qualitative feedback from participants) | **Is there any report or spreadsheet summarising the data that you're able to share?** | ***IF YES* – are you able to attach a copy of the report/ spreadsheet?** | ***IF NOT* – are you able to provide any key statistics from the data collected (especially in relation to outcomes – eg: changes in knowledge or attitudes for training sessions)** |
|---|---|---|---|---|
| | | | | |
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## **SUSTAINABILITY** – *to help understand how MHLR may continue to improve after the MHLI*

| | |
|---|---|
| 1. Is your PHN planning to continue to work on improving mental health literacy responsiveness in your region? *IF YES* – please can you describe how | |

| | |
|---|---|
| 2. Please can you indicate which (if any) of the activities listed in the first section of this report will continue after the funding period ends in June 2022. *(Activity numbers are ok)* | |

# Appendix D: PHN interview guide

In this interview we're keen to get your feedback about the current implementation phase of the mental health literacy initiative, from June 2021. (This phase is also known as phase 3).

| Theme | Question | Prompt |
|---|---|---|
| **Interviewee role** | First, could you tell me about how you've been involved during the implementation phase? | How was your experience with the initiative? |
| **Process evaluation** | Can you describe what is being implemented at your PHN as part of the initiative? | What resources have been used or adapted?<br><br>How have you adapted and packaged resources developed by SUNNY?<br><br>What other activities have been implemented as part of the initiative? |
| | How have you engaged commissioned services to be involved in the initiative? | Has this worked well? Why/why not?<br><br>What could have been done to improve it? |
| | What have been some of the key successes or enablers of the implementation of the initiative? | Add questions about support/cop/sunny |
| | What were some of the barriers/challengers to implementation? | e.g. COVID, lack of engagement, or challenges with online training, natural disasters |
| | In your opinion, how well have people with lived experience and priority populations been engaged during Phase 3? | Has the impact had any impact on people with lived experience and their carers? |
| | Looking back is there anything that could be improved in terms of designing and implementing an initiative of this sort? | Do you have any suggestions for future MHLR approaches? |
| **Outcomes** | What has been the most significant change as a result of the initiative? | |
| | What else has changed as a result of the initiative? What have been some of the main achievements/outcomes?<br>a) For you and your organisation<br>b) For service providers | |
| **Sustainability** | In your opinion, what parts of the initiative are most likely to have a long-term benefit or be sustainable? | Any activities that will continue beyond the initiative? |
| | Has there been any planning in relation to sustainability of the work that has happened so far? | |
| | Have any of the principles been integrated into structures, policies, etc at your PHN? | How did this happen?<br><br>What do you think are the implications of this going forward? |

| | | |
|---|---|---|
| | What do you think are the enablers of sustainable MHLR practices and approaches for health and community service organisations? | e.g., secure funding, adequate resourcing, supportive commissioning environments |
| **Other** | Do you have any other comments you would like to make? | |

# Appendix E: Additional PHN MHLI implementation case studies

## CONTEXT

Central Eastern Sydney PHN stretches from Strathfield to Sutherland and east to Bondi. It also includes Lord Howe Island and Norfolk Island. The boundaries align with South Eastern Sydney LHD and Sydney LHD.

Activities implemented mainly targeted GPs and CMOs with a particular focus on CALD communities.

## KEY IMPLEMENTATION ACTIVITIES

**CALD-FOCUSSED MHLR TRAINING**
MHLR training for community managed organisations working with culturally and linguistically diverse communities. Incorporated some of the SUNNY resources.

*We created the content of that training through the resources provided by the consortium and Mental Health Commission. So things like you know the service experience journey like what is mental health literacy responsiveness, those things. And we provided that training to the CMOs.*

**EMBRACE FRAMEWORK**
Framework to improve cultural responsiveness aimed at PHNs and commissioned services. It includes a self-assessment tool and supporting resources.

*...The cultural responsiveness action plan. So that's through the Embrace framework that we have undertaken like a self-assessment of our PHN and cultural responsiveness and created an action plan following that self assessment.*

## OTHER IMPLEMENTATION ACTIVITIES

**SERVICE NAVIGATION**

- HeadStart App: Online service directory to assist consumers, carers and service providers to navigate local mental health services.

*And also through that [CALD-focussed MHLR] training we were able to share mental health resources, service navigation tools like HeadStart to the CMO's to utilise.*

**TRAINING**

- State-wide MHLR training
- Mental Health First Aid instructor training
- GP-focussed basic mental health skills
- Stepped care e-mental health
- THIS WAY UP iCBT

*It's more things, yeah they're part of our business as usual in an ideal world when we have time for them. But so often we don't, and so a lot of things like you know, getting out the e-mental health resources or or doing the partnerships with Black Dog and This Way Up.*

**RESOURCES**

- e-Mental Health self-help resources
- While You Wait: a resource kit to help patients and GPs plan for the first specialist mental health appointment
- Physical Health Conversation Guide for people with lived experience of mental health issues
- Re-design of health literacy webpages on PHN website

## IMPLEMENTATION HIGHLIGHTS

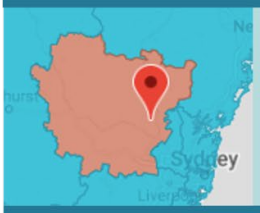
- Development and delivery of CALD-focussed MHLR training
- Establishment of CALD working group
- The Embrace framework and the culturally responsive action plan
- Successful delivery of 5 e-mental health trainings
- Having funding to promote HeadStart app and update health literacy webpages

*I was really impressed with the level of engagement from them...But one of the organisations invited all of their managers to it and the senior staff we had the CEO there as well because it was something that they could see the value in and and yeah, that was that was a really great outcome and then they also had a good experience after the training as well. They said they gave us good feedback.*

*The other success is being able to think beyond the initiative. So the Embrace Framework and the action plan is continuing beyond 30th of June for a year...so to start moving forward is a great achievement for us.*

Nepean Blue Mountains PHN

## CONTEXT




Nepean Blue Mountains PHN covers the Blue Mountains, Hawkesbury, Lithgow and Penrith.

Activities implemented as part of the initiative were focused on general practice and commissioned services, PHN staff and consumers.

## KEY IMPLEMENTATION ACTIVITIES

**STATE-WIDE MHLR TRAINING**
Led GP MHLR training session in collaboration with other PHNs and the SUNNY consortium. The training covered MHLR and quality improvement approaches. It also incorporated many of the SUNNY resources.

*So we ended up delivering that [state-wide MHLR training], I think in March this year and it went quite well. So it was really, it was led by myself, Southwest Sydney PHN and Western Sydney PHN. And then the other PHNs kind of just shared it. Broadly I think there was about 40 attendees. That was just like a little bit of us kind of testing the waters and we're hoping to continue some of that training again kind of out even after this project.*

**MENTAL HEALTH NAVIGATION TOOL**
Online navigation tool designed to direct people with lived experience and their carers to locally available mental health services.

*And the navigation tool. That was from my perspective that's gone quite well and actually expanded beyond its original scope. So originally it was just meant to be not just, but it was meant to be an upgrade of the current navigation tool that we had, which though it was great at the time, there's been new technology since, and you know, you reflect on things, and there was some navigation issues too. That is almost kind of finalised now.*

## OTHER IMPLEMENTATION ACTIVITIES

**RESOURCES**
- Health Literacy Framework: Techniques, strategies and tools to increase consumers' comprehension of health information based on personal needs

*We've launched a health literacy framework that was the first step. With health literacy framework from the very top filtering down there's key responsibilities for everyone around implementing health literacy, so we've got the framework in place, and now we're working on the underpinning systems, policies and procedures.*

**INFRASTRUCTURE**
- Quality improvement strategy

## IMPLEMENTATION HIGHLIGHTS

- Collaboration with other PHNs to deliver the state-wide MHLR training
- Mental Health Navigation Tool
  - Collaboration with multiple stakeholder and consumer groups
  - Integration of navigation tool with the Initial Assessment and Referral Tool (IAR)

*From my perspective the training was really just that joint effort. I thought that was great that we were able to because it was quite a lot of hands involved...So I thought like that was quite a good news story just around kind of yeah combining kind of resources.*

North Coast PHN

## CONTEXT

North Coast PHN covers Mid North Coast LHD and North Coast LHD.

Activities implemented as part of the initiative mainly focussed on community and service users. The North coast region was particularly impacted by bush fires and floods.

## KEY IMPLEMENTATION ACTIVITIES

### PRIMARY CARE IMPACT WEBPAGE

Webpage that links to a range of mental health literacy related tools, quality improvement resources and training. More broadly focused on health literacy in general practice.

*Primary Care Impact is a web page that is specifically for doctors, general practice and health professionals and they can go if there's an area in their practice that they're saying is not so good or that they could do some improvements. They have all of the resources on one page that they can undertake really short, quick upskilling or go deep and have a proper quality improvement initiative and get support from MediCoaches and other things to really beef up their organisation responses around that key area.*

### HEALTH LITERACY CONSIDERATIONS IN PROCUREMENT AND COMMISSIONING PROCESS

MHLR will be built into the commissioning process. This will ensure the commissioned activity is considering health literacy elements such as access, way-finding and engagement from commencement

*One of the main ones is in commissioning and so we've changed the way that we write procurements too... and the way that we write procurement so we can consider improving the way that services are delivered to the community by factoring in those action areas and also evidence around how to improve health literacy in general.*

## OTHER IMPLEMENTATION ACTIVITIES

### SERVICE NAVIGATION

- Review of existing service directories
- Centralised phone contact point for Mental Health, Alcohol & Other Drugs and National Disability Insurance Scheme supports

*So we will have those resources ready to go that are localised and they've been designed by people in the community and even from the communities have been affected so and that yeah, really robust discussion about the sorts of things that they've experienced and how we can really formulate those resources to speak the language of people that need supporting.*

### TRAINING

- State-wide MHLR training

### RESOURCES

- Locally relevant MHLR resources targeted toward community members, co-designed with consultancy and lived experience panel

*Having over 50 people actively engaged in a in a piece of work to design locally relevant resources is amazing and, you know and a good way to help.*

## IMPLEMENTATION HIGHLIGHTS

- Internal commissioning and procurement process
- The willingness to collaborate from key stakeholders
- Establishment of the state-wide Intake, Assessment and Referral service, Head to Health

*So we had really quite clear agenda in and buying from the both LHDs anyway and also, other stakeholders like such a range of health professionals, you know we had ambulance, police all sorts of different stakeholders on our co-design workshops, which was so great to have such a diverse range of stakeholders be part of that decision making around what we focus on.*

North Sydney PHN

## CONTEXT

North Sydney PHN covers 9 LGAs: Hornsby, Hunters Hill, Ku-ring-gai, Lane Cove. Mosman, North Sydney, Northern Beaches, Ryde and Willoughby. It aligns with Northern Sydney LHD.

Activities implemented as part of the initiative mainly focussed on mental health service providers, CALD communities, and the broader community.

## KEY IMPLEMENTATION ACTIVITIES

**HEADSTART**
Online service directory to assist consumers, carers and service providers to navigate local mental health services. Existing phone and web-based support services will be integrated with new directory.

*I'm looking at implementing a consumer facing mental health service directory. So in the process of contracting with Bright agency for the HeadStart App. It's a platform that's currently operating across other regions of Metro Sydney. We've done initial consultation and development of what that needs to look like in our region, and we're looking at launching in the next couple of months. So that's kind of been one of the big focuses of our health literacy work.*

**COMMUNITY CAPACITY BUILDING**
Training for local service providers and community members. Training included Mental Health First Aid and suicide prevention (ASSIST).

*There's also the community capacity training which has been commissioned through Living Works…so we've actually just managed to finally get around to having the first of those again, kick off again last week, ASSIST – which I was a part of.*

## OTHER IMPLEMENTATION ACTIVITIES

**TRAINING**
- Cultural responsiveness
- Capacity building training to support stigma reduction

**RESOURCES**
- Promotion of SUNNY resources (integrated onto Sydney North Health Network (SNHN) website
- CALD-focussed mental health literacy resources including translated resources and translation services

**INFRASTRUCTURE**
- MHLR included within Regional Mental Health Planning

**THERAPEUTIC**
- Stigma reduction campaign: 'Better Off With You'

*So that's been about working with Commission services and others just to let them know that those resources are available, including education and webinar events. Linking people to those and a continuous process of making people aware that those resources have now been developed and therefore be used.*

*Because we've kind of retrofitted these activities to our regional plan, which is a five year our focus, a 5 year timeline. You know, they're all these activities should be expected to continue.*

## IMPLEMENTATION HIGHLIGHTS

- Successful stakeholder consultation workshop despite being forced online due to COVID-19 restrictions for
- Aligning the MHLI action areas to Regional Mental Health Plan
- Commissioning of HeadStart

*"So the service directory [HeadStart] will live as a resource beyond the time frame of this project, which is really positive.*

South Eastern New South Wales PHN

## CONTEXT

South Eastern NSW PHN stretches from Helensburg to the Victorian border, and inland to Cooma/Monaro, Queanbeyen, Yass and Golburn.

Activities implemented as part of the initiative were mainly focussed on GPs.

## KEY IMPLEMENTATION ACTIVITIES

**INTERNAL COLLABORATION**

Internal workshop with 18 PHN staff to discuss the importance of mental health literacy responsiveness is and how it can be embedded within mental health service delivery and initiatives. The workshop included representation from many teams including the Mental Health commissioning team, Suicide Prevention and Aboriginal Health.

*We actually did this internal workshop for four hours with most of our Mental Health Commissioning team, Drug and Alcohol Manager for Aboriginal Health and Suicide Prevention team and our Peer Workforce Coordinator.*

## OTHER IMPLEMENTATION ACTIVITIES

**SERVICE NAVIGATION**

- HealthPathways update

**TRAINING**

- Mental Health Forum - delivery of MHLR capacity building training for GPs (e.g., e-mental health supports and stepped mental health care)
- Mental health training for practice nurses (planned)

**RESOURCES**

- Website update to include information about MHLR

*…A capacity building activity is with practice nurses. Because you know, there's a demand across the regions...so we can increase the capacity of the practice nurses to support their patients. So we're doing some work with the Australian College of Mental health Nursing. They've got an online program that we're looking to roll out across our region to support the nurses, and they've been quite willing to do a lot of training we've been offering and upskill.*

## IMPLEMENTATION HIGHLIGHTS

- Internal collaboration involving Mental Health, Suicide Prevention, Drug and Alcohol colleagues to discuss mental health literacy
- Internal collaboration with Mental Health and Suicide Prevention colleagues to deliver activities
- Having 44 GPs participate in the mental health forum

*We had a really good internal meeting... So we actually did a heap of work that they then all took back to their business lines to consider how they can embed things.*