CHSD
centre for health service development

Evaluation of the LikeMind Pilot

Final Report

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Dedication

This report is dedicated to the memory of Sonia Bird, our friend and colleague who tragically passed away in December 2021. Sonia genuinely loved working on the LikeMind evaluation and valued the relationships she built with the teams at both Uniting and Stride. She will be greatly missed by all of us.

About the LikeMind evaluation reports

Three reports have been produced for this final reporting cycle of the LikeMind evaluation:

- This final report which provides a comprehensive evaluation of the LikeMind pilot and a set of recommendations for consideration by the NSW Ministry of Health (Gordon R et al., 2022);
- A literature review which provides context and situates the evaluation within the broader evidence-base (Grootemaat et al., 2022);
- The LikeMind V2 Minimum Dataset specification which underpins the quantitative data results contained in this report (Bird et al., 2020).

LikeMind
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Acknowledgements

The evaluation team would like to acknowledge and thank the LikeMind consumers and the many LikeMind, Local Health District and consortium member stakeholders who generously contributed to this report by participating in interviews. Our particular thanks go to Ms Rebecca McLean, Mr Stephen Zammitt and Ms Joanne Barbara for their extensive efforts in providing the quantitative data for the evaluation. Finally, our thanks go to Mr Lam Huynh and Ms Francesca Frino from the NSW Ministry of Health for their ongoing support throughout this evaluation.

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Glossary of terms

ACCT	Acute and Continuing Care Team
AHSRI	Australian Health Services Research Institute
CHSD	Centre for Health Service Development
CMO	Community Managed Organisation
GP	General Practitioner
K10	Kessler Psychological Distress Scale
LHD	Local Health District
MDS	Minimum dataset
MHCC	Mental Health Coordinating Council
MHDAO	The Mental Health and Drug and Alcohol Office
MLHD	Murrumbidgee Local Health District
the Ministry	The NSW Ministry of Health
NDIS	National Disability Insurance Scheme
NBMLHD	Nepean Blue Mountains Local Health District
OOS	Occasion of service
PWI	Personal Wellbeing Index
RAS-DS	Recovery Assessment Scale – Domains and Stages
RFT	Request for Tender
SEIFA	Socio-Economic Indexes for Areas
SLA	Service Level Agreement
UOW	University of Wollongong
WHO	World Health Organisation
WNSWLHD	Western New South Wales Local Health District
WSLHD	Western Sydney Local Health District

Executive Summary

Introduction

The NSW Ministry of Health established the LikeMind Pilot in 2015 as an integrated service with co-located mental health and other service providers in two metropolitan and two regional NSW locations. Approximately $27.5m has been invested in LikeMind to provide readily accessible community-based services for people with moderate to severe mental illness.

The current LikeMind Phase 2 evaluation formally covers the 20-month period from June 2020 to February 2022. Importantly, as CHSD completed the earlier evaluation of LikeMind (covering the period January 2015 to September 2018), this report provides a set of evaluation findings that have drawn on data collected over the whole 75 months during which LikeMind has operated.

The current funding agreements between the LikeMind lead agencies and the Ministry are in place until 30 June 2022. The timing of this final evaluation report was agreed to ensure the Ministry, LikeMind service providers, and other stakeholders have empirical data and associated evaluation findings to support the decision-making processes that will occur in the coming months.

Data sources and methods

The evaluation applied a mixed methods approach combining quantitative and qualitative data collected from multiple sources. It has been underpinned by an evaluation framework and program logic that define expected outcomes at three levels: consumers, service providers, and the broader health system.

The LikeMind Minimum Dataset (MDS) provided a rich source of information in relation to the clinical, demographic and social profile of consumers. This report includes a longitudinal analysis of MDS data collected from the commencement of LikeMind in January 2015 to October 2021.

A consumer survey was conducted in 2021 and provided important data on consumer perspectives of LikeMind. A series of stakeholder interviews were also held with LikeMind staff, consortium members and relevant LHD representatives in late 2021. These interviews supplemented the quantitative data and facilitated a more robust understanding of the issues that emerged at each site.

Based on this considerable body of evidence, the evaluation has been able to assess the impact and outcomes of LikeMind and produce a set of findings regarding the extent to which it has achieved its objectives.

The evaluation has sought to address four high-level questions:

- Whether the LikeMind model is effective, efficient and appropriate and what, if any, change(s) could be made to enhance these outcomes;

- How well resources have been targeted at the identified need and what, if any, change(s) could be made to enhance this;
- What the level of 'value-add' has been achieved through the use of the funds including by enhancing CMO service delivery and linkages with public health and other services;
- Whether there have been any unintended outcomes and how this could be corrected.

Key findings - Introduction

Approximately $27.5m has been invested in LikeMind to provide readily accessible community-based services for people with moderate to severe mental illness. Since 2015, LikeMind has delivered 53,200 occasions of service to more than 22,000 consumers. The number of clinical services delivered by each LikeMind service has continued to increase over that period.

At one level, LikeMind has achieved its objective. Consortia have been established at each of the four locations. Clinical and psycho-social support services are being provided to consumers across the four target streams of mental health, primary health, drug and alcohol, and vocational/social needs. Evidence from multiple sources has identified that LikeMind is meeting genuine and previously unmet need and is extremely well regarded in each of the local communities in which it provides services.

At the same time, implementation has not occurred as initially intended or as reflected in the Service Plans and funding agreements between the lead CMOs and the Ministry. Elements of the proposed model of care have either not progressed or have not been sustained.

Most significantly, it was intended that co-location in community accessible premises would underpin an integrated model and result in improved outcomes for consumers. In practice, LHD mental health teams are no longer co-located at any of the four LikeMind sites. Similarly, while CMO consortium members continue to be co-located on a fractional basis, their physical presence at LikeMind sites has also decreased largely as a result of COVID-19. Importantly however, each of these provider groups have continued their involvement in service delivery and governance processes, although not within a co-located environment.

It is clear that a range of internal and external factors have contributed to the relatively low level of 'implementation fidelity' - that is, the extent to which the LikeMind model has been implemented as intended. The challenge for the evaluation has been to assess the outcomes that have clearly been achieved by LikeMind in their own right, while also assessing whether the core objectives of LikeMind have been compromised as a result of the model not being implemented as intended. That is, does it matter that the LikeMind model has not been implementation as originally planned.

This report seeks to address this question by considering the overall impact and outcomes of LikeMind for consumers, service providers and the broader health system. At the time of writing, a decision had not been made in relation to future funding of LikeMind services. A series of recommendations to enhance the outcomes being achieved by LikeMind is

provided in Section 7. These recommendations are based on a presumption that funding will continue.

Key findings - Impact and outcomes for consumers

LikeMind has clearly been successful in delivering services to consumers that experience moderate to severe mental illness. More than 60% of LikeMind consumers reported levels of severe psychological distress at initial assessment. This proportion decreased to less than 40% at follow-up[1] highlighting that LikeMind consumers have achieved demonstrably positive clinical outcomes.

Consumers have consistently reported positive outcomes being associated with their use of LikeMind. This positive feedback dates as far back as focus groups conducted in 2018 and as recently as a consumer survey completed in February 2022. Consumers reported very high levels of satisfaction in relation to: 'access to services', 'experiences with staff' and 'overall satisfaction with the service' in the recent survey. These findings are significant and provide clear evidence that LikeMind has delivered meaningful mental health outcomes for a significant number of consumers at each site.

It is difficult to assess the impact that LHD services no longer being co-located has had on consumer experiences of the service. In the recent consumer survey, a minority of consumers reported valuing being able to access multiple service providers in one location. However, because most consumers had not accessed multiple services at LikeMind in the first place, the LHD no longer being co-located did not emerge as an issue.

A set of recommendations to enhance LikeMind outcomes at the consumer level is provided in Section 7.3.1.

Key findings - Impact and outcomes for service providers

Provider level outcomes have been evaluated in terms of how effectively staffing structures and partnership arrangements have been established and maintained. Despite a lack of progress in service integration, important formal and informal links between LikeMind, the LHD and other consortium staff have developed.

In many cases, trusted relationships have developed between staff across services. For example, when LikeMind staff participate in clinical review meetings with LHD mental health teams to discuss shared care arrangements, a degree of capacity building takes place with both teams benefiting from each other's knowledge and experience.

LikeMind staff have benefited more generally from working closely with their LHD colleagues, particularly when the mental health teams were co-located. This proximate environment provided LHD staff with the opportunity to informally mentor LikeMind staff and provide professional support, advice and guidance. These interactions were highly valued by LikeMind staff and were an excellent example of informal service integration that

[1] Follow-up K10 assessment data available for 497 consumers.

underpins the LikeMind model of care. Unfortunately, the opportunities for this level of interaction have largely been removed with LHD teams no longer being co-located.

LikeMind has also provided an important opportunity for less experienced and less qualified staff to gain professional experience in a clinical environment. LikeMind has been described as a 'training ground for provisional psychologists' where LikeMind intake staff would progress to working for the LHD or other organisations after completing their registration. There is no doubt that LikeMind has provided an important opportunity for provisional psychologists to develop their careers.

Workforce issues have been an issue for the four LikeMind services. The key problems relate to high levels of staff turnover and the lack of experience and/or qualifications of LikeMind intake staff. These workforce issues have had a bigger impact at the two regional sites. For the two metropolitan LikeMind sites this problem was largely ameliorated by recruiting key personnel into senior positions that operate across both services. This resulted in highly valued professional support for staff and promoted quality and consistency of care in the delivery of mental health support services across the two services.

A set of recommendations to enhance LikeMind outcomes at the service provider level is provided in Section 7.3.2.

Key findings - Impact and outcomes for the health system

At the system level, there is no question that LikeMind is delivering a significant level of additional mental health services to its target population. This is particularly important given the increased demand for mental health services because of COVID-19.

However, LikeMind services are not being delivered as an integrated 'one-stop-shop' approach as envisaged when the model was developed. Services are being delivered largely independently with well-established mechanisms to facilitate inter-service collaboration. At its most functional, LikeMind can be described as an effective and well-regarded collaboration with co-location arrangements in place between the lead and some partner CMOs.

A range of policy developments at both the state and national level have influenced the internal and external environment in which LikeMind operates. Many of these have been a direct response to the COVID-19 pandemic. Examples include the introduction of new services (such as Head to Health), the extension of existing services (Better Access Program), and a raft of changes in the way in which mental health services are delivered. The evaluation has found LikeMind has been able to adapt to this rapidly evolving policy and service delivery environment quickly and effectively.

The scope of the evaluation did not allow the impact of LikeMind on the use of services such as emergency department and hospital inpatient units to be formally assessed. However, anecdotal evidence suggests that LikeMind has not had a material impact on the use of acute mental health services. This is consistent with another Australian study that found decreases in inpatient admissions, length of inpatient stays and emergency department

attendances were not significantly reduced following the introduction of a similar model (Beere et al., 2019). Further research in this area would provide a stronger evidence base on this issue in relation to LikeMind services.

More broadly, the evaluation has found that LikeMind has been very successful in developing brand recognition in each of the four local communities in which it operates. The appointment of community engagement officers has been identified in previous research as essential in promoting brand recognition (Yap et al., 2017). Each LikeMind service has employed staff to raise community awareness of the service. Feedback from multiple LikeMind stakeholders, including consumers has confirmed that LikeMind is very well regarded and has been a welcome addition to the mental health service system.

A set of recommendations to enhance LikeMind outcomes at the health system level is provided in Section 7.3.3.

1 Introduction

This is the final evaluation report of the LikeMind Pilot, an integrated service for adults with mental health needs. LikeMind was established in 2013 by the NSW Ministry of Health (the Ministry) as part of a major reform agenda which has a core focus of building an effective and integrated community support sector.

This evaluation has been undertaken by the Centre for Health Service Development (CHSD), Australian Health Services Research Institute (AHSRI), University of Wollongong. It is the second evaluation of the LikeMind pilot undertaken by CHSD. The first evaluation (referred to in this report as the LikeMind Phase 1 evaluation) was also undertaken by CHSD between January 2016 and January 2019 (Gordon et al., 2019).

At the conclusion of the first evaluation, LikeMind services had funding agreements in place until 30 June 2019. The Ministry subsequently approved additional funding to the four LikeMind services covering the period 1 July 2019 to 30 June 2022. In line with the decision to extend the delivery of LikeMind services, the Ministry commissioned CHSD to conduct the current LikeMind Phase 2 evaluation between June 2020 and February 2022.

1.1 Purpose and scope of this report

This purpose of this report is to provide a comprehensive evaluation of the LikeMind Pilot. It is hoped that the evaluation findings and associated recommendations can make a meaningful contribution to the decision-making processes regarding the future of the LikeMind.

This report includes both formative and summative results that have emerged during the three years of the evaluation. The formative evaluation results focus on identifying lessons learnt during the implementation process, including whether LikeMind has been implemented as intended (sometimes referred to as process evaluation). The summative evaluation results focus on assessing the extent to which the aims and objectives of LikeMind have been achieved at this stage of its implementation and providing recommendations regarding its future direction.

The approach to the evaluation builds on the LikeMind Phase 1 evaluation. The same overarching framework and a similar approach to stakeholder engagement, data collection and data analysis activities has been applied. This has allowed the evaluation to effectively span the entire period during which LikeMind has been operating.

2 Background and policy context of the LikeMind Pilot

2.1 The LikeMind Model of Care

The LikeMind pilot was established by the then Mental Health, Drug and Alcohol (MHDAO) Branch of the Ministry in 2013[2]. It can be characterised as a service-hub approach to the integrated provision of care and support for adults aged between 25 and 65 who experience mental illness.

LikeMind was commissioned to provide proof of concept for a community managed organisation (CMO) led and managed model of integrated care for people with moderate to severe mental illness which is readily accessible in a community setting. It was hypothesised that co-locating mental health service providers in community accessible premises with shared service protocols would lead to improved outcomes for consumers.

LikeMind aims to promote integrated service delivery across four specific areas or service streams: mental health, primary health, drug and alcohol and vocational/social needs including linkages to employment and housing.

The specific objectives of LikeMind, as outlined in the initial approach to market (NSW Health, 2013) are to:

- Provide mental health services to adults with moderate to severe mental illness in a co-located engaging community setting that provides a range of services across the four core streams;
- Create an environment that enables diverse service providers to participate in the delivery of person-centred, multi-disciplinary, evidence-based services, and to work towards service integration;
- Work towards a model of shared Clinical Governance and shared decision-making that provides improved service outcomes and experience for individuals using the service as well as their carers and families, and other key stakeholders;
- Make effective use of co-location to establish links to general and specialist services to enable appropriate and efficient referrals for consumers;
- Take an innovative approach to the provision of adult mental health services including through the use of communication technologies and in reaching out to those who may not ordinarily engage with the health system;
- Help build capacity in adult mental health services across the Local Health District region(s);
- Raise health and mental health literacy and awareness throughout the community via education, focusing on improved understandings of health and mental health issues, potential impacts on adult consumers, and availability of supports and services.

Within this framework, each lead agency was responsible for leasing suitable premises and undertaking any necessary capital works. The consortium members at each LikeMind pilot

[2] The first LikeMind service commenced delivering services in January 2015.

site (service providers) included representatives from mental health, primary health, drug and alcohol and vocational/social needs. Each service provider was expected to operate in a 'spirit of cooperation' with memoranda of understanding between consortia members. The LHD, also a member of the consortia, was required to sign a Service Level Agreement (SLA) with the lead agency as part of the agreement.

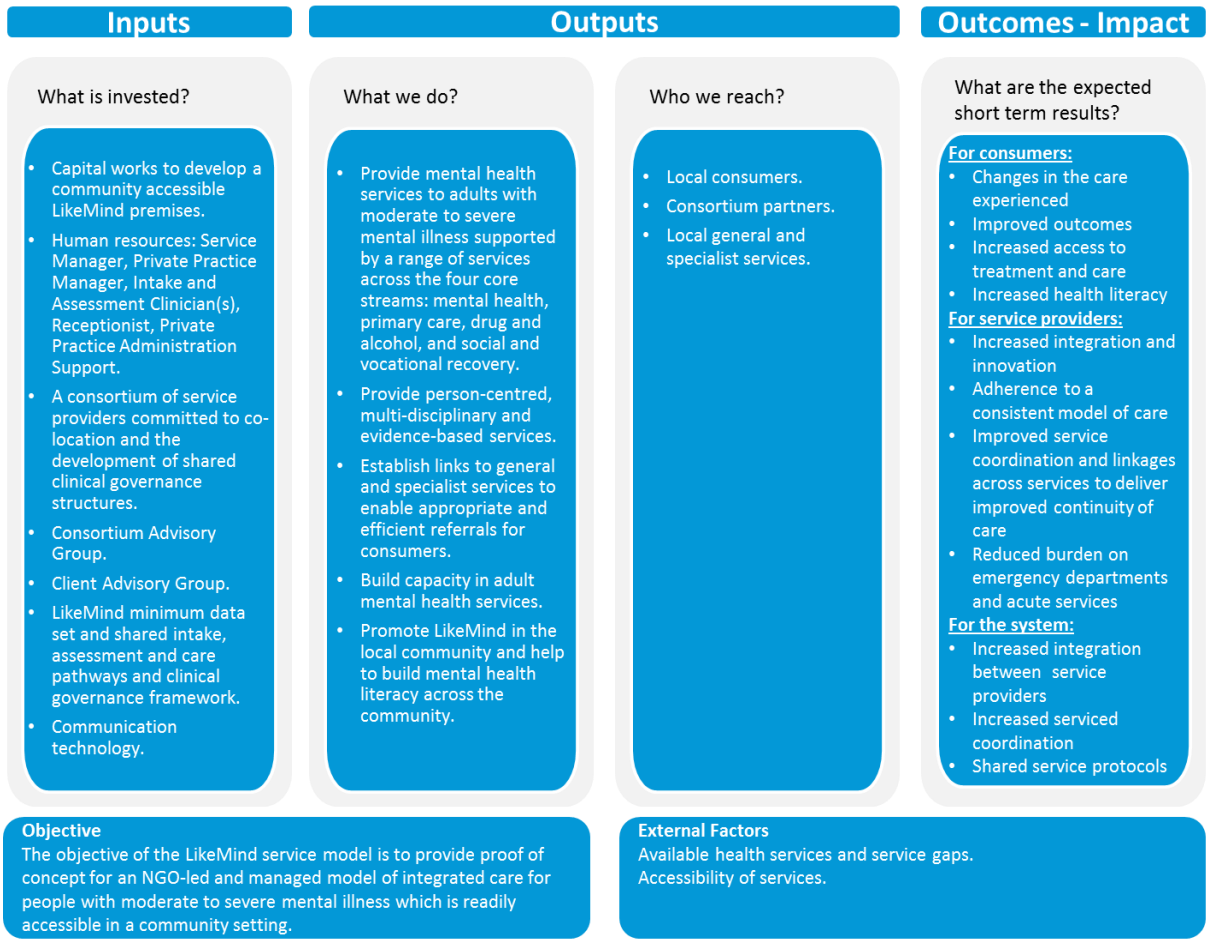
The LikeMind model was structured to allow the consortium to act as an advisory group to the lead agency and had an elected independent chair. As part of their co-contribution to LikeMind, the consortium members were to provide sessional services under guidelines that clearly articulated roles and responsibilities as well as clinical accountabilities when working within a shared model of care. In delivering services, pilot sites would be required to have a proactive outward focus to reach individuals in need in their home and other community settings.

2.1.1 The LikeMind Program Logic

Program logics are often used to demonstrate how various inputs and activities will interact to achieve desired outcomes. They aim to provide a clear summary of the different elements of an initiative and how they fit together, demonstrating the 'theory of change'. Program logic is also a useful resource in the planning and completion of evaluations. The relationships between the different elements are clearly articulated and the aspects that are most important in achieving the intended outcomes can be identified.

A program logic as shown in Figure 1 was developed at the outset of the LikeMind Phase 1 evaluation. It describes the proposed inputs, outputs and outcomes of LikeMind and aims to succinctly outline the key relationships described in the previous section. The LikeMind program logic provides a useful framework for considering the LikeMind evaluation findings presented in the following sections of this report.

Figure 1 LikeMind Program Logic



2.2 Policy context underpinning the LikeMind pilot

The mental health policy context has been important in considering key issues that have arisen during the evaluation. This section provides a brief overview of the broader policy context in which the LikeMind Pilot has been implemented.

Mental health services in NSW are delivered through a mixture of state and Commonwealth government agencies and funding streams. These services are supported by a range of community managed organisations and private enterprise that perform a variety of health service related, community support, research and advocacy roles.

2.2.1 The NSW strategic plan for mental health

At a state level, the policy context for the evaluation of the LikeMind Pilot is underpinned by a major ten-year reform agenda with a core focus of building an effective and integrated community support sector. The key policy document underpinning the expansion of the CMO-led and managed model of integrated care is the 'Living Well: A Strategic Plan for Mental Health in NSW 2014 - 2024 (NSW Mental Health Commission, 2014a). A fundamental principle in the strategic plan is social equity. The indicators and the change process goals also provide a foundation for the LikeMind pilot sites.

2.2.2 Commonwealth reform processes

The Commonwealth is currently implementing a series of national reforms across the health and disability sectors, many of which target improvements to the delivery of mental health services. These include the National Disability Insurance Scheme (NDIS), which began its national roll-out in 2016. In addition, the Commonwealth has identified a range of responses to the recent Review of Mental Health Programmes and Services (National Mental Health Commission, 2014).

Other federally funded initiatives aim to promote access to mental health services. Headspace was one such initiative that was set up in 2006 to treat young people under 25 years of age. Headspace has steadily expanded, and the concept has been applied to older ages with a trial of eight Adult Mental Health Centres (AMHCs) announced in 2019. This led to a further announcement in the 2021–2022 federal budget of $487.2 million for the development of 24 additional AHMCs newly badged as Head-to-Health services (Looi et al., 2021).

2.2.3 Integrated care

The emphasis on integrated care in mental health is a logical service response to the poor health outcomes and significantly reduced life expectancy for people who experience mental illness (NSW Mental Health Commission, 2014b). To meet the physical health needs of people who experience mental illness requires a collaborative effort by primary care providers, such as GPs and secondary health care providers such as mental health and drug and alcohol services.

In addition to addressing the physical health needs of people who experience mental illness, is the key element of addressing the social and vocational aspects of these individuals. These are often highly influenced by the social determinants of health such as: housing, education and employment.

The World Health Organisation's Social Determinants of Mental Health Report (2014) highlights the integral nature of mental health to human health and well-being. The Report states that social, economic and physical environments across the human life span shape a person's mental health and risk factors for mental health conditions are strongly associated with social inequalities (World Health Organization and Calouste Gulbenkian Foundation, 2014).

The World Health Organisation defines integrated care as:

> *The organisation and management of health services so that people get the care they need, when they need it, in ways that are user-friendly, achieve the desired results and provide value for money.' (World Health Organization and World Organization of Family Doctors (Wonca), 2008)*

Integrated care is defined by the NSW Ministry of Health in the 'Living Well: A Strategic Plan for Mental Health in NSW 2014 – 2024' document as:

'Integrated care involves the provision of seamless, effective and efficient care that responds to all of a person's health needs, across physical and mental health, in partnership with the individual, their carers and family. It means developing a system of care and support that is based around the needs of the individual, provides the right care in the right place at the right time, and makes sure dollars go to the most effective way of delivering health care for the people of NSW.'

Overall, from a policy perspective, there are compelling arguments supporting the LikeMind pilot. In an often fragmented health system, LikeMind has represented an opportunity to provide coordinated health and social care services focussed on the needs of the consumer in a one-stop-shop environment.

2.3 Current status of the LikeMind Pilot

As part of their contract with the Ministry, the two LikeMind lead agencies were required to form a consortium of LHD mental health services, CMOs and relevant private sector organisations. CMO and private sector organisations include practitioners employed directly by the lead agencies (private practitioners, general practitioners, and intake/assessment clinicians) as well as LHD and CMO practitioners.

An important development over the last two years is that the WSLHD, NBMLHD and WNSWLHD mental health teams are no longer co-located. The status of co-location arrangements for the four LikeMind sites is summarised in Table 1.

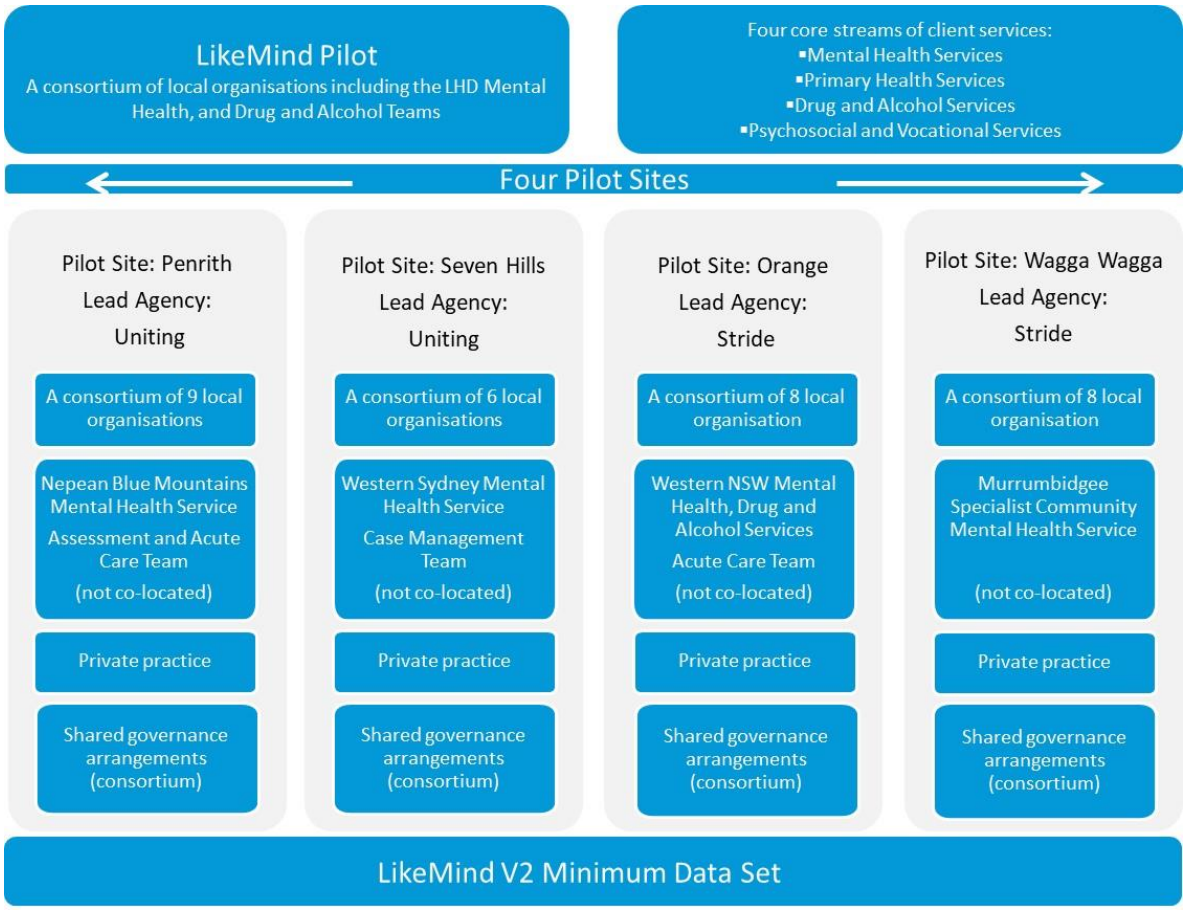
Table 1 LikeMind/LHD Co-location arrangements

LikeMind Site	Date service commenced	Date co-location ceased	Period of co-location	Co-located LHD team
Penrith	Jan-15	Jul-21	78 months	Nepean Blue Mountains LHD, Mental Health Access team
Seven Hills	Jul-15	Feb-20	55 months	Western Sydney LHD, Community Mental Health Team
Orange	Oct-16	Jan-20	39 months	Western NSW LHD, Acute and Continuing Care Team (ACCT)
Wagga Wagga	Feb-18	Never co-located	Never co-located	Murrumbidgee LHD, Community Mental Health Services Team

The implications of these changes are significant in the context of the original LikeMind Pilot objectives. These implications are described and discussed in detail throughout this report. The current structure of the LikeMind Pilot (as at February 2022) is shown in

Figure 2 and is followed by a summary of the current service structure and staffing arrangements at each LikeMind site.

Figure 2 Structure of the LikeMind Model



2.3.1 Uniting

At Seven Hills, the LikeMind offices were closed in early 2020 due to flooding and associated water damage. Throughout the office closure the LikeMind service was still operational offering telehealth/telephone consultations and some face-to-face appointments via local service providers in the Seven Hills/Mount Druitt region. When the premises were re-opened in mid-2020, the LHD community mental health team re-located to the Embark Building on the grounds of Blacktown Hospital. The Embark Building hosts several LHD mental health services including inpatient acute care and non-acute rehabilitation.

The current service structure and staffing arrangements for Seven Hills and Penrith LikeMind sites are shown in
Table 2. The number of salaried on-site LikeMind staff at Seven Hills and Penrith has remained largely unchanged from the LikeMind Phase 1 evaluation with three of the roles (service manager, operations manager, and practice manager) operating across both sites.

With regards to private practice, Seven Hills and Penrith no longer has access to an on-site after-hours GP and only Seven Hills has access to a psychologist and Penrith continues to have access to a part-time occupational therapist. The organisational structure for consortium members (CMOs) has remained largely unchanged.

Table 2 Uniting: Service structure and staffing arrangements as at December 2021

Title	Seven Hills	Penrith	Role
Salaried staff on-site			
Operations Manager	0.3 FTE	0.3 FTE	Responsible for managing the LikeMind business operations across both sites. Responsible for managing team and consortium relationships.
Team Leader	0.5 FTE	0.5FTE	Responsible for managing all clinical matters across both sites and providing clinical leadership to the senior clinicians.
Practice Manager	0.25 FTE	0.25 FTE	Responsible for supporting and growing the private practice model.
Community Development Coordinator	0.5 FTE	0.5 FTE	Responsible for promoting the LikeMind brand and model of care in the local community in addition to increasing community awareness of mental health and mental illness to reduce stigma and reduce barriers to accessing supports.
Administration staff	1 FTE	1.0 FTE	The provision of administrative support for LikeMind to assist in the day-to-day operations of LikeMind
Senior Clinician	0.5 FTE	0.5 FTE	Providing clinical leadership and support for the LikeMind intake and assessment clinicians.
Clinician (Senior Intake and Assessment Clinician)	1 FTE	1 FTE	Responsible for the intake, assessment and ongoing management of consumers with LikeMind. *Increased experience and therapy skills
Intake and assessment clinicians	2.6 FTE	2.6 FTE	Responsible for the intake, assessment and ongoing management of consumers with LikeMind. *Entry level position
Senior Occupational Therapist	0.05 FTE	0.05 FTE	Provides OT (Mental Health) assessment and intervention to enhance outcomes for consumers.
Group Program Coordinator	0.3 FTE	0.3 FTE	Responsible for the development and delivery of evidence-based group programs.
Private practice			
Psychologist	0.9 FTE	n/a	The provision therapeutic supports under Better Access to Mental health Care via MHTP
Occupational therapist		0.4 FTE	The provision therapeutic supports under Better Access to Mental health Care via MHTP
Local Health District			
Western Sydney Mental Health Service – Case Management Team	Not co-located		Major referral partner and provision of clinical support and advise
Nepean Blue Mountains Mental Health Service – Assessment and Acute Care Team		Not co-located	Major referral partner and provision of clinical support and advise
On-site consortium members			
Global skills	0.1 FTE	0.1 FTE	Providing job seekers with quality training and employment support services. Provide education and support to LikeMind team regarding employment support systems and access. Provide ad-hoc career counselling.
Wentworth Health Care (NBMPHN)		PHN is currently recruiting new staff typically 0.4 FTE	The provision of mental health nurses to work with LikeMind clinical staff to support clients under the Mental Health Nursing Incentive Program (MHNIP)

Title	Seven Hills	Penrith	Role
LinkWentworth		0.08 FTE	Provides affordable, rental housing and other assistance to eligible people who are on low to moderate incomes
NBMLHD Drug and Alcohol		0.1 FTE	Provide direct linkage and support with AOD assessment and interventions
Evolve	0.02 FTE		The provision of consultation and advice to consumers with housing support needs including information and support to access current initiatives.
Other consortium members			
TAFE NSW	Both sites		Consultation and support for consumers seeking further education options
FaCS Housing	Both sites		Consultation and referral pathways for consumers seeking housing assistance
Diabetes NSW and ACT	Both sites		Education and consultation. Participation in health promotion events. LikeMind also provides education sessions on mental health for Diabetes NSW & ACT
Western Sydney University	Both sites		Support for research and student placements
Penrith City Council		Attend consortium meetings only	Partnership to promote LikeMind activities and events and support inclusion of LikeMind at relevant interagency meetings.

2.3.2 Stride

At Orange, the LHD Acute and Continuing Care Team moved out of the LikeMind office to the Curran Centre in January 2020 to work alongside the LHD community mental health team. However, a few non-ACCT LHD practitioners (youth link coordinator, dietician, occupational therapists) continue to provide services to their own clients at the LikeMind office.

The arrangement for the MLHD has not changed from its commencement in 2018. However, the community mental health team recently moved into the new Health Services Hub on the Wagga Wagga Base Hospital campus. The increased distance between the two teams has meant that the LHD no longer delivers services from the LikeMind offices.

The current service structure and staffing arrangements for Orange and Wagga Wagga LikeMind sites is shown in

Table 3. Orange has filled its full-time service manager position which had been vacant for some time.

The level of private practice support at the two regional LikeMind services has reduced since the LikeMind Phase 1 evaluation. The LikeMind office at Orange does not have any direct support from private practice. Wagga Wagga is supported by a 0.2 FTE mental health accredited social worker.

At both Orange and Wagga, on-site consortium membership has increased with numerous service providers attending the LikeMind office as required.

Table 3 Stride: Service structure and staffing arrangements as at December 2021

Title	Orange	Wagga Wagga	Role
Salaried staff on-site			
Service Manager	1.0 FTE	1.0 FTE	Responsible for managing the LikeMind business operations
Regional Manager - Integrated Services NSW	0.5 FTE	0.5 FTE	Responsible for managing the LikeMind business operations across both services
Intake and assessment clinicians	2.6 FTE	2.6 FTE	Responsible for the intake, assessment and ongoing management of new clients into LikeMind
Intake officer/Community engagement coordinator	1.0 FTE	n/a	Responsible for the intake and assessment of new clients and develop and implement new community and stakeholder engagement initiatives
Aboriginal health worker	n/a	1.0 FTE	The provision of culturally safe mental health services to LikeMind clients from an Aboriginal and/or Torres Strait Islander background. Includes intake and community work.
Mental health accredited social workers	n/a	1.4 FTE	The provision of assessment and therapy to LikeMind clients
Administration staff	1.0 FTE	1.0 FTE	The provision of administrative support for LikeMind to assist in the day-to-day operations of LikeMind
Private practice			
Mental health accredited social workers	n/a	0.2 FTE	The provision of assessment and therapy to LikeMind clients
Local Health District			
Western NSW Mental Health, Drug and Alcohol Services - Acute and Continuing Care Team (ACCT)	Not co-located		Major referral partner and provision of clinical support and advise
Murrumbidgee Mental Health Services		Not co-located	Major referral partner and provision of clinical support and advise
On-site consortium members			
Mission Australia	As required		Psychosocial support
Lives Lived Well	As required		Providing AOD counselling & SMART recovery group (Addiction treatment program)
Housing Plus	As required		The provision of consultation and advise to consumers with housing support needs
Marathon Health	0.02 FTE		Psychological services
Wellways	0.02 FTE		Psychological services
Neami	As required		Suicide prevention and housing support
Interrelate	As required		The provision of support for parents and children, and strengthening family relationships
OCTEC	As required		Disability and vocational services and support
Tend		0.1 FTE	The provision of financial counselling, family support services and sexual assault counselling

Title	Orange	Wagga Wagga	Role
Amaranth Foundation		0.2 FTE	Targeting the social, emotional, psychological and existential needs of people living with advanced chronic and life limiting illness.
Open Arms		0.1 FTE	Provision of mental health assessment and clinical counselling services for Australian veterans and their families
Calvary Riverina Drug and Alcohol Centre		0.4 FTE	The provision of drug and alcohol withdrawal and rehabilitation programs
Personnel Group		0.1 FTE	Offering disability employment services for assisting job seekers to find and keep a meaningful job
Live Better		As required	Dietician services
Uniting		As required	The provision of gambling counselling
PSYCH2U		As required	The provision of telehealth psychiatry
Pathways Murrumbidgee		As required	Treatment and support services for people impacted by drug use
Other consortium members			
Murrumbidgee Primary Healthcare Network		Attend consortium meetings	For the benefit of funding opportunities and strategic planning

3 Evaluation methodology

The current evaluation has built on the approach developed for the LikeMind Phase 1 evaluation. It has applied the same overarching framework and a similar approach to stakeholder engagement, data collection and data analysis activities. This approach has allowed the analyses to span the entire period where appropriate and compare results between the two phases of the evaluation.

A mixed methods approach has been applied to capture both quantitative and qualitative data throughout the evaluation. A detailed outline of the evaluation methodology was submitted to the Ministry in June 2020 (Gordon et al., 2020). The evaluation has aimed to address four high-level questions:

- Whether the LikeMind model is effective, efficient and appropriate and what, if any, change(s) could be made to enhance these outcomes;
- How well resources have been targeted at the identified need and what, if any, change(s) could be made to enhance this;
- What the level of 'value-add' has been achieved through the use of the funds including by enhancing CMO service delivery and linkages with public health and other services;
- Whether there have been any unintended outcomes and how this could be corrected.

3.1 The LikeMind evaluation framework

The evaluation has sought to understand how well the core LikeMind service streams (mental health, primary care, drug and alcohol, and social and vocational recovery) delivered integrated services as reflected in the Program Logic.

In doing so, it was important to measure outcomes from the investment in the integrated service model for individuals, providers and the broader health system. An existing evaluation framework, developed by CHSD, was modified for this purpose (refer Appendix 1). This framework provides a basis for understanding the impact at each of these levels:

- Level 1: Impact on, and outcomes for, consumers (care recipients, families, carers, friends, communities);
- Level 2: Impact on, and outcomes for, providers (care providers, professionals, mental health services);
- Level 3: Impact on, and outcomes for, the system (structures and processes, networks, relationships).

3.2 Literature review

An ongoing review of academic and practice literature has been maintained throughout the evaluation to provide context and situate the evaluation within the broader evidence-base. The aim of the literature review was to assess the evidence supporting the co-location of mental health providers with primary health, drug and alcohol and vocational and social service providers (i.e., employment and housing) in relation to improved consumer outcomes and/or effectiveness of service delivery.

The full literature review results have been produced as a separate report and included as a companion document to this report (Grootemaat et al., 2022). Section 4 provides a summary of the approach and key findings of the literature review.

3.3 Quantitative data collection

The LikeMind Phase 2 evaluation involved extensive quantitative data collection processes. The aim of the data collection was to ensure that the evaluation could report on the impact of the LikeMind Pilot as well as identify key issues that emerged for each site.

3.3.1 The LikeMind V1 Minimum Data Set

The LikeMind V1 MDS was collected from beginning of service delivery at each LikeMind Pilot site until October 2020[3]. It was designed to capture specific information about each consumer and the services provided during their LikeMind episode. The LikeMind V1 MDS comprised three component datasets:

- 33 variables collected at initial assessment (IA);
- 14 variables collected at each occasion of service (OOS);
- 25 variables collected at exit from LikeMind (exit).

The dataset included two clinical tools (the RAS-DS and the K10) which were included in both the IA and the exit datasets.

3.3.2 The LikeMind V2 Minimum Data Set

The final report of the LikeMind Phase 1 evaluation included a range of recommendations related to the LikeMind V1 MDS. The evaluation team undertook an extensive consultation with two LikeMind lead agencies during March 2020 and September 2020 to review and identify ways in which the MDS could be improved.

The LikeMind V2 MDS was subsequently finalised and approved by the Ministry in September 2020. The LikeMind V2 MDS and associated materials were incorporated into a stand-alone document that was used by LikeMind services in the collection of the dataset from November 2020 to October 2021.

A summary of the changes between each LikeMind MDS is provided at Appendix 4. The LikeMind V2 MDS specification (Bird et al., 2020) is included as a companion document to this final report.

The results of a detailed series of analyses of the LikeMind V2 MDS is provided in Section 5.

3.3.3 LikeMind Consumer Survey

A survey of LikeMind consumers was conducted between 15 November 2021 and 18 February 2022. This period included an eight-week extension due to the impact of COVID-19. The survey provided an important opportunity to directly explore consumers' experiences of LikeMind.

[3] The V1 MDS was collected at each site between the LikeMind Phase 1 and the LikeMind Phase 2 evaluation.

The consumer survey was open to all current or previous LikeMind consumers aged 18 or over. The focus of the survey was on understanding consumers' overall experiences of LikeMind, ways in which services had been effective, and to gauge overall levels of satisfaction with the service. A number of demographic questions were included to understand of the profile of the survey respondents.

The survey instrument was piloted, and changes made based on feedback. The final survey instrument comprised 26 questions and was available in hardcopy and through an online survey platform. LikeMind staff provided consumers with a link to the online survey and assisted with the distribution of the hard copy of the survey where required. LikeMind consumers completed the survey independently of staff, except where they requested assistance. The survey instrument is provided at Appendix 3.

The results of the analysis of the LikeMind consumer survey are presented in Section 5.5.

3.4 Qualitative data collection

The primary source of qualitative data for the LikeMind Phase 2 evaluation was a series of key stakeholder interviews with LikeMind, LHD and CMO staff. This qualitative data supplemented the quantitative data provided by LikeMind services and facilitated a more robust understanding of the issues that arose for each LikeMind service.

Interviews with key LikeMind stakeholders were held at two points in time during the LikeMind Phase 2 evaluation. A relatively small number of semi-structured interviews were conducted with LikeMind services and LHD representatives in January and February 2021. The results from these interviews were included in the LikeMind Phase 2 LikeMind evaluation interim report (Gordon et al., 2021).

A second set of key stakeholder interviews was undertaken in October and November 2021 with key LikeMind staff, consortium members and relevant LHD representatives. The interviews were semi-structured, open-ended and conversational in tone to allow for discussion on other issues that emerged. The interviews were recorded with the permission of the interviewees. The audio files were confidentially transcribed and uploaded into NVivo 12 Plus to facilitate data management and analysis.

The analysis of these interviews applied a methodology known as the Framework Method. This is a well-established thematic analysis process that is particularly applicable when using data from semi-structured interviews (Gale et al., 2013). A copy of the questions that formed the basis of the semi-structured interviews is provided at Appendix 2.

The results of the thematic analysis of the stakeholder interviews are provided in Section 6.

3.5 Ethical approval

Ethical approval to conduct the evaluation was received from the Human Research Ethics Committee of the University of Wollongong and the Illawarra Shoalhaven Local Health District in June 2020 (Ref: 2020/265).

4 Results: Literature review

4.1 Introduction

A key recommendation from the Productivity Commission Inquiry into Mental Health was 'Reorienting surrounding services to people' to promote 'care integration and coordination', together with 'care pathways for people using the mental health system' that are 'obvious and joined up' (Productivity Commission, 2019). Leutz (1999) defines integration as the search to connect the health care system (acute, primary medical and skilled) with other human service systems (e.g., long term care, education, vocational and housing services) in order to improve outcomes. Key benefits of co-located services is that they bring together multiple services into one location making it easier for consumers to access services they need (Productivity Commission, 2019, pg. 363, pg. 363).

We reviewed literature about whether co-locating mental health service providers in community accessible premises with shared service protocols will lead to improved outcomes for consumers. Originally conducted in 2016, we updated this review in 2018 and again in 2021. Previous iterations of this review found a number of positive outcomes for clients including some benefits in physical health when primary care and mental health services are co-located. The review showed that the co-location of primary care and mental health care as well as other services such as employment services, social work and allied health, were feasible and may help to reduce stigma, increase satisfaction and engagement of mental health clients with health care and other services. This review also finds that co-location of services does not necessarily promote integration and thus explores some of the challenges to the co-location and integration of care.

4.2 Methods

Academic database searches, web searches and snowball technique searches identified 412 items for review. Applying the inclusion criteria resulted in 220 studies being excluded in the second stage of the screening process, leaving 192 citations for full review. After reading the articles in full 133 were excluded. This process identified 59 citations, of which 16 are literature reviews relating to co-location and integrated care and 43 are studies involving co-location.

4.3 Results

The majority of studies are Level III (promising) or Level IV (emerging) level studies. There were three level II (best practice) studies, all from the USA. Of the 16 reviews, five were from the USA, one from Canada, three were from UK/European countries, one was international and six were Australian. The grey/practice literature report was Australian and of the 43 studies, 20 were from Australia, 16 were from the USA, four from Canada, three from UK/Europe and one from New Zealand. This review focuses on evidence relating to co-location of mental health services from Australian sources.

This review assessed evidence relating to outcomes across three main themes: client outcomes, provider outcomes and system level outcomes. This review discusses the implications of evidence related to the co-location of mental health, primary and allied

health care and other mental health support services in the context of patient, provider and system outcomes.

4.3.1 Client outcomes

The Productivity Commission draft report into mental health points to a range of approaches to collaboration that improve service delivery and benefit consumers, including co-location, alliances and networks (Productivity Commission, 2019, pg. 66, pg. 66). Several studies indicated an improvement in consumer outcomes (Beere et al., 2018; Blackmore et al., 2018; Lee-Tauler et al., 2018) and access to allied health services (Furness et al., 2018). Blackmore et al. (2018) found that co-location combined with a collaborative care model improved patients' outcomes more than co-location alone. Yogman et al. (2018) studied the integration of behavioural health into primary care found there was a reduction in costs for the consumer as well as the practice. Johnson et al (2020) also found an overall reduction in costs to clients attending co-located medical care, care coordination and social services. Several qualitative studies also provide feedback from consumers on their experiences with co-located care projects in which consumers were largely supportive of co-located care as part of integrated care (Banfield et al., 2017; Dawson et al., 2020; Ewais and Banks, 2018; Flatau et al., 2010).

Several studies indicated an improvement in consumer outcomes, (Beere et al., 2019; Blackmore et al., 2018; Lee-Tauler et al., 2018) and access to allied health services (Furness et al., 2018). Several qualitative studies also provide feedback from consumers on their experiences with co-located care projects in which consumers were largely supportive of co-located services as part of integrated care (Banfield et al., 2017; Dawson et al., 2020; Ewais and Banks, 2018; Flatau et al., 2010). The co-location and integration of mental health and employment services has been shown to give better employment outcomes (Killackey and Waghorn, 2008; Petrakis et al., 2018; Waghorn et al., 2012).

Several studies and reviews observed benefits to clients of co-located care; however, a finding of this review is that not all studies reported co-located or integrated care as being associated with direct benefits to clients. Headspace is an Australian initiative that has been reviewed by several authors (Flatau et al., 2010; Hilferty et al., 2015; Pomare et al., 2018). Client outcomes showed mixed results with a reduction in psychological distress in 47% of clients and an increase in 24%, with greater reductions in those with more attendances (Hilferty, Cassells et.al. 2015). An international study of co-located GP services (Bonciani et al., 2018) found that while co-location was positive for GPs, clients tended to be less satisfied with services.

We found a range of studies from overseas whose findings showed improved consumer outcomes from co-located primary and mental health care (Bartels et al., 2004; Blackmore et al., 2018; Druss et al., 2001; Druss et al., 2017; Lee-Tauler et al., 2018) however, some studies also found that co-located care was less effective without efforts to fully integrate care services (Blackmore et al., 2018; Landis et al., 2013; Rosenheck et al., 2002). Co-located and integrated care services were also shown to reduce disparities in consumer outcomes for racial and ethnic minorities (Ayalon et al., 2007; Lee-Tauler et al., 2018) and reduce stigma (Calkins et al., 2013; Hine et al., 2008; Ion et al., 2017).

4.3.2 Provider outcomes

There were few studies that provided quantitative results for provider outcomes, however those that did collect data regarding providers found that integration and co-location of care may reduce time spent on administrative tasks and more time spent with consumers (Knight et al., 2018) and improvements in provider experience (Dawson et al., 2020; Jacobs et al., 2018; Yogman et al., 2018).

A number of qualitative studies also gave insight into provider outcomes, such as the potential for improved understanding and knowledge between providers (Furness et al., 2018; Sutherland et al., 2018), the tensions that may arise between mental health care, primary care and other support staff (Shepherd and Meehan, 2019) and uncertainties such as role ambiguity (Pomare et al., 2018). Factors that can act as facilitators of or barriers to success in co-located services included:

- Proximity and physical space (Ion et al., 2017; Lalani and Marshall, 2020).
- Funding models, additional cost and resourcing (Kharicha et al., 2005; Sullivan and Lozowski-Sullivan, 2021).
- Staff roles, skill mix and training (Ion et al., 2017; Jacobs et al., 2018; Kharicha et al., 2005; Shepherd and Meehan, 2019; Sullivan and Lozowski-Sullivan, 2021).
- Inter-professional communication and valuing staff feedback, role ambiguity and time management (Hine et al., 2008; Rousseau et al., 2017; Shepherd and Meehan, 2019; Sutherland et al., 2018).
- Leadership, conflict resolution, work culture, high caseloads and clinical governance (Hine et al., 2008; Ion et al., 2017; Kharicha et al., 2005; Shepherd and Meehan, 2019).

A study by Lennart et al. (2018) also looks at the impact of provider relationships in the integration of mental health care into Aboriginal Community Controlled Health Services to improve access to culturally appropriate mental health services.

A number of studies have shown that staff buy in, appropriate levels of funding for additional costs, support for education, communication and care coordination staff are essential factors for providers (Ion et al., 2017; Lane et al., 2017; Lawn et al., 2014; Overbeck et al., 2016).

Co-location has been shown to have a positive effect on time management within co-located services (Haggarty et al., 2012; Knight et al., 2018; Lane et al., 2017) as well as reducing costs (Hine et al., 2008; Yogman et al., 2018). Some studies found that the distance between co-located services was important in improving communication and referrals and reducing stigma (Calkins et al., 2013; Ion et al., 2017; Lawn et al., 2014).

Co-location has been shown to be linked to improvements in inter-professional collaboration and that work climate is predictive of whether inter-professional collaboration will be consolidated or undermined over time (Rousseau et al., 2017). Lalani and Marshall (2020) found that co-location reduced bureaucracy and improved inter-professional discussion and referral. They also found that challenges to overcome for effective

collaboration included an investment in adequate facilities, local IT systems for sharing information, continuity of personnel and organisational development activities. A review by Rawlinson et al (2021) looked at barriers and facilitators to inter-professional collaboration found that, while co-location was a facilitator for inter-professional collaboration, other factors including funding, payment issues and incentives, communication, training, roles, governance and power were also important.

4.3.3 System outcomes

Several articles focussed on system level outcomes. Fernandez (2017) mapped mental health related services in Western Sydney. The Study identified service gaps included acute and sub-acute community residential care, no services providing acute and non-acute day care, few employment services for people living with mental ill-health and a lack of information on availability of supported housing. Lennart et al. (2018) identified factors related to the success of integrating culturally appropriate mental health care into Aboriginal Community Controlled Health Services or organisations and found that all participating services encountered difficulties in establishing service partnerships. Along with staffing issues, the major barriers or facilitators were the ability to establish relationships with Aboriginal community-controlled health services and co-location of services within ACCHSs.

Clarke and Burns (2017) asked whether co-location can address fragmentation of rural mental health care delivery in Australia but found that co-location was difficult in rural areas without a change in thinking aimed at supporting the provider. More often than not, services were clustered rather than co-located and this reduced their ability to address stigma, proximity and the need for regional planning and fostering local initiatives (Clarke and Burns, 2017). Fernandez et al (2017) and Richman et al (2020) also found difficulties in attaining the co-location of care in rural areas. A review by Whiteford et al (2014) found that while co-location in rural areas may present greater implementation challenges, alternative options may achieve equivalent benefits, as long as barriers and facilitators to service coordination are addressed. Sullivan et al (2021) argued that purposeful effort and funding is required to support integrated levels of care.

While physical co-location may facilitate an integrated care model through a shared client base that attaches a higher value to co-location of services (Jackson et al., 2007) it may be an insufficient condition to promote service integration (Flatau et al., 2010; Lane et al., 2017). Inadequate and siloed IT systems are a barrier to integration and increase the burden of data entry (Lalani and Marshall, 2020; Lawn et al., 2014). Without adequate funding models while administrative processes and routines act as barriers to integration, the objectives of integration may be unattainable (Ewais and Banks, 2018; Lane et al., 2017). Getting co-located and integrated care right may result in reductions in costs for consumers and providers (Conroy et al., 2016; Yogman et al., 2018).

Lane et al. (2017) looked at the outcome of a GP Super clinic program involving co-location of primary care services, including mental health care and found that a lack of meaningful supports and effective incentives can make integrated care objectives unobtainable.

Ellis et al. (2017) reviewed evidence relating to lessons learned from evaluations of headspace and integrated mental health services. The authors described headspace services as a complex adaptive system and concluded that:

> *…to achieve coordinated care, an environment must be created that fosters connectivity among mental health service providers, providing them with sufficient autonomy to respond adaptively to community needs.*

Several challenges for the headspace model were identified by Rosenberg and Hickie (2013), including inconsistent application of the model, funding challenges and workforce challenges.

Staffing was a significant factor in a number of studies in which successful models involved the employment of full time specialist staff, such as employment specialists (Waghorn et al., 2012) and a stable workforce with reduced staff turnover and responsibility taken to ensure patients are taken care of (Hansen et al., 2016). Differences in mental health culture and for example the business culture of an employment service, must also be managed to foster communication between professionals (Killackey and Waghorn, 2008). A bottom-up approach - as opposed to top-down approach - may be both less costly and more effective in changing a system, at least in the short term (Morrissey et al., 2002).

A benchmarking study by the Economist Intelligence Unit (2016) found that, while Australia ranked well overall in relation to integrating people with mental illness into the community, there was room for improvement in the system. This included improvements in governance, including human rights issues and efforts to reduce stigma. It was found that an important difficulty was obtaining secure accommodation for those living with mental illness, arguing that housing policy rather than health being the important issue to address (Economist Intelligence Unit, 2016).

4.3.4 Conclusion

Studies have shown that mental health consumers are largely supportive of co-located care and that co-located care can contribute to improved outcomes for mental health patients, reduce stigma and improved reach to diverse communities. On the other hand, co-located care without effective integration of care is less effective for consumers. For providers, co-located care can improve many aspects of practice and reduce time and costs associated with disparate services. However, it is critically important to foster good inter-professional communication, conflict resolution, governance, staff mix and training and address funding issues at all levels, staff concerns and work culture. Co-location facilitates integrated care but it is insufficient on its own to improve outcomes for consumers and providers. In rural areas, co-location may face additional pressure from provider centric thinking with a need for regional planning efforts as well effective supports and incentives. Australia is doing well regarding integrated care but there is room for improvement. Co-located care has the potential to facilitate integrated care but is not the only factor required for effective implementation and outcomes. Efforts to address barriers and facilitators of co-located and integrated care services are encouraged.

5 Results: LikeMind Minimum Dataset and Consumer Survey

A significant volume of quantitative data were collected and analysed for the LikeMind Phase 2 evaluation. This included both routinely collected data provided by each LikeMind site and client survey data collected on behalf of the evaluation team. This section presents the results of a series of analyses across these datasets.

The results in this section build on those presented in the previous LikeMind evaluation reports. Where appropriate, the results span both the LikeMind Phase 1 and the LikeMind Phase 2 evaluation to provide insights across the six-year period of service delivery. In other cases, the results focus on a more recent time period focussing on variables not captured in the earlier stages of the evaluation.

5.1 Quantifying LikeMind services: the LikeMind Minimum Data Set

Examining the total volume of LikeMind services provides a useful understanding of its overall reach. A cross-sectional overview of the total number of consumers, the total number of service contacts and the number of service contacts per consumer is presented below followed by longitudinal analysis of the number of monthly service contacts for each LikeMind site.

5.1.1 Number of consumers and service contacts

Each LikeMind site commenced operations at a different point between January 2015 and October 2018. Table 4 shows the number of consumers who received services at each LikeMind site from the commencement of its operations until 31 October 2021.

At the two metropolitan sites, 2,989 consumers received services at Penrith during 82 months from January 2015 while 1,699 clients received services at Seven Hills during 76 months from July 2015. At the two regional sites, 2,258 clients received services at Orange during 60 months from October 2016, while 1,767 clients received services at Wagga Wagga during the 44 months from February 2018.

At 31 October 2021, a noticeably higher number of active consumers were observed at the two regional sites (Orange: n=488; Wagga Wagga: n=631) relative to the two metropolitan sites (Penrith: n= 274; Seven Hills: n= 168).

Table 4 Number of LikeMind consumers and service contacts

Service contacts and consumers	Penrith (Jan 2015-Oct 2021)	Seven Hills (Jul 2015-Oct 2021)	Orange (Oct 2016-Oct 2021)	Wagga Wagga (Feb 2018-Oct 2021)
Number of initial assessments[1]	3,156 (2,989)	1,805 (1,699)	3,156 (2,258)	1,996 (1,767)
Number of OOS	11,674 (2,188)	6,771 (1,147)	10,080 (1,633)	6,541 (1,302)
Number of exits	2,872 (2,715)	1,619 (1,531)	2,206 (1,770)	1,326 (1,136)
Number of Active[2]	274	168	488	631

[1] Consumers can have more than one distinct LikeMind 'episode' of care (each episode begins with an initial assessment), and hence the number of consumers is less than or equal to the number of initial assessments.

[2]Number of active consumers as on 31 October 2021 was obtained by subtracting the number of consumers with an exit assessment from the total number of consumers.

The pattern of service delivery for LikeMind varies depending on the needs and circumstances of each client. A complete episode of LikeMind services would typically comprise an initial clinical assessment followed by one or more occasions of service, with a further assessment completed on exit/discharge.

Table 5 shows the number of service contacts per consumer at each site from the commencement of its operations until 31 October 2021. Almost half of the consumers in the two metropolitan sites (Penrith 45% and Seven Hills 53%) received either only an initial assessment (one service contact) or an initial assessment along with one OOS/exit assessment (two service contacts). In the regional sites, the corresponding figures were 32% in Orange and 37% in Wagga Wagga. At least one-quarter of consumers at metropolitan sites (26%) and one-third of consumers in regional sites (36% at Orange and 31% at Wagga Wagga) received six or more service contacts.

Table 5 Number of service contacts per consumer by site

Number of service contacts per consumer[1,2,3]	Penrith (Jan 2015-Oct 2021) (N = 3,237)		Seven Hills (Jul 2015-Oct 2021) (N = 1,866)		Orange (Oct 2016-Oct 2021) (N = 2,265)		Wagga Wagga (Feb 2018-Oct 2021) (N = 1,772)	
	n	%	n	%	n	%	n	%
One	806	24.90	588	31.51	299	13.2	332	18.74
Two	687	21.22	406	21.76	422	18.63	324	18.28
Three	438	13.53	201	10.77	314	13.86	238	13.43
Four	280	8.65	118	6.32	241	10.64	184	10.38
Five	173	5.34	76	4.07	181	7.99	139	7.84
Six or more	853	26.35	477	25.6	808	35.67	555	31.31

[1]Some consumers had multiple initial assessments with no subsequent occasions of service.
[2] Service contacts include initial assessments and subsequent occasions of service. Unplanned exits with no assessment data recorded were excluded.
[3]A small number consumers had initial assessment in another site within same CMO and were included in that site.

5.1.2 Trend in LikeMind service activity

This section provides an overview of service activity data from the commencement of operations at each site until 31 October 2021. The number of service contacts is defined as the number of initial assessments, occasions of service and exit assessments (excluding unplanned exit). Figure 3 shows the number of service contacts at Penrith from January 2015 to October 2021. While there have been regular variations, the trend line indicates a smooth overall increase in number of service contacts over the entire period. The average number of monthly contacts during 2015 was 116 and this increased to 362 by early 2020 before a sharp decline.

Figure 3 Number of service contacts per month (January 2015 to October 2021) – Penrith

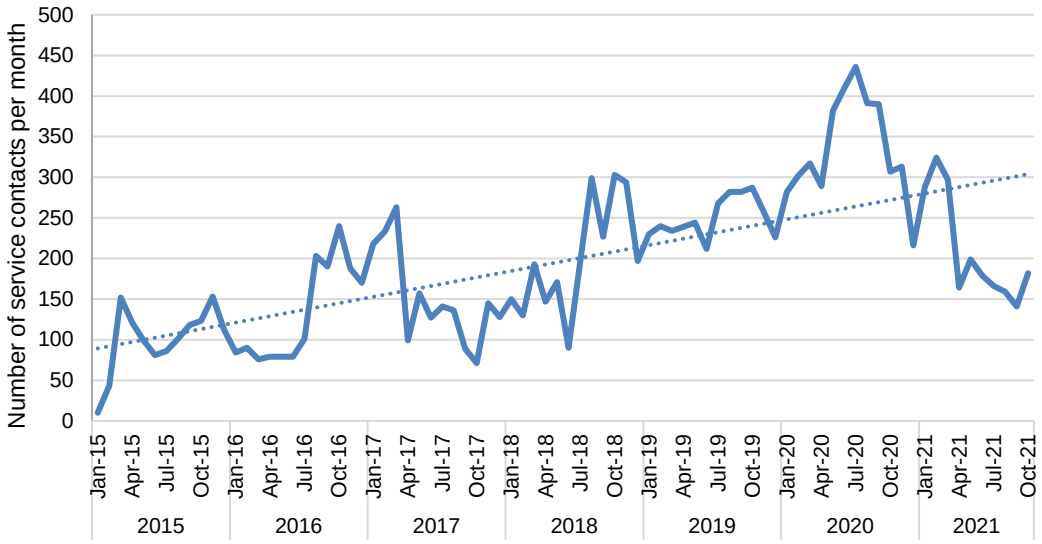


Figure 4 shows the number of service contacts at Seven Hills from July 2015 to October 2021. Monthly variation was also observed at this site but the speed of increase in the overall number of contacts was much slower compared with Penrith, and the number of service contacts has remained consistently lower over the entire period.

The average number of monthly contacts during the initial six-month period from July to December 2015 was 65. This increased to a monthly average of 179 by 2021 but remained substantially lower volume than activity levels at Penrith. Unlike Penrith, the overall number of service contacts moderately increased in 2021.

Figure 4 Number of service contacts per month (July 2015 to October 2021) - Seven Hills

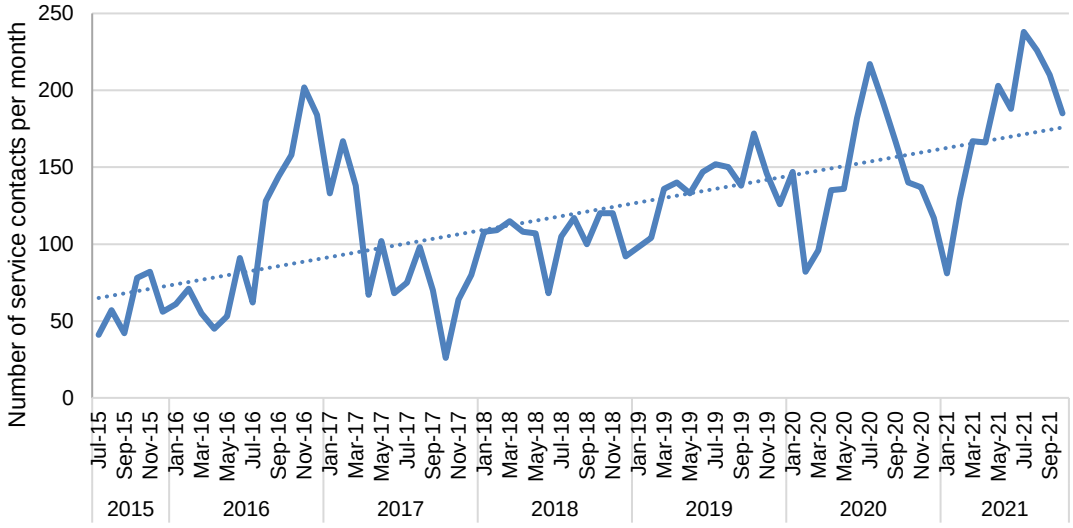


Figure 5 shows the number of service contacts at Orange from October 2016 to October 2021. The pattern here shows considerable variation over time. There was a sharp decline in

the number of service contacts at the end of 2018. However, our understanding is that this was due to data collection issues associated with the end of the LikeMind Phase 1 evaluation rather than reflecting an actual decline in service activity.

Despite this decline, the overall average number of monthly service contacts was 165 during the initial six-month period from October 2016 to March 2017. This increased to an average of 420 in 2020, the highest volume of activity across the four sites. The number of monthly contacts declined sharply to 264 during the first 10 months of 2020 due to COVID-19.

Figure 5 Number of service contacts per month (October 2016 to October 2021) – Orange

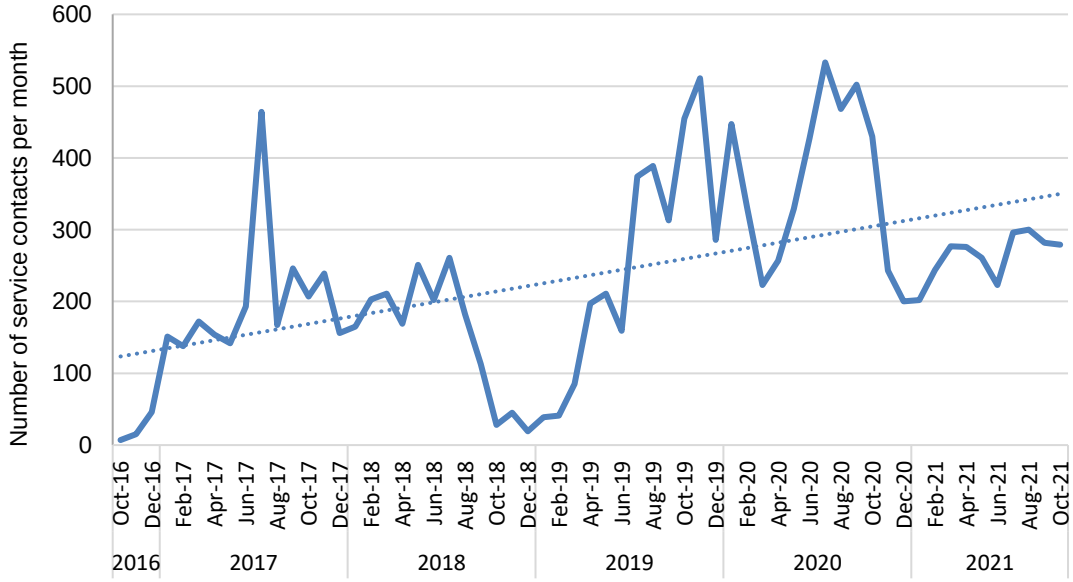
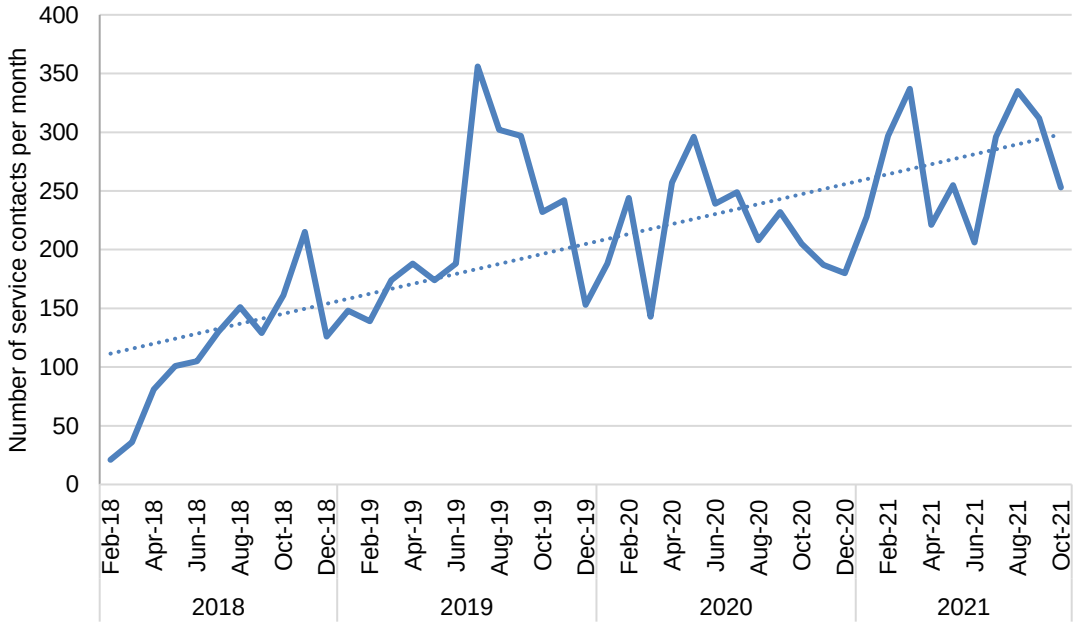


Figure 6 shows the number of service contacts undertaken at Wagga Wagga from February 2018 to October 2021. While there were some variations, the trend line indicates a smooth overall increase in number of contacts over the entire period.

The average number of monthly service contacts during the initial six-month period in 2018 was 124 and this increased to 274 in 2021, which was the highest volume of service activity across four sites in 2021. Unlike the Orange and Penrith, the average number of monthly service contacts increased moderately in 2021.

Figure 6 Number of service contacts per month (February 2018 to October 2021) - Wagga Wagga



In summary, there has been a substantial increase in volumes of service activity across all LikeMind sites over the last six years. The Penrith and Orange sites have reported an overall higher volume of service activities compared with Seven Hills and Wagga Wagga. However, the number of service contacts at Seven Hills and Wagga Wagga increased in 2021, whereas Penrith and Orange observed a substantial decrease.

5.2 Characteristics of the LikeMind cohort

This section presents the demographic and socio-economic characteristics of LikeMind consumers from the commencement of services at each site to 31 October 2021.

5.2.1 Demographic characteristics

The demographic profile of consumers at each site is presented in Table 6. Female consumers were moderately overrepresented across all sites (Penrith 53%, Seven Hills 55%, Orange 55% and Wagga Wagga 54%). More than 30% of consumers were aged less than 30 across the four sites, with Wagga Wagga having the highest proportion of young consumers (41% aged less than 30 years).

A substantially high proportion of consumers in the regional sites (Orange: 19% and Wagga Wagga: 14%) identified as Indigenous, compared with 9% at Penrith and 5% at Seven Hills. In contrast, noticeably a higher proportion of consumer in the metropolitan sites were born outside of Australia (Penrith 22% and Seven Hills 26%) compared with the regional sites (6%). English was the main language spoken at home by most of the consumers across all sites with very few consumers requiring an interpreter.

Table 6 Demographic characteristics of LikeMind consumers by site

Demographic characteristics	Penrith (Jan 2015 - Oct 2021)		Seven Hills (Jul 2015 - Oct 2021)		Orange (Oct 2016 - Oct 2021)		Wagga Wagga (Feb 2018 - Oct 2021)	
	n	%	n	%	n	%	n	%
Sex								
Male	1,371	45.9	755	44.4	1,004	44.5	807	45.7
Female	1,596	53.4	941	55.4	1,246	55.2	955	54.1
Other	22	0.7	3	0.2	8	0.4	5	0.3
Age group[1]								
Younger than 25	609	20.4	316	18.6	318	14.1	377	21.3
25 - 29	496	16.6	301	17.7	409	18.1	354	20.0
30 - 34	370	12.4	210	12.4	298	13.2	250	14.2
35 - 39	340	11.4	199	11.7	290	12.8	194	11.0
40 - 44	315	10.5	163	9.6	257	11.4	156	8.8
45 - 49	302	10.1	176	10.4	208	9.2	148	8.4
50 - 54	201	6.7	143	8.4	184	8.2	115	6.5
55 - 59	152	5.1	96	5.7	149	6.6	98	5.6
60 - 64	99	3.3	57	3.4	102	4.5	50	2.8
65 and over	104	3.5	38	2.2	43	1.9	25	1.4
Indigenous status								
Aboriginal but not Torres Strait Islander	213	7.8	66	4.1	346	16.9	222	13.4
Torres Strait Islander but not Aboriginal	12	0.4	3	0.2	16	0.8	5	0.3
Both Aboriginal and Torres Strait Islander	18	0.7	6	0.4	9	0.4	6	0.4
Neither Aboriginal nor Torres Strait Islander	2,477	91.1	1,523	95.3	1,672	81.8	1,429	86.0
Country of birth								
Australia	2,383	79.8	1,265	74.5	1,915	93.7	1,613	94.2
Other	603	20.2	433	25.5	129	6.3	99	5.8
Main language spoken at home								
English	2,713	90.9	1,537	90.5	1,988	98.8	1,610	98.5
Other	271	9.1	161	9.5	25	1.2	24	1.5
Need for interpreter								
No	2,776	99.5	1,609	98.8	2,247	99.5	1,732	98.0
Yes	15	0.5	20	1.2	11	0.5	35	2.0

[1.] Age was calculated based on the date of birth and the date of initial assessment.

5.2.2 Socio-economic characteristics

Table 7 provides a summary of the socio-economic characteristics of LikeMind consumers. More than half of LikeMind consumers in the metropolitan sites (Penrith 53% and Seven Hills 52%) and two-fifths of regional sites (Orange 40% and Wagga Wagg 41%) reported being unemployed. Almost one-quarter of consumers at Orange reported being in receipt of a government pension (disability support, aged or other). The corresponding proportion in other sites were relatively low (just over 15%). Almost 50% of consumers across all sites reported never being married/single, followed by 27%-35% married/de-facto and 13% to 17% being either divorced or separated.

Approximately one in three consumers at both Penrith and Seven Hills and over half at Orange and Wagga Wagga reported having dependent children. Almost half of the consumers (48%) across all sites (except for Wagga Wagga 26%) reported living in a 'private residence - rental'. Wagga Wagga reported the highest proportion of consumers living in a 'private residence - owned/purchasing' (37%) and 'private residence – public rental' (23%). However, the corresponding figures other sites were relatively low, with 19% - 24% 'private residence - owned/purchasing' and 13 - 17% 'private residence -public rental'.

Table 7 Socio-economic characteristics of LikeMind consumers at initial assessment by site

Socio-economic characteristics	Penrith (Jan 2015 - Oct 2021)		Seven Hills (Jul 2015 - Oct 2021)		Orange (Oct 2016 - Oct 2021)		Wagga Wagga (Feb 2018 to Oct 2021)	
	N	%	n	%	n	%	N	%
Employment status								
Employed/self employed	960	33.6	566	37.0	1,111	38.9	813	42.9
Unemployed	1,507	52.8	791	51.8	1,127	39.5	774	40.8
Supported employment	4	0.1	3	0.2	5	0.2	1	0.1
Home duties	101	3.5	41	2.7	290	10.2	155	8.2
Student	54	1.9	21	1.4	54	1.9	61	3.2
Retired for age	73	2.6	17	1.1	17	0.6	10	0.5
Retired for disability	53	1.9	26	1.7	11	0.4	9	0.5
Other	102	3.6	63	4.1	239	8.4	72	3.8
Source of income								
Paid employment	863	35.4	529	36.2	961	35.4	797	41.4
Unemployment benefits	910	37.3	591	40.4	768	28.3	646	33.5
Study payments	33	1.4	19	1.3	28	1.0	40	2.1
Disability pension	217	8.9	159	10.9	321	11.8	184	9.6
Aged pension	64	2.6	17	1.2	28	1.0	14	0.7
Other pension	162	6.7	53	3.6	322	11.9	96	5.0
Other	166	6.8	83	5.7	282	10.4	138	7.2
No income	22	0.9	12	0.8	4	0.2	12	0.6
Relationship status								
Married/de-facto	867	29.8	449	26.5	961	35.0	671	35.3
Separated	266	9.1	149	8.8	252	9.2	158	8.3
Divorced	217	7.5	131	7.7	161	5.9	92	4.8
Widowed	54	1.9	26	1.5	33	1.2	17	0.9
Single/Never married	1,508	51.8	942	55.5	1,338	48.8	964	50.7
Dependent children								
No	2,130	67.8	1,148	63.9	1,194	48.5	760	39.4
Yes	1,011	32.2	648	36.1	1,268	51.5	1,168	60.6
Type of accommodation								
Private residence – owned /purchasing	488	21.7	344	23.8	556	19.3	696	36.8
Private residence – private Rental	1,071	47.5	695	48.2	1,392	48.4	488	25.8
Private residence – public Rental	293	13.0	209	14.5	484	16.8	429	22.7
Independent living unit in a retirement village	2	0.1	4	0.3	2	0.1	1	0.1
Institutional setting (e.g. aged care, psychiatric)	13	0.6	10	0.7	16	0.6	3	0.2
Supported accommodation /living facility	86	3.8	52	3.6	84	2.9	38	2.0

Socio-economic characteristics	Penrith (Jan 2015 - Oct 2021)		Seven Hills (Jul 2015 - Oct 2021)		Orange (Oct 2016 - Oct 2021)		Wagga Wagga (Feb 2018 to Oct 2021)	
	N	%	n	%	n	%	N	%
Other[1]	301	13.4	126	8.7	343	11.9	239	12.6

[1]Also includes 'Homeless', Specialist housing, emergency temporary accommodation

5.3 Clinical and service-related characteristics

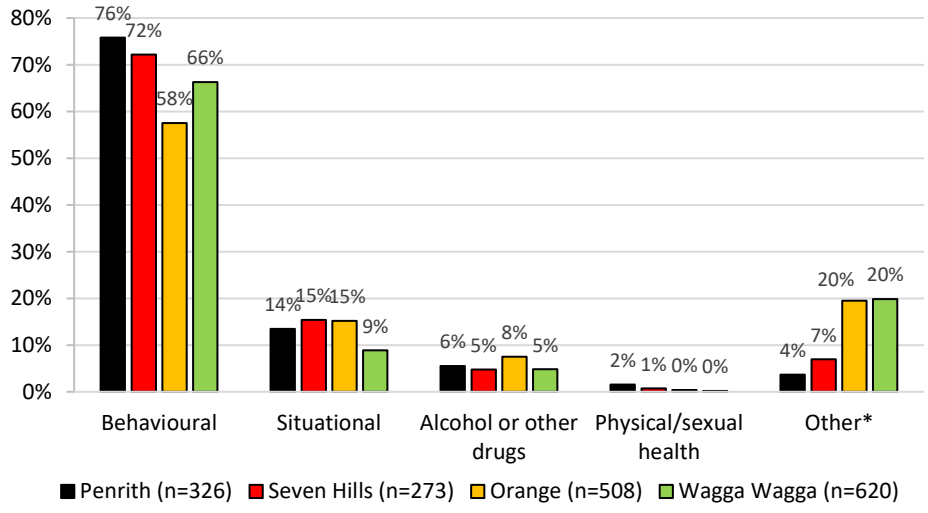
This section presents clinical and service-related data based on the LikeMind V2 MDS. It covers the 12-month period from November 2020 to October 2021. This analysis specifically reports on the most recent evaluation data collection period with the aim of reflecting the current profile of LikeMind clients. The profile of LikeMind consumers' clinical characteristics, referral source, main service provided at OOS, discipline of service provider, and mode of discharge are outlined.

It is important to note that the COVID-19 pandemic had a significant impact on the delivery of LikeMind services across the four sites during this period. Between June 2021 and October 2021 Sydney went into lockdown. Regional NSW followed shortly afterwards and was in lockdown between August 2021 and September 2021.

5.3.1 Clinical profile of LikeMind consumers

Figure 7 shows the key primary presenting issue reported at initial assessment for each site. Behavioural issues were consistently and by far the most reported primary presenting issue across all sites (76% at Penrith, 72% at Seven Hills, 58% at Orange and 66% at Wagga Wagga) followed by situational issues and alcohol or other drugs related issues. A substantial proportion (20%) of consumers in Orange and Wagga Wagga reported their primary presenting issue in 'other' category which includes 'Emotional dysregulation' and 'Difficulty with personal relationships' and 'Other').

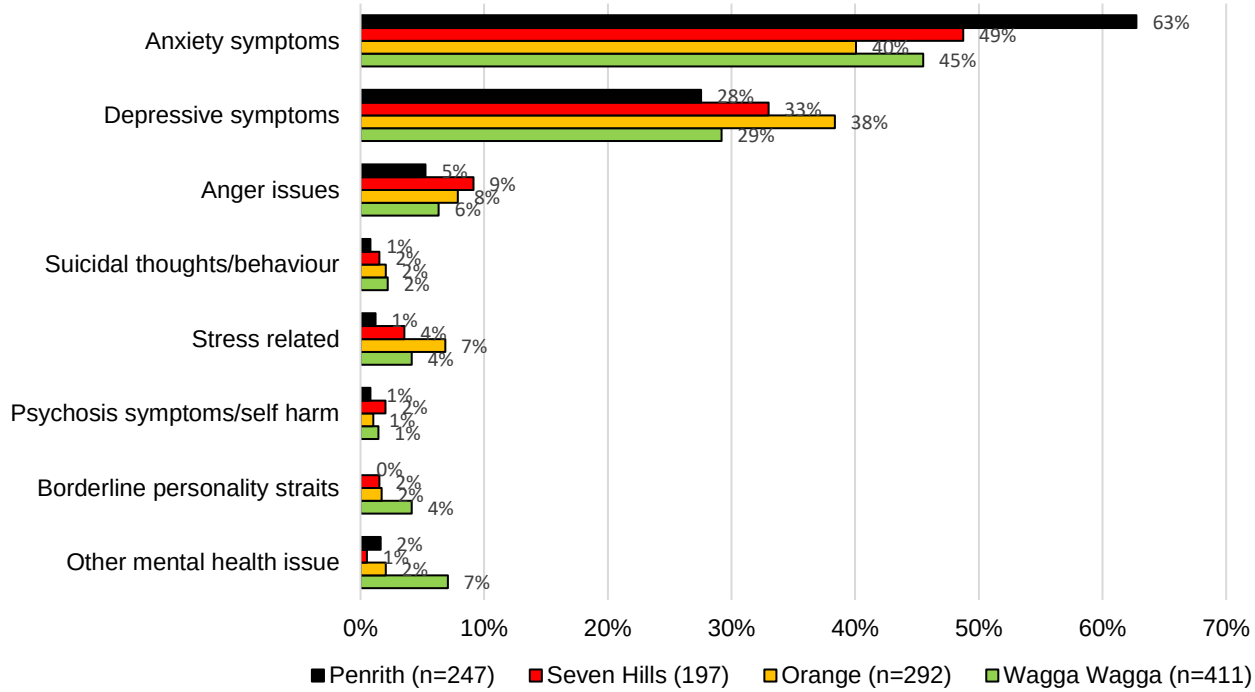
Figure 7 Primary presenting issue at initial assessment by sub-category and site (November 2020 to October 2021)



*Other includes 'Emotional dysregulation' and 'Difficulty with personal relationships'

A breakdown of those consumers with a primary presenting issue of 'behavioural issues' is shown in Figure 8. Within this group, 'anxiety' and 'depressive symptoms' were the two most common behavioural presenting issues. The majority of consumers at Penrith (63%) reported anxiety symptoms, followed by Seven Hills (49%), Wagga Wagga (45%), Orange (40%). The highest proportion of consumers with depressive symptoms was reported at Orange (38%) followed by Seven Hills (33%), Wagga Wagga (29%) and Penrith (28%). Between 5% and 9% of consumers reported anger issue across all sites. A small proportion (1% to 4%) of consumers across all sites reported a range of other behavioural issues including stress (except for Orange 7%), suicidal thoughts, psychosis symptoms, borderline personality straits and other mental health issues (except for Wagga Wagga 7%).

Figure 8 Primary presenting issue at initial assessment by site - breakdown of behavioural issues (November 2020 to October 2021)



5.3.2 Referrals to LikeMind

Table 8 shows the source of referral for each LikeMind site from November 2020 to October 2021. 'Self-referral' and 'primary health care - GP' were the two most common referral sources. However, the proportion of consumers receiving referrals from these two sources differed by region, with the two metropolitan sites reporting a higher proportion of self-referral (Penrith 58%, Seven Hills 50%) and the two regional sites reporting a higher proportion of 'Primary health care - GP' (44% at Wagga Wagga and 56% at Orange). About 4% - 6% of consumers reported referral from employment agency across all sites (except for orange which reported 11%), and a small proportion (<5%) reported referral from community-based mental health service (except for Wagga Wagga which reported 14%).

Table 8 Referral source by site from November 2020 to October 2021

Referral source	Penrith (n=326)		Seven Hills (n=273)		Orange (n=503)		Wagga Wagga (n=542)	
	n	%	N	%	n	%	n	%
Self-referral	190	58.3	137	50.2	103	20.5	160	29.5
Primary health care – GP	94	28.8	49	18.0	283	56.3	239	44.1
Employment agency	17	5.2	16	5.9	54	10.7	19	3.5
Community-based mental health service[1]	5	1.5	12	4.4	8	1.6	73	13.5
LDH (Acute or case management team or other)	4	1.2	7	2.6	7	1.4	-	-
CMO (same or different organisation)	3	0.9	20	7.3	-	-	-	-
Legal, justice, correction services	2	0.6	21	7.7	19	3.8	29	5.4
Other[2]	11	3.4	11	4.0	29	5.8	22	4.1

[1]Also included one inpatient consumer in Penrith and five inpatient/acute patient in Seven Hills

[2]Also included four consumers who received referral by NDIS at Seven Hills, and one consumer by Community housing provider at each site except for Wagga Wagga.

5.3.3 Main services provided at OOS

The LikeMind V2 MDS includes 32 options to capture the main service provided at each occasion of service (OOS) following the initial assessment. Table 9 shows the breakdown of main service provided at each OOS by LikeMind site. While there was a wide variation across sites, 'general or supportive counselling' and 'consumer contact/case note' were the two most provided services. The highest proportion of consumers receiving general or supportive counselling were at Orange (52%), followed by Wagga Wagga (35%), Penrith (35%) and Seven Hills (32%). Over one quarter of consumers in the regional sites received 'consumer contact/case note' service (Orange 26% and Wagga Wagga 29%) but a relatively lower proportion of consumers received these services in the metropolitan sites (Penrith 23% and Seven Hills 16%).

A noticeably higher proportion of consumers had either 'mental health assessment' or 'cognitive behavioural therapy' reported as the main service provided at OOS across all sites (Penrith 23%, Wagga Wagga 20%, Seven Hills 14% and Orange 12%). Similarly, a substantial proportion of consumers (25%) in Seven Hills received either 'mindfulness-based therapy' (17%) or 'coordinated care plan developed' (8%) but this proportion was very small at other sites (Penrith 7%, Orange <1% and Wagga Wagga 2%).

Table 9 Main service provided to consumers by site – OOS

Main Service provided at OOS	Penrith (N=1,976)		Seven Hills (N=1,615)		Orange (N=2,463)		Wagga Wagga (N=2,345)	
	n	%	n	%	n	%	n	%
General or supportive counselling	692	35.0	510	31.6	1,287	52.3	825	35.2
Consumer contact/Case note	453	22.9	257	15.9	627	25.5	683	29.1
Mental health assessment	278	14.1	155	9.6	34	1.4	44	1.9
Cognitive behavioural therapy	174	8.8	70	4.3	254	10.3	418	17.8

Main Service provided at OOS	Penrith (N=1,976)		Seven Hills (N=1,615)		Orange (N=2,463)		Wagga Wagga (N=2,345)	
	n	%	n	%	n	%	n	%
Coordinated care plan developed	106	5.4	134	8.3	1	0.1	5	0.2
Clinical review (3mth)	95	4.8	46	2.9	-	-	-	-
Mindfulness-based therapies	39	2.0	281	17.4	7	0.3	37	1.6
Case review	28	1.4	58	3.6	127	5.2	6	0.3
Mental health group work	25	1.3	12	0.7	21	0.9	73	3.1
Physical/clinical health assessment	18	0.9	-	-	2	0.1	1	0.0
Liaison with other service providers within/outside LikeMind	17	0.9	6	0.4	16	0.7	2	0.1
Relaxation strategies	12	0.6	29	1.8	2	0.1	5	0.2
Outcome assessment	8	0.4	2	0.1	1	0.0	0	0.0
Employment assistance	7	0.4	2	0.1	-	-	4	0.2
Motivational Interviewing/enhancement	6	0.3	4	0.3	3	0.1	26	1.1
Psycho-education (including harm minimisation)	5	0.3	14	0.9	7	0.3	69	2.9
Alcohol and other drugs (AOD) group work	-	-	-	-	-	-	27	1.2
Triage and safety plan	-	-	2	0.1	6	0.2	11	0.5
Other[1]	17	0.86	33	2.03	69	2.75	109	4.64

[1]Also included a range of minor services including 'Training assistance', 'vocational counselling', 'rehabilitation', 'couple counselling', 'family therapy', 'cultural support', 'consultation with parent/carer with consumer consent', 'legal, justice, corrections service' and discharge plan.

5.3.4 Discipline of service provider at initial assessment

The LikeMind V2 MDS includes ten options to capture clinician discipline at initial assessment. Table 10 shows this breakdown by site. Social workers provided a large proportion of initial assessments across all sites (Penrith 59%, Orange 58%, Seven Hills 37%, Wagga Wagga 32%). Provisional psychologists provided the largest proportion of initial assessments at Seven Hills (58%) and a substantial proportion at Penrith (17%), but very few at the regional sites. A noticeable proportion of service providers at Penrith were either registered psychologists (13%) or nurses (10%).

Consistent with the results from the LikeMind Phase 1 evaluation and as reported in the interim report of the current revaluation, a large proportion of 'other' responses were reported at Orange (41%) and Wagga Wagga (49%). This variable was revised in the LikeMind MDS V2 with an additional option 'Aboriginal mental health worker' to reduce the response in this category. Despite, this, the proportion of responses in the 'other' category has remained relatively high at both sites.

Table 10 Discipline of service provider by site - initial assessment

Discipline of service provider – IA	Penrith (N=326)		Seven Hills (N=273)		Orange (N=510)		Wagga Wagga (N=621)	
	n	%	n	%	n	%	n	%
Social worker	193	59.2	101	37.0	295	57.8	200	32.2
Provisional psychologist	55	16.9	157	57.5	1	0.2	-	-
Registered psychologist	41	12.6	11	4.0	4	0.8	1	0.2
Nurse	30	9.9	-	-	-	-	-	-
Psychiatrist	-	-	-	-	-	-	4	0.6
Drug and alcohol counsellor	-	-	-	-	-	-	13	2.1
Aboriginal mental health worker	-	-	-	-	-	-	99	15.9
Other	7	2.3	4	1.5	210*	41.2	304*	49.0

* Other includes services provided by LikeMind intake staff with undergraduate qualifications in psychology, social work and/or counselling.

5.3.5 Discipline of service provider at OOS

The LikeMind V2 MDS included the same ten options as at initial assessment to capture clinician discipline for each OOS. Table 11 shows this breakdown by site. While the four LikeMind sites noticeably differ by discipline of service provider at OOS, social worker and registered psychologist represented a large proportion of OOS across all sites. Social workers provided the highest proportion of OOS at Orange (46%) followed by Wagga Wagga (41%), Orange 28% and Seven Hills 23%), whereas registered psychologist reported the highest at Seven Hills (49%) followed by 23% at Orange, 20% at Penrith, and only 8% at Wagga Wagga.

A high proportion (18%) of OOS at Wagga Wagga were provided by 'Aboriginal mental health worker' but no data were reported under this discipline at other sites. Provisional psychologists provided a high proportion of services (22%) at Seven Hills, but only a small proportion at Orange, and none at the regional sites. A substantial proportion of services were provider by 'other' discipline across all sites, with the highest proportion at Orange (30%), Penrith (29%), Wagga Wagga (24%) and Seven Hills (13%). (Need to contact with the agencies about the 'other' category).

Table 11 Discipline of service provider by site - OOS

Discipline of service provider – OOS	Penrith (N=1976)		Seven Hills (N=1615)		Orange (N=2464)		Wagga Wagga (N=2345)	
	n	%	n	%	n	%	n	%
Social worker	559	28.3	251	15.5	1136	46.1	957	40.8
Nurse	416	21.1	-	-	-	-	-	-
Registered psychologist	388	19.6	792	49.0	563	22.9	189	8.1
Provisional psychologist	28	1.4	353	21.9	-	-	-	-
Occupational therapist	16	0.8	15	0.9	2	0.1	-	-
Psychiatrist	-	-	-	-	26	1.1	24	1.0
Drug and alcohol counsellor	-	-	-	-	-	-	177	7.6
Employment consultant	-	-	-	-	-	-	6	0.3
Aboriginal mental health worker	-	-	-	-	-	-	421	18.0
Other	569	28.8	204	12.6	737*	29.9	571*	24.3

* Other comprises services provided by LikeMind intake staff with undergraduate qualifications in psychology, social work and/or counselling.

5.3.6 Mode of Discharge

The LikeMind V2 MDS includes seven options to capture the 'mode of discharge', of which only six were recorded during the data collection period as shown in Table 12. This item would not normally apply to unplanned exits. Hence consumers with unplanned exits were excluded from this analysis. The two most commonly reported modes of discharge were 'discharge to self-care' and 'discharge to external agency' across the four sites. Two of every five planned exits (40%) at Seven Hills were reported as discharge to self-care followed by 38% at Orange, 35% at Wagga Wagga and 33% at Penrith. However, Seven Hills reported a noticeably lower proportion (14%) of discharge to external agency compared with the other sites (Wagga Wagga 37%, Orange 26% and Penrith 25%).

Again, a substantial proportion of responses for this item were reported as 'other' across all sites, with the highest at Seven Hills (34%) and the lowest at Wagga Wagga (16%). It is worth noting that all the four sites continue to report high proportion of unplanned exits. Over the 12 months during which the LikeMind V2 MDS was collected, 79% of exits at Orange, 58% at Wagga Wagga, 41% at Penrith, and 35% at Seven Hills 35% were reported as 'unplanned'.

Table 12 Mode of discharge by site (planned exits)

Mode of discharge	Penrith (n=326)		Seven Hills (n=159)		Orange (n=107)		Wagga Wagga (n=138)	
	n	%	n	%	n	%	n	%
Discharge to Self-Care	106	32.5	63	39.6	41	38.3	48	34.8
Discharge to external agency	80	24.5	22	13.8	28	26.2	51	37.0
Cease current treatment - consumer refused further treatment	33	10.1	8	5.0	-	-	4	2.9
Discharge to Referrer	12	3.7	12	7.6	1	0.9	13	9.4
Discharge to Consortium organisation	2	0.6	-	-	3	2.8	-	-
Other	93	28.5	54	34.0	34	31.8	22	16.0

5.4 Clinical assessment tools

Two clinical assessment tools were included in each LikeMind MDS. The V1 MDS included the Kessler Psychological Distress Scale (K10) and RAS-DS and were collected from the commencement of LikeMind at each site to October 2020. The K10 and Personal Wellbeing Index (PWI) were included in the V2 MDS and collected from November 2020 to October 2021.

The analysis of RAS-DS data collected as part of the LikeMind V1 MDS were reported in the LikeMind Phase 1 evaluation report and in the interim report of the current LikeMind Phase 2 evaluation. No analysis of RAS-DS data has therefore been included in this report. The results included in this report are based on an analysis of available K10 data completed at the initial assessment and OOS/exit during the period October 2018 to October 2021 (V1 and V2 MDS), and PWI data collected between November 2020 and October 2021 (V2 MDS).

5.4.1 Kessler Psychological distress scale (K10)

The K10, a widely used reliable and validated screening scale of psychological distress, based on 10-items questions about the level of nervousness, agitation, psychological fatigue and depression in the relevant rating period (Kessler et al., 2002). Each of the 10-item questions has five-point rating options (generally for last four weeks or one month) ranging from 1= none of the time to 5=all of the time and sum up to get the K10 total score. A copy of the K10 scale is provided at Appendix 5.

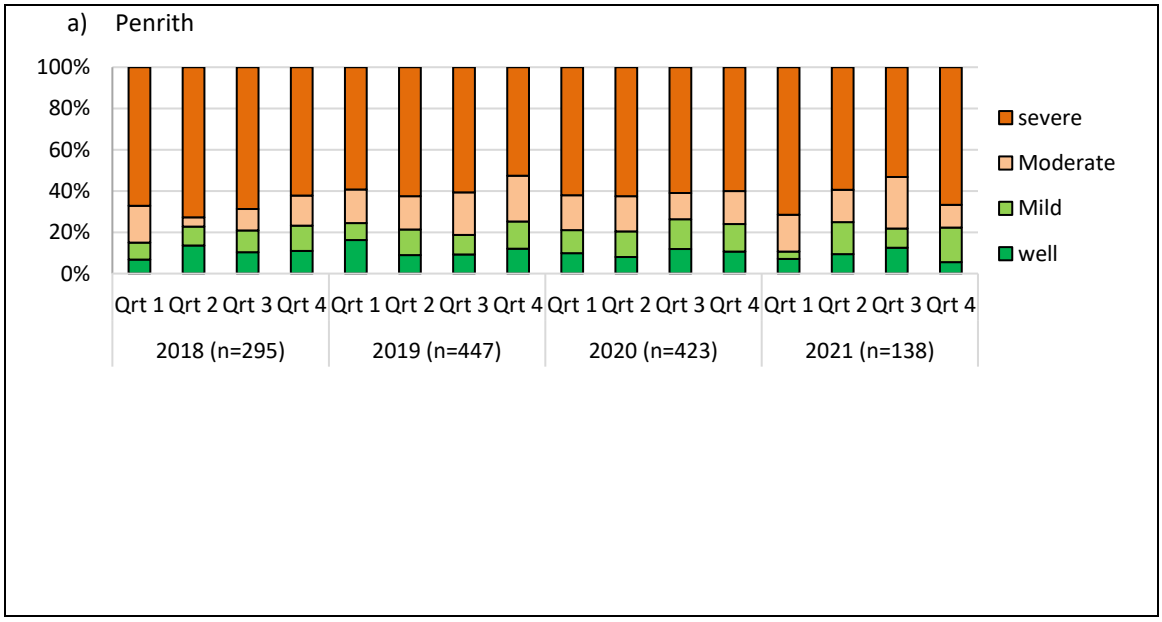
The population reference material (norms) of the K10 total score are: scores under 20 indicate that the consumer is 'likely to be well', scores in the range 20-24 indicate the consumer is 'likely to have a mild disorder', scores in the range 25-29 indicate the consumer is 'likely to have a moderate disorder' and scores of 30 or more indicate the consumer is 'likely to have a severe disorder'.

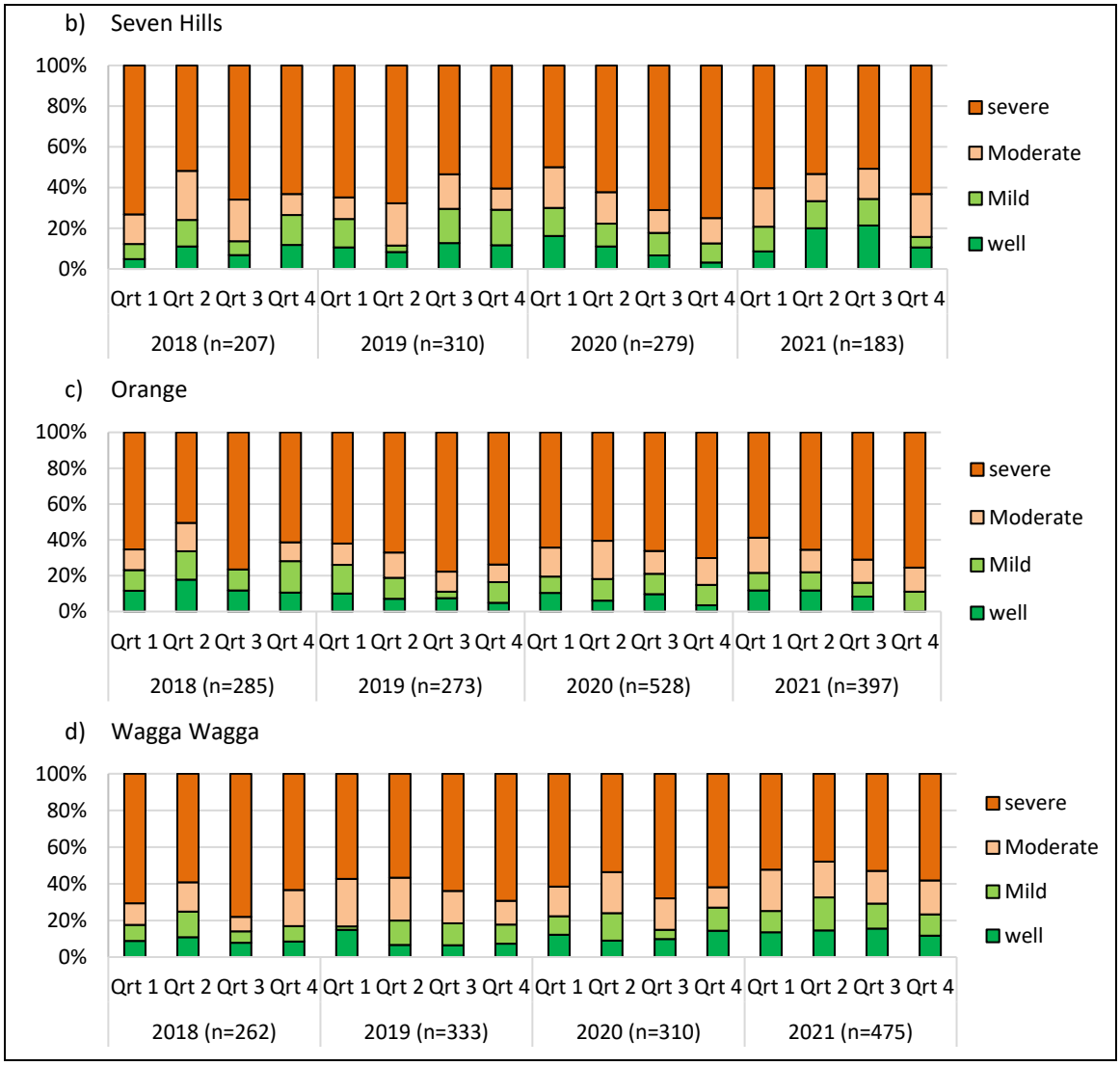
Completion of the K10 at initial assessment over the period October 2018 to October 2021 was higher in the metropolitan sites (83% at Penrith, 82% at Seven Hills) than the regional sites (57% at Orange and 67% at Wagga Wagga). However, collection of the K10 assessments at exit during this period was very low across all LikeMind sites, with the biggest proportion in the regional sites (49% at Orange and 34% at Wagga Wagga) as opposed to the metropolitan sites (18% at Penrith, 30% at Seven Hills).

K10 at initial assessment

Figure 9 presents the levels of psychological distress reported at initial assessment across the four LikeMind sites in each quarter from January 2018 to October 2021. The trend is very similar across all sites with the majority of LikeMind consumers reporting severe psychological distress. Only about 10% of consumers reported scores on the K10 as 'likely to be well' at initial assessment.

Figure 9 K10 assessment results at initial assessment by site from January 2018 to October 2021

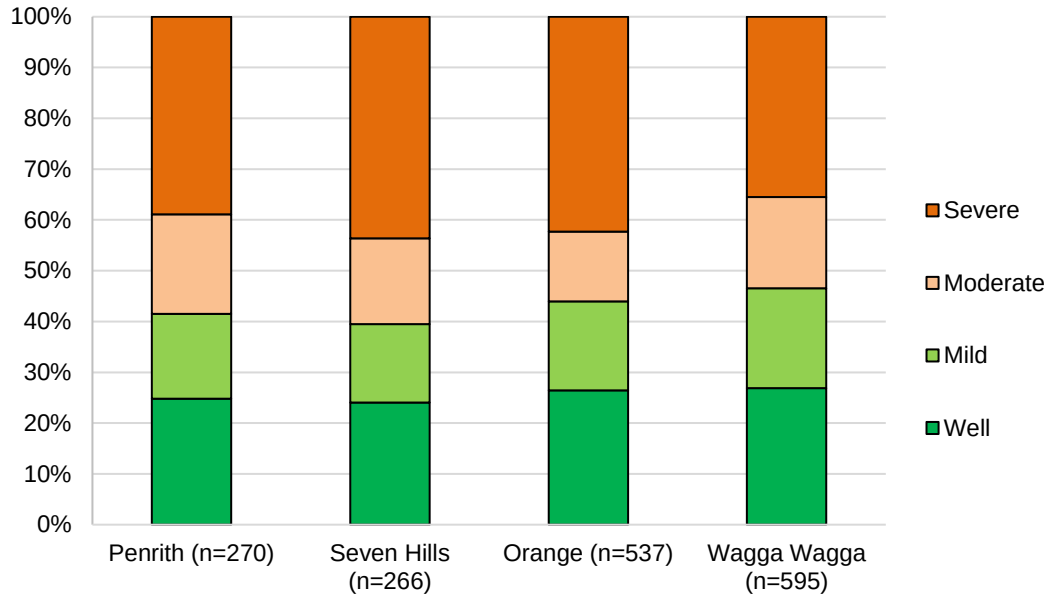




K10 at exit assessment

Figure 10 presents K10 assessment data at exit (or last OOS) across the four LikeMind sites between October 2018 and October 2021. Reported levels of psychological distress improved noticeably relative to the rating at initial assessment. The proportion of consumers reporting severe psychological distress decreased from about 60% to 40%. Similarly, almost 25% of consumers reported as 'likely to be well' compared with only 10% at the initial assessment. Reported levels of psychological distress across LikeMind sites was very similar with more than 50% of consumers reporting 'moderate to severe'.

Figure 10 Levels of K10 at follow-up: October 2018 to October 2021



Paired K10 assessments

The clinical assessment tools were intended to be collected at both the initial assessment and at the time of the final (exit) assessment. Unfortunately, the number of paired assessments at each site remained low throughout the evaluation. Table 13 shows the change in K10 scores between initial assessment and exit (or last OOS) for those consumers who had two K10 assessments. A substantial decrease in the proportion of consumers recording severe psychological distress was evident across all sites (Penrith: 65%/35%; Seven Hills: 54%/34%; Orange: 63%/34%; Wagga Wagga: 54%/38%). Similarly, a significant reduction in psychological distress between initial and exit assessment was also observed in K10 total mean score across the four sites (Penrith: 32/26; Seven Hills: 32/25; Orange: 30/26; Wagga Wagga: 30/26).

Table 13 Paired comparison of psychological distress (K10) at baseline (initial assessment) and follow-up (exit assessment) October 2018 to October 2021

Levels of K10	Penrith (n=66)		Seven Hills (62)		Orange (n=182)		Wagga Wagga (n=187)	
	Baseline % (n)	Follow-up % (n)	Baseline % (n)	Follow-up % (n)	Baseline % (n)	Follow-up % (n)	Baseline % (n)	Follow-up % (n)
Well	12.1 (8)	28.8 (19)	21.0 (13)	30.7 (13)	12.6 (23)	34.6 (63)	16.6 (31)	27.3 (51)
Mild	10.6 (7)	21.2 (14)	6.5 (4)	14.5 (9)	11.5 (21)	18.1 (33)	11.8 (22)	20.3 (38)
Moderate	12.1 (8)	15.2 (10)	16.1 (10)	21.0 (13)	12.6 (23)	13.2 (24)	18.2 (34)	14.4 (27)
Severe	65.2 (43)	34.9 (23)	56.4 (35)	33.9 (21)	63.2 (115)	34.1 (62)	53.5 (100)	38.0 (71)
Mean K10 total score (SD)	32.4 (9.1)	26.3(9.3)	29.9 (8.7)	25.9 (9.9)	32.0 (9.3)	25.3 (9.8)	29.7 (9.4)	25.9 (8.6)

Note 1: The difference between the mean K10 total score at baseline and follow-up were significant at p<0.01 across all LikeMind sites (using paired t-test).
Note 2: The difference between the level of K10 score at baseline and follow-up were significant across all LikeMind sites with p-value p<0.001 in Penrith, Orange and Wagga Wagga and p=0.04 in Seven Hills (using McNemar test)

5.4.2 Personal Wellbeing Index (PWI)

The Personal Wellbeing Index (PWI) measures subjective wellbeing by asking individuals to rate their level of satisfaction across seven keys areas of a person's life: 'your standard of living', 'your health', 'what you are achieving in life', 'your personal relationships', 'how safe you feel', 'feeling part of your community', and 'your future security'. The PWI was originally developed from the Comprehensive Quality of Life Scale and after a series of adjustments, with the 5th edition of the PWI manual published in 2013 (Cummins et al., 1994; International Wellbeing Group, 2013). A copy of the PWI is provided at Appendix 6.

The PWI is a self-administered instrument with an 11-point rating scale, anchored by 0 -'Not at all satisfied' and 10 - 'Completely satisfied'. This scale also includes a standalone (PWI Part 1, an optional level) global question 'How satisfied are you with your life as a whole?' The first level is also represented by the seven domains (PWI Part 2) which are theoretically embedded. The scores in the seven domains are combined to yield an overall Index score, which is adjusted/standardised to have range 0-100, where 0 is completely dissatisfied and 100 is completely satisfied.

The PWI overall Index score ≥70 presents the normal level of wellbeing that people feel good about themselves, well-motivated to conduct their life and have an adequate sense of optimism (Capic et al., 2016). Index scores of 50-69 are considered as 'Challenged' when personal wellbeing is likely to be challenged or compromised, and scores of <50 are considered to be 'High risk' when personal well-being is very low, essential qualities of life are severely compromised and people are at high risk of depression.

The PWI scores at population level are remarkably stable. For the Australian adult population, the average standardised score reported in the regular surveys by the Australian Unity Wellbeing Index Team ranges from 73.5 to 76.6, with a variation of only 3.1 (Capic et al., 2016).

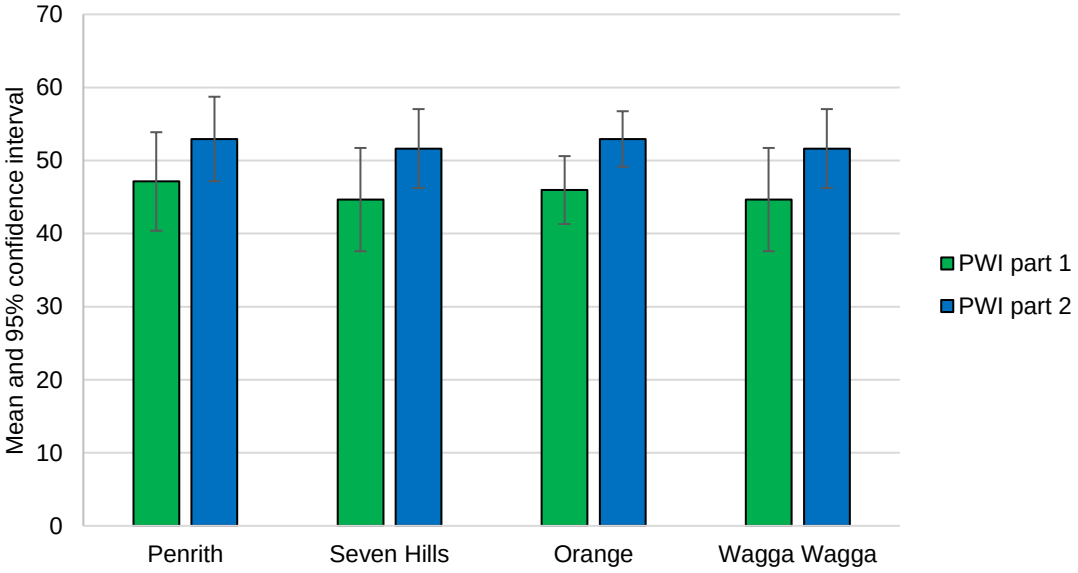
Table 14 presents the levels of the PWI at initial assessment undertaken between November 2020 and October 2021 across the four LikeMind sites. Almost 75% of consumers across the four sites reported their personal wellbeing was either "Challenged' or at "High risk'. Notably, almost two out five consumers across all sites reported their personal wellbeing was at high risk, indicating they were at high risk of depression, exposure to chronic stress, or failed personal relationships.

Table 14 Personal Well-being Index at initial assessment - November 2020 to October 2021

Personal wellbeing index	Penrith (n=188)		Seven Hills (n=214)		Orange (n=435)		Wagga Wagga (n=479)	
	N	%	N	%	n	%	n	%
Normal (Score>=70)	41	21.81	41	19.16	92	21.15	127	26.51
Challenged (50<=Score<70)	72	38.3	77	35.98	166	38.16	171	35.7
High risk (Score<50)	75	39.89	96	44.86	177	40.69	181	37.79

Figure 11 shows the average PWI standardised score (both Part 1 and Part 2) at initial assessment undertaken between November 2020 and October 2021 across the four LikeMind sites. The average scores in the PWI Part 1 (satisfaction with own life as a whole) and PWI Part 2 (satisfaction across seven keys areas of a person's life) were similar across the four sites, with Part 1 average scores (45 to 47) reported as lower than the Part 2 average scores (52-53). When compared with normative data for the Australian adult population (average score ranges 73 to 76), the scores in both the PWI Part 1 and Part 2 were substantially lower across all LikeMind sites.

Figure 11 Mean and 95% confidence interval of standardised score of PWI



Note: PWI part 1: Satisfaction with own life as a whole. **PWI part 2:** includes seven questions covering satisfaction in standard of living, health, achieving in life, personal relationship, how safe you feel, feeling part of community, and future security.

The number of paired PWI assessments at each site remained low throughout the evaluation. Table 15 shows the change in PWI scores between initial assessment and exit for those consumers who had two PWI assessments. A significantly higher proportion of consumers reported normal PWI score at exit assessment compared to initial assessment at the regional sites (Orange: 43%/29%; Wagga Wagga: 42%/24%). However, the difference was not significant at Seven Hills. Given the small number of paired assessments at Penrith, a statistical test was not conducted to examine the differences in PWI scores at this site. In terms of the total means score, the average PWI score at exit assessment was significantly improved compared to initial assessment at Orange (38/45) and Wagga Wagga (38/43) but remained in the high-risk group of the PWI and far below the Australian norm for the adult population.

Table 15 Paired comparison of levels of the Personal Wellbeing Index at baseline (initial assessment) and follow-up (exit assessment) between November 2020 and October 2021

	Penrith (n=25)		Seven Hills (n=51)		Orange (n=119)		Wagga Wagga (n=158)	
Personal Wellbeing Index	Baseline % (n)	Follow-up % (n)	Baseline % (n)	Follow-up % (n)	Baseline % (n)	Follow-up % (n)	Baseline % (n)	Follow-up % (n)
Normal (Score>=70)	28.0 (7)	28.0 (7)	25.5 (13)	31.4 (16)	28.6 (34)	42.9 (51)	24.1 (38)	42.4 (67)

Personal Wellbeing Index	Penrith (n=25)		Seven Hills (n=51)		Orange (n=119)		Wagga Wagga (n=158)	
	Baseline % (n)	Follow-up % (n)	Baseline % (n)	Follow-up % (n)	Baseline % (n)	Follow-up % (n)	Baseline % (n)	Follow-up % (n)
Challenged (50<=Score<70)	24.0 (6)	28.0 (7)	37.3 (19)	39.2 (20)	28.6 (34)	36.1 (43)	38.6 (61)	33.5 (53)
High-risk (Score<50)	48.0 (12)	44.0 (11)	37.3 (19)	29.4 (15)	42.7 (51)	21.0 (25)	37.3 (59)	24.1 (38)
Total mean score (SD)	37.3 (14.1)	38.8 (14.3)	39.0 (15.5)	41.6 (14.0)	38.2 (15.0)	44.7 (14.8)	38.4 (14.0)	43.1 (13.6)

Note 1: The differences between the personal wellbeing index total mean score at baseline and follow-up were significant at p<0.01 in Orange and Wagga Wagga but not at Seven Hills (using paired t-test). Test was not performed for Penrith given low number of paired observations.
Note 2: The differences between the levels of personal wellbeing index at baseline and follow-up were significant at p-value p<0.001 in Orange and Wagga Wagga but not significant in Seven Hills (using McNemar test). Test was not performed for Penrith given low number of paired observations.

5.5 The LikeMind Consumer Survey

The LikeMind consumer survey (refer Appendix 3) was open from 15 November 2021 to 22 February 2022, which included an eight-week extension due to the impact of COVID-19. Surveys were able to be completed on paper or online via an online survey platform (www.qualtrics.com). The survey instrument included closed and open-ended questions, and was designed to collect consumer feedback on different aspects of the program as well as overall levels of satisfaction and comments. The results of both the quantitative and qualitative survey data analyses are presented below.

5.5.1 Demographic profile of participants

A total of 107 surveys were completed by consumers from across the four LikeMind sites. The highest number of survey participants were from Orange (n=37), followed by Penrith (n=30), Wagga Wagga (n=25) and Seven Hills (n=15). In comparing these results against the number of active participants in the program as at 31 October 2021 (refer Section 5.2.1) there is most notably an underrepresentation of Wagga Wagga consumers, at less than a quarter of survey participants compared to 40% of active program participants. The demographic characteristics of the survey respondents are shown in Table 16.

Table 16 LikeMind Consumer Survey – demographic characteristics

Demographic characteristics	Penrith (N = 30)		Seven Hills (N = 15)		Orange (N = 37)		Wagga Wagga (N = 25)		All sites (N = 107)	
	n	%	n	%	n	%	n	%	n	%
Gender										
Female	17	56.7	7	46.7	26	70.3	11	44.0	61	57.0
Male	11	36.7	7	46.7	10	27.0	13	52.0	41	38.3
Non-binary/gender diverse	2	6.7	0	0.0	0	0.0	1	4.0	3	2.8
Prefer not to say	0	0.0	1	6.7	1	2.7	0	0.0	2	1.9
Main language spoken at home										
English	28	93.3	14	93.3	35	97.2	25	100.0	102	96.2
Other	2	6.7	1	6.7	1	2.8	0	0.0	4	3.8
Aboriginal and/or Torres Strait Islander origin										
Neither Aboriginal nor Torres Strait Islander	30	100.0	14	93.3	31	86.1	21	84.0	96	90.6
Aboriginal	0	0.0	1	6.7	4	11.1	4	16.0	9	8.5

Demographic characteristics	Penrith (N = 30)		Seven Hills (N = 15)		Orange (N = 37)		Wagga Wagga (N = 25)		All sites (N = 107)	
	n	%	n	%	n	%	n	%	n	%
Torres Strait Islander	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Aboriginal and Torres Strait Islander	0	0.0	0	0.0	1	2.8	0	0.0	1	0.9
Age group										
18-24	8	26.7	2	13.3	7	18.9	3	12.0	20	18.7
25-34	5	16.7	5	33.3	6	16.2	13	52.0	29	27.1
35-44	3	10.0	0	0.0	9	24.3	3	12.0	15	14.0
45-54	8	26.7	2	13.3	7	18.9	4	16.0	21	19.6
55-64	5	16.7	3	20.0	5	13.5	1	4.0	14	13.1
65-74	1	3.3	3	20.0	3	8.1	1	4.0	8	7.5
Over 74	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0

Note: n and % shows the count and percent of all available answers. The number of missing answers is not reported.

Consistent with the proportions in the LikeMind consumer profile (refer Table 6), just over half of the survey respondents were females, although they were a larger majority in the Orange survey participants (70%) and participants from the Wagga Wagga service included a slight majority of males (52%). The vast majority of survey participants reported not being of Aboriginal or Torres Strait Islander origin (91%) and had English as the main language (96%). Again, this generally reflects the consumer profile across the program, although there were no Aboriginal or Torres Strait Islander people participants from Penrith.

Close to half the total survey participants were under 35 years of age, which is similar to the proportions seen in each of the sites' consumer profiles, however some differences were noted in the profiles of the survey participants from Orange (with 35%) and Wagga Wagga (with 64%).

5.5.2 Service-related profile of survey participants

Table 17 shows the service-related profile of survey participants. The majority of survey participants from Penrith had been in the program for less than two weeks and had accessed the service only once or twice. In contrast, a larger proportion of Seven Hills participants had been in the program between six and twelve months and had accessed the service more than ten times, and from Orange, the majority of participants were in the highest groups for both.

There were notable differences between the metropolitan and regional services in the types of contact, with the large majority of respondents from Orange and Wagga Wagga receiving mostly face-to-face contact, whereas in the metropolitan services there was more of a mix of face-to-face and telephone/video contacts. Most survey participants (89%) had received mental health services from LikeMind (100% of Seven Hills respondents), with some participants from each service receiving community mental health services (>25% of participants from Orange) and employment services.

The most common means of referral across the sites was from the GP, with more than two thirds engaging with the service in this way.

Table 17 LikeMind Consumer Survey – service-related characteristics

Service-related characteristics	Penrith (N = 30)		Seven Hills (N = 15)		Orange (N = 37)		Wagga Wagga (N = 25)		All sites (N = 107)	
	n	%	n	%	n	%	n	%	n	%
Means of referral										
Self-referred	6	20.7	1	6.7	7	18.9	4	16.0	18	17.0
Referred from my GP	20	69.0	10	66.7	24	64.9	15	60.0	69	65.1
Referred from a mental health service	2	6.9	3	20.0	3	8.1	3	12.0	11	10.4
Referred from another service	0	0.0	1	6.7	1	2.7	1	4.0	3	2.8
Other	1	3.4	0	0.0	2	5.4	2	8.0	5	4.7
Length of time in LikeMind										
Up to 2 weeks	12	42.9	1	6.7	1	2.7	0	0.0	14	13.5
2 to 4 weeks	4	14.3	1	6.7	2	5.4	1	4.2	8	7.7
1 to 3 months	3	10.7	0	0.0	8	21.6	6	25.0	17	16.3
4 to 6 months	0	0.0	1	6.7	8	21.6	5	20.8	14	13.5
6 months to 12 months	3	10.7	7	46.7	3	8.1	6	25.0	19	18.3
Over 1 year	6	21.4	5	33.3	15	40.5	6	25.0	32	30.8
Number of times LikeMind services accessed										
1 to 2 times	16	57.1	5	33.3	5	13.5	4	16.0	30	28.6
3 to 5 times	3	10.7	2	13.3	5	13.5	3	12.0	13	12.4
6 to 10 times	3	10.7	1	6.7	8	21.6	8	32.0	20	19.0
More than 10 times	6	21.4	7	46.7	19	51.4	10	40.0	42	40.0
Type of contact with LikeMind										
Mostly telephone/video contact	11	36.7	4	28.6	1	2.7	0	0.0	16	15.1
Mostly face-to-face contact	15	50.0	2	14.3	32	86.5	24	96.0	73	68.9
About the same amount of telephone/video and face-to-face contact	3	10.0	8	57.1	2	5.4	1	4.0	14	13.2
Other	1	3.3	0	0.0	2	5.4	0	0.0	3	2.8
Type of services received										
Mental health services delivered by LikeMind	27	90.0	15	100.0	32	86.5	21	84.0	95	88.8
Mental health services delivered by community mental health	2	6.7	2	13.3	10	27.0	1	4.0	15	14.0
Alcohol and other drug services	1	3.3	0	0.0	3	8.1	3	12.0	7	6.5
Employment assistance/support	3	10.0	3	20.0	3	8.1	2	8.0	11	10.3

Service-related characteristics	Penrith (N = 30)		Seven Hills (N = 15)		Orange (N = 37)		Wagga Wagga (N = 25)		All sites (N = 107)	
	n	%	n	%	n	%	n	%	n	%
Housing assistance/support	0	0.0	1	6.7	2	5.4	1	4.0	4	3.7
Disability services/support	1	3.3	0	0.0	0	0.0	0	0.0	1	0.9
Other	2	6.7	1	6.7	0	0.0	1	4.0	4	3.7

Note: n and % shows the count and percent of all available answers. The number of missing answers is not reported.

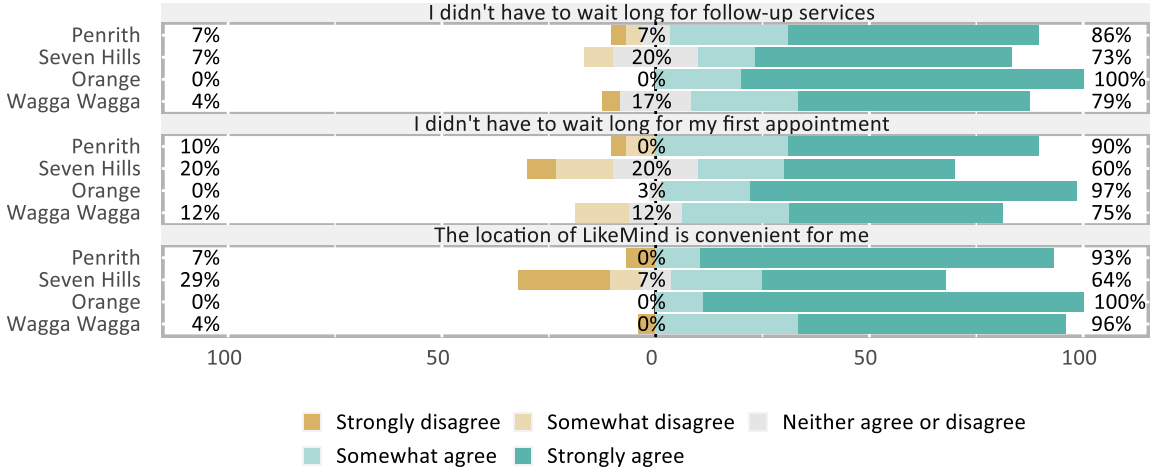
5.5.3 Consumer experience

Survey participants were asked several questions about their experience of the LikeMind program using a five-point Likert scale to indicate their level of satisfaction, from strongly disagree to strongly agree.

Three questions were related to the accessibility of the services for the consumer, including wait times and location (see Figure 12). Survey participants were generally satisfied with the wait times for follow-up services, with the majority indicating they strongly agreed that the wait time was not long. There was similar feedback on the wait time for the first appointment, although there were more participants indicating the wait time was unacceptable from both the metropolitan services and Wagga Wagga, with the largest proportion being from the Seven Hills service (20%).

The highest proportion of negative feedback was reported in the question regarding the convenience of the LikeMind location. There were again a small number from Penrith and Wagga Wagga, but a much larger proportion of the Seven Hills participants (29%), with most indicating strong disagreement that the location was convenient. Notably, nearly all the participants from Orange responded positively to the questions regarding access, with most 'strongly' agreeing and no one responding negatively.

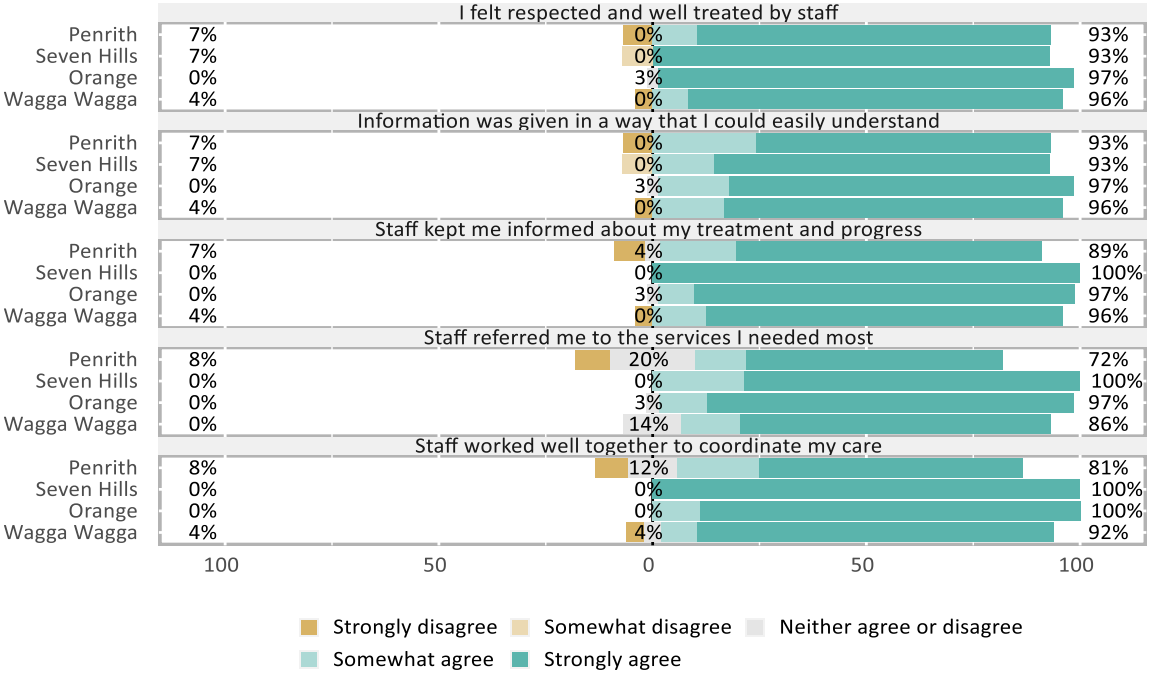
Figure 12 LikeMind Consumer Survey – access to services



Consumers were also asked about their experiences with the LikeMind staff (refer Figure 13). These questions covered different aspects of their interactions with staff, including feeling respected and well treated, being informed, and receiving appropriate care management and referrals. Overwhelmingly, the participating consumers from all sites

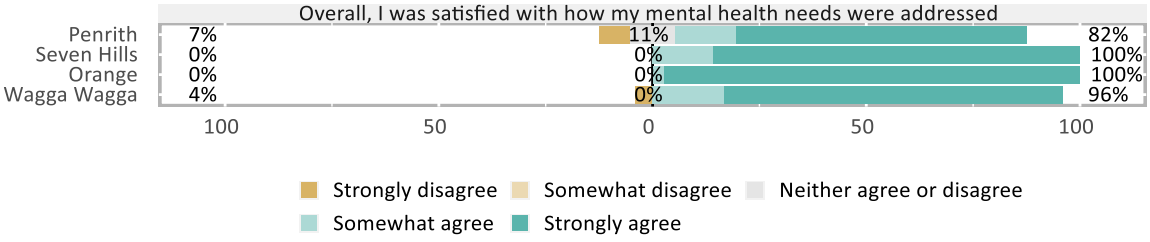
reported very positive experiences with staff, with only a very small number responding negatively (0% from Orange).

Figure 13 LikeMind Consumer Survey – experiences with staff



Similar feedback was seen regarding participants' overall satisfaction with how their mental health needs were addressed by the LikeMind services (see Figure 14).

Figure 14 LikeMind Consumer Survey - overall satisfaction



The consumer survey included a number of questions where participants were invited to provide comments. Regarding whether being able to access different services at one location was of benefit to them, the majority of consumers from all sites agreed that it was (Penrith 64%, Seven Hills 73%, Orange 70%, Wagga Wagga 74%). Participants commented on the convenience of the co-location of services and reported that it made linking in with other services much easier.

> *'I like very very much the other services that are there, or I can ask' [Wagga Wagga]*
>
> *'Was engaged with Global Skills this way' [Penrith]*

'It was great to get information about the other services – it made it easier to engage with them' [Seven Hills]

'Yes I feel like it does so I don't have to go from place to place and love overall' [Orange]

Around a quarter of participants answered 'Unsure' to this question (Penrith 36%, Seven Hills 27%, Orange and Wagga Wagga both 22%). Further investigation of the 'Unsure' responses revealed that these respondents had reported only receiving mental health services delivered by LikeMind, with no additional services used. Some of the comments indicated that this question was not applicable to them, as they did not require other services, while they could see there would be benefits for others.

In response to being asked whether they would recommend LikeMind to others, the overwhelming majority of participants indicated that they would (Penrith 86%, Seven Hills 80%, Orange 100%, Wagga Wagga 96%). There were a number of positive comments provided by participants, with some reporting they had already recommended the service based on their own experience.

'Already have recommended LikeMind. Honestly amazing.' [Seven Hills]

'100% yes I would as I have seen a vast improvement in my mental health' [Orange]

While there were seven 'Unsure' responses to this question, six of them submitted very positive comments about the program, with some confirming that they would recommend LikeMind, or in one case, already had.

Given the ongoing impacts of the COVID-19 pandemic, participants were asked for feedback about whether there had been changes to the way they accessed LikeMind services. There were an equal number of 'Yes' and 'No' responses (n=44 for each) and 11 that were 'Unsure'. However, the large number of comments received from consumers were all very positive about their experience with the program, regardless of the response. Some consumers reported that while they continued to access services via video call/phone consultations, they felt that face-to-face sessions were less awkward and more beneficial for them. Many expressed their appreciation for the ongoing provisions of services throughout this period.

'… staff made the adjustment to phone appointments during lockdown comfortable! [Orange]

(Changed to) 'online video call rather than face-to-face. Although my support person removes all barriers!'[Penrith]

'It is a safe environment to talk' [Wagga Wagga]

Sur0076ey participants were given the opportunity to provide more general feedback in three open-ended questions: 'What did you like most about LikeMind'; 'Do you think there are any ways in which LikeMind services could be improved; and 'Do you have any final comments about LikeMind'.

In describing what they liked most about LikeMind, the majority of respondents gave very positive feedback about the staff, with descriptions such as 'warm', 'calm', 'respectful', 'caring' and 'professional'. Participants commented that the staff were easy to talk to, were non-judgemental, and were able to understand their situation and provide valuable support.

> *'Being listened to and validated' [Penrith]*
>
> *'I finally got the mental support I wasn't able to get elsewhere' [Wagga Wagga]*
>
> *'(Staff member's) enthusiasm and engagement in helping me become a better person' [Seven Hills]*

There were a number of suggestions provided for ways in which the LikeMind services could be improved. Some participants highlighted where they felt additional services could be beneficial, including: more group activities; increased access to psychologists (including face-to-face sessions rather than via phone); access to a psychiatrist. A couple of consumers mentioned improving wait times for appointments, and one participant noted having extended office hours, such as Thursday nights, would be useful. Improving inclusion for LGBTQI+ consumers was also suggested. The difficulty in accessing the Seven Hills office was also raised by some respondents.

Many participants commented that they were happy with the LikeMind service as it was and could not think of any way it could be improved.

> *'Really not for me… their support has really turned my life around' [Wagga Wagga]*

The final question invited respondents to provide any comments about LikeMind, and these were again extremely positive. Consumers expressed their thanks for the services and supports they had received.

> *'Amazing work and amazing support - when I really wanted someone to help me I found the best organisation to understand and listen to me and try hard to help me' [Penrith]*
>
> *'I am so grateful I have someone who works well with me. It is a nice change from bad and failed attempts with other services in the past' [Orange]*

A number of participants commented on the difference that being engaged with the LikeMind service had made to them and expressed their support for the service to be ongoing.

> *'I am so thankful that I went ahead and did the appointments. It greatly helped me to move forward' [Penrith]*
>
> *'I don't know where I would be without them. I was in a deep hole without realising how deep or how to get out of it. I am extremely thankful for the assistance that LikeMind has and is continuing to give me.' [Orange]*
>
> *'Please keep existing' [Wagga Wagga]*
>
> *'There should be more of you's around' [Seven Hills]*

5.6 LikeMind YES Survey

The YES survey (Australian Institute of Health and Welfare, 2021) was developed in 2010 by the Australian Government Department of Health as part of the National Consumer Experiences of Care project. It was designed to gather information from consumers about their experiences of care. It aimed to help mental health services and consumers work together to build better state and territory funded clinical mental health services health services.

The survey is a good indicator of client satisfaction and during the LikeMind Phase 1 evaluation of LikeMind the evaluation team worked with both Uniting and Stride to incorporate the YES survey into routine practice as a quality improvement measure. Since that time, these data have been collected by all four LikeMind services independently of the evaluation team.

A copy of the YES survey data results has been made available from Uniting and the results for LikeMind Penrith and LikeMind Seven Hills are shown in Appendix 7. Survey data from Stride were not available at the time of writing this report and LikeMind Orange and LikeMind Wagga Wagga YES survey results have not been included.

6 Results: Key stakeholder interviews

Qualitative data were a key source of information for the evaluation. This information supplemented the quantitative data reported in the previous chapter and facilitated a more robust understanding of the issues that emerged during the implementation of LikeMind services at each site.

Qualitative data were collected during 20 semi-structured interviews with staff from each lead agency, the partner LHD, and members of the consortium CMOs conducted during October and November 2021. The questions that formed the basis of the semi-structured interviews are provided at Appendix 2.

The interviews were structured around three broad themes: service integration, workforce issues, and the impacts of COVID-19 and other recent developments. Table 18 shows the number of interviews by agency conducted at each site. The results of the thematic analyses are presented below in Section 6.1 to Section 6.4.

Table 18 Number of interviews by LikeMind site

Location	Interviews LikeMind and CMO Staff (n)	Interviews LHD Staff (n)	Total (n)
Seven Hills	2	3	5
Penrith	3	2	5
Orange	4	2	6
Wagga Wagga	2	2	4
Total	**11**	**9**	**20**

6.1 Service integration

6.1.1 Co-location of LikeMind and LHD services

The co-location of LikeMind and LHD mental health services is currently a formal requirement specified in each lead agency contract with the Ministry. LHD mental health teams where originally co-located at the Penrith, Seven Hills and Orange LikeMind sites. The LHD community mental health team in Wagga Wagga was not co-located but regularly attended the LikeMind site to provide services to LikeMind consumers as required. Over the last two years, these arrangements have changed and mental health teams are no longer co-located at any of the LikeMind sites.

Interview participants were asked to comment on the impact of not being co-located on LikeMind service delivery. Most LikeMind participants generally supported the one-stop shop model and agreed that not having the two services co-located was a disadvantage to their consumers. Participants from the LHD had a more mixed view, whilst there was some support for co-location, more senior LHD participants felt that not being co-located had little or no impact on service delivery as the two services were not effectively integrated in the first place.

> *LikeMind is delivering a good set of services but fairly independently from the LHD. (LHD manager)*

One LikeMind manager felt that non-co-location had actually improved the way that the two services worked together.

> *Since the acute team left the building, I think they've taken on more clients than what they did when they were co-located with us. Access to them [the acute team] is important, but co-location isn't. [LikeMind manager]*

LHD management from Seven Hills had a more positive outlook on co-location. They felt that being 'under the same roof' with LikeMind facilitated cooperation between the two services which resulted in a faster and more effective service response for the consumer.

> *If a consumer just walked in and we thought LikeMind can help, then straightaway we will go to their office and they will do an assessment. Straightaway things were done. [Now] it's not that effective…it's not that we are not providing care, but it's not as effective as it was before. (LHD manager)*

Wagga Wagga was the only LikeMind service where the LHD was never co-located. LHD management felt that both services offered consumers very different types of support which could have been complemented if they were co-located. The less-threatening environment of the centrally located LikeMind offices was also a positive factor for LHD management in Wagga Wagga.

> *We have just moved back into the hospital which means that our clients now have to come to the hospital to see the community team which can be quite distressing. (LHD manager)*

Overall, LikeMind staff were more positive about co-location and valued having immediate access to LHD staff who were able to provide intake staff with mentoring and consumer support where necessary. Having the LHD on site also facilitated 'warm transfers' (referrals) between both services. More informally, casual corridor conversations about consumers were also valued by LikeMind staff as was the opportunity provided for upskilling LikeMind staff and providing advice and guidance where necessary.

> *But it seemed really helpful to have them on site, because they were so much more aware of our service, how we operate and how we might be able to support somebody. And now there's a lot of phone tag, so there's that disconnect, which I imagine will filter down to people just not getting access to that support as easily or as quickly. And that really warm transfer that we used to have is just a lot more difficult when you're not co-locating. (LikeMind clinician)*

6.1.2 Care delivery processes

One factor that influences the success of service integration between LikeMind and the LHDs is the degree of commitment to the service level agreement (SLA).

The agreement between LikeMind Orange and WNSWLHD is a good example of an effective SLA. Here, the LHD work with a leadership group that includes both their acute and community mental health teams, LikeMind and local CMOs to monitor clinical governance and identify potential gaps in service delivery and to develop and build on existing partnerships. Accordingly, a 'shared care' model has developed in which the LHD provide

acute care support and LikeMind focus more on consumers' social concerns such as housing and employment.

> *So that's been the main focus…looking at where we've been and where we need to go to move forward in our partnership…there's a lot of that conversation around who would benefit from a LHD service versus LikeMind and different NGO services through that process. (LHD manager)*

This process is supported by regular meetings between the two services.

> *…there's been a big commitment from the LikeMind team and our LHD team to have twice weekly intake referral meetings with each other, and that's where they will refer back and forth to each other…so there's much tighter governance of those referral processes now. So that we know that people aren't getting missed. (LHD manager)*

It is also supported by a positive attitude from LHD management.

> *…we do have a partnership and we are the key primary partner with the LikeMind service. So whilst ever this model exists the way it is, we have a responsibility to find ways to work together. (LHD manager)*

At Wagga Wagga the LHD have not had a permanently co-located team at the LikeMind premises. Instead, members of the LHD mental health community team have attended the LikeMind site as required. Despite the teams not being co-located, there is daily contact between the LikeMind intake officers at Wagga Wagga and the LHD community team.

> *We are frequently in contact with them. There obviously are some clunks to that, I suppose, in that if we need to speak with them, they might be with clients…but I think we definitely have a good relationship…with the staff there and communicate with them where appropriate. (LikeMind intake officer)*

LikeMind staff also participate in clinical reviews with the LHD mental health community team to discuss any shared care arrangements and senior LikeMind and LHD staff meet every quarter to discuss the partnership and opportunities for service development.

LHD management from Wagga Wagga recognise that both services can complement each other and in some instances consumers are co-case managed by both services. The LHD also recognise that LikeMind offer the opportunity for step-down care for their consumers.

> *We, very much, promote and refer to LikeMind. They're probably our primary referrer…there's that transition that they've been with the acute team, the clinicians work with them…and they're ready to move to that next phase so it's about that support phase of going back into their recovery…of what they see as normal. (LHD manager)*

LHD management in NBMLHD acknowledge that their Mental Health Assessment and Acute Care team have good synergy with Penrith LikeMind. LikeMind are able to support consumers with low to moderate mental health needs whilst the LHD focused more on consumers with the 'most acute, severe, enduring and complex problems'. This was positive from two perspectives. Firstly, by taking walk-in consumers LikeMind acted as a first triage point and potentially diverted consumers away from the already busy publicly funded acute

mental health service and, secondly, LikeMind also provided the LHD with a potential to step-down their consumers to support them in their mental health recovery.

However, once the Penrith LikeMind office moved to a "work from home" model due to the onset of the Pandemic the opportunity for the LHD to step-down consumers was largely lost. The benefits that LikeMind offered the LHD prior to the Pandemic disappeared. Support services slowly withdrew from the LikeMind office and were largely confined to the online setting. With the 'walk in' consumers having nowhere else to go the LHD Mental Health Assessment and Acute Care team soon became busier.

> *All of that walk-in traffic then moved over to our acute team…our kind of emergency department, and [they] would have seen more walk-ins because there wasn't any other option available to them in the community. (LHD director)*

This situation has perpetuated and the LHD are now mostly providing services independently of LikeMind. The LHD still refer consumers to LikeMind but only if it was felt that LikeMind was the most appropriate service.

> *…we would refer back to LikeMind but no different than what we would for any other provider. If that was the appropriate service for them than we'd look at referring them to them…so where there's superior services we tend to give the consumer what we think is best or what's the most appropriate for them. (LHD manager)*

At Seven Hills, opinion from LHD participants was polarised and ranged from "the arrangement [with LikeMind] doesn't exist any longer…there's minimal interaction" to "LikeMind is now a good network of CMOs and are supported by a proactive steering committee" and "I would like that co-location back personally".

The less positive opinions about care coordination processes between LikeMind and the LHD stem from a belief that there is a lack of synergy between LikeMind and the case management team. One LHD manager believed that it was easier for the LHD to manage their own consumers as the long waiting lists at LikeMind made referrals prohibitive. LHD management also commented that the mental health case management team prefers to step-down their consumers to primary care. This provides GPs with the opportunity to coordinate their care by linking them into relevant community services and providing medications. In the words of one LHD manager, "Medicare is looking after mental health in an improved way…we now go through Medicare".

On the other hand, more positive comments stem from a belief that LikeMind can be very effective for the outcomes of mental health consumers that do not need case management. This more positive view recognises that LikeMind, although operating relatively independently from the LHD offers a good range of wrap-around services. In this way the LHD views LikeMind as "a preventative mental health service…not a treating mental health service".

One LHD manager was far more positive about the care coordination process between LM and the LHD case management team and believed that LikeMind still had a role to play in step-down care.

I would say that for low case management consumers, and mid-psychosocial needs, LikeMind was quite good – is quite good – and we still refer our consumers, those who don't need much high intense follow up, LikeMind still look after our consumers. (LHD manager)

6.1.3 Consortium arrangements with CMOs

The co-location of LikeMind with non-government and private sector organisations was also a formal requirement in the lead agencies contract with the Ministry. The contract specified that consortium members at each LikeMind site should include representatives from mental health, primary health, drug and alcohol and vocational/social needs. Each service provider was expected to operate in a 'spirit of cooperation' with a memorandum of understanding between consortia members.

Individual members of the consortium, including LikeMind staff, had very positive views about the consortium arrangements between CMOs. The two most positive aspects expressed by participants related to improved communications between service providers and the opportunity for shared care.

Improved communications between service providers was facilitated by the fact that many members of the consortia worked alongside LikeMind staff at the LikeMind offices. Being "under the same roof" promoted the opportunity for informal "corridor chats" about service provision. One consortium participant noted that members of the consortia were very supportive of each other and held regular briefings.

We have a team meeting every morning. Like a get together about our clients where we can share information about what we're doing with our clients. And then we're giving each other ideas - something that we may not have thought about. So it's all about the client. (Consortium member)

Two other LikeMind services have formalised these arrangements and hold regular case review meetings with relevant service providers as required. This collegiate aspect of the model of care also encourages referrals between different consortium members and provides an opportunity for joint service provision (including joint appointments as required). At one LikeMind service consumers provide consent for their information to be shared amongst different service providers to facilitate this process.

…from a shared-care perspective, all notes go into the one system. If an employment provider, say Global Skills are doing work with a consumer, then notes of that session…go into the same file, same with the private practitioners. So everything is going into the one file, so that at any point an intake and assessment clinician can go into that consumer's file and see where they're up to in terms of their care. (LikeMind manager)

LHD participants did not express many opinions with regards to consortia relationships with LikeMind and the CMOs as, since no longer being co-located, they only had limited involvement with the consortium.

6.2 Workforce, private practice and referral issues

6.2.1 Workforce issues

Recruitment to LikeMind clinical positions has been challenging from the commencement of the pilot. The two main issues relate to high levels of staff turnover and lack of experience and/or qualifications. This was not surprising at Orange and Wagga Wagga given that recruitment of health staff to rural / regional areas is known to be difficult.

LHD staff were concerned that fluctuations in LikeMind staffing levels and skill levels made them question whether to refer their consumers to LikeMind. There was also a belief that LikeMind staffing shortages increased the LHD mental health team workload as potential LikeMind consumers had to seek services elsewhere.

> *…that intake space, and whether the staff employed in that space have the clinical skills and experience to make those decisions. That sometimes makes the psychiatrist in our services uncomfortable, because they worry about that. And then when the staffing is low, or they're unable to recruit positions, then a lot of the work comes back to the community team anyway. [LHD manager]*

There was widespread agreement that the reason for the staffing issues at LikeMind related to remuneration. It was believed that LikeMind does not have the budget to offer salaries commensurate of the role expected of an intake officer.

> *…retaining staff, like higher quality, great clinician staff is really hard…I think what that really comes down to unfortunately is funding and how much we have allocated to salaries…the role that I think we're demanding of the intake assessment clinicians is not an entry-level role, but I think it's paid as such, and so that comes with complications…that's overwhelming and a lot to demand of a person if they're quite early on in their clinical career. [LikeMind manager]*

Another workforce difficulty concerned the fact that LikeMind could only offer short-term contracts to staff due to the time limited nature of the funding.

> *…that length of contract that's being offered has a significant impact on being able to retain quality staff and develop them, looking at kind of a permanent contract gives you a chance to kind of really develop staff, or a longer contract. You get a different level of commitment and engagement with your staff group. [LHD director]*

LikeMind participants argued that the biggest challenge in recruitment was competing for available staff with the LHD and other organisations. LHDs are able to offer higher salaries and better conditions such as salary packaging and ongoing training. One participant felt that LikeMind was a "training ground for provisional psychologists", "we see them through to registration, and then they move on". There were many examples from the four sites where LikeMind staff would "move on" to working for the LHD or other organisations after registration.

This recruitment conundrum was amplified during the COVID-19 pandemic as border closures prevented the international clinical workforce from entering Australia.

It just meant that the pool was slim, it really was a buyers' market, people could ask for anything…not that we actually employed them, but the LHD did. [LikeMind manager]

Despite these challenges in recruitment, staffing in the two rural/regional LikeMind services had improved recently.

We've got more staff on board. We've got a fantastic team…they are very supportive of each other, and I think the atmosphere has totally changed. [LikeMind intake officer]

6.2.2 Private practice services

The lead agencies contract with the Ministry mandates that LikeMind consumers should have the opportunity for mental health care and assessment plans through a LikeMind Private Practice model (including psychiatrists, psychologists and general practitioners) as an alternative to, or complimentary to co-located LHD services. This model was to be financially supported through the Medicare Benefits Scheme (MBS).

One of the key issues identified in the previous evaluation report was the difficulty for LikeMind services to attract and retain private practitioners resulting in a high turnover of clinicians and gaps in service provision. This challenge has continued to be an issue.

All participants agreed that the biggest barrier to recruiting psychiatrists, psychologists and general practitioners through the MBS was remuneration. It was felt that the rebates offered through Medicare were simply not sufficient to attract staff. This is further complicated by the potential loss of revenue associated with consumers not presenting for appointments. Participants from Orange and Wagga Wagga felt attracting private practitioners was even more challenging in rural and regional Australia.

I think to get a GP, and a psychiatrist especially, there's massive challenges with getting psychiatrists, even in salaried positions, let alone a bulk billing psychiatrist willing just to take the Medicare rebate, with no gap fee, I think. As much as I'd love one, I think it's going to be a consistent challenge. [LikeMind manager]

The challenges of recruiting private practice services has meant that the practitioners working at LikeMind are very busy and have long waiting lists. This has proved to be a deterrent for the LHDs when referring consumers to LikeMind.

However, the rise in the use of telehealth facilitated by the Better Access Initiative was a surprising bonus for the LikeMind private practice model during the pandemic. This program provides Medicare rebates to eligible people who live in rural and remote areas to access mental health services via telehealth with a GP, psychologist, social worker or occupational therapist[4]. According to one LikeMind Manager.

[Telehealth] They're a really easy service to use. They'll even support people to get their own mental health care plans, if they don't have them already. It's a

[4] https://www.health.gov.au/initiatives-and-programs/better-access-initiative

> *telehealth service, staffed by psychologists. Again, which a lot of people can't afford that psychology service, so it's a really good option. You can get an appointment within a week. [LikeMind manager]*

This access to telehealth mental health services has been further bolstered in response to the impacts of the COVID-19 pandemic. The Australian Government has increased the number of Medicare subsidised individual support sessions from 10 to 20[5]. However, this increase in the number of sessions has been a "double edged sword". Whilst the outcomes for the consumer improve the waiting list time increases due to the extra number of appointments. In the words of one LikeMind manager:

> *It makes a huge difference that we can offer 20 sessions to someone. That's a huge, huge difference in their care and in the types of consumers that we can see and treat effectively. So providing 10 sessions to someone with trauma. Drop in the ocean, not that helpful. Twenty sessions, we start to see the needle move a little bit which is really good. It does also impact our wait times though, because someone who would have stayed for 10 sessions now stays for 20. [LikeMind manager]*

One LikeMind participant also felt that the move towards telehealth facilitated the recruitment of private practitioners as they could support LikeMind consumers whilst working from home.

> *For us, I think telehealth has been one of the big, big game changers to be able to support recruitment. So we've had private practitioners in the past who live in the beaches and are definitely not keen on travelling two- and a-bit hours each way, but are very happy to work from home or to minimise their travel where they're doing part time in the office and part time from home. So fingers crossed, the government continues to support the delivery of services via telehealth. [LikeMind manager]*

However, the growth of telehealth has not had any positive impact on the recruitment of GPs to LikeMind. To address this, one LikeMind service has bolstered its relationships with local GPs to encourage them to consult with LikeMind consumers under a bulk-billing arrangement.

> *There are a lot of GPs in Orange that we have really good relationships with though…and at times, we've been able to advocate for clients to see GPs fee free, so bulk billed under Medicare…these GPs aren't normally bulk billing. (LikeMind manager]*

Despite the challenges of recruiting and retaining private practice staff the model of care works best when it is supported by a practice manager. At Seven Hills and Penrith LikeMind have access to a practice manager that is employed by Uniting to work across all of their programs. Not only is the practice manager responsible for recruitment, they also try and ensure that the private practitioner feels part of a bigger team and, in this case, work closely together with LikeMind clinicians.

[5] https://www.health.gov.au/health-alerts/covid-19/support/mental-health

So they [Practice Manager] run the recruitment of the private practitioners, and they on-board the private practitioners, and they come with us and they make sure everything is running. They really encourage the private practitioners to attend our morning meetings. So more engagement with the [LikeMind] team, so communication can flow better. (LikeMind manager)

6.2.3 Referral patterns

LikeMind participants agreed that referrals between consortium members were seamless. This was supported by a standardised referral form and LikeMind administrative staff who managed the diaries of consortium members. When a referral is received, LikeMind administrative staff simply book appointments into the CMOs diary. Where the consumer has previously provided consent to share information these appointments can be, and often are, jointly attended by both CMO and LikeMind representatives. For example:

So with regards to our drug and alcohol counsellors – they [LikeMind administrative staff] will book their calendars out on the same day that a client may be attending here. And so, we have like a bit of a joint appointment that the client has agreed to. So they sit in on the initial appointment with the client. And we can work out - okay - so where to from here? And so, the client knows that we are working with his drug and alcohol counsellor as well as with them. So it's like a little - we're building a village for them in a little way, I guess. So a little support network around them. (LikeMind intake officer)

The fact that LHD mental health services are no longer co-located with LikeMind has effected the way referrals occur between the two services. When the services were co-located referrals were straightforward.

…if a LikeMind consumer needed LHD input, they will straightaway come to us, we'll do an assessment of the consumer, and we will decide which way they need to go. (LHD manager)

Currently, with LHD mental health services no longer being co-located, referrals have to be more systematic and formal. According to both LikeMind and LHD management they now have to refer to the LHD mental health team through an intake line (a 1300 number).

…so there's still some referrals that happen, but they happen much like they would have happened before LikeMind, just between two separate organisations making a referral from one to the other (LikeMind manager)

Things are not as easy as it used to be, because we were just next door and we could just walk around and do things with the consumer. But now it's like a proper referral…you're basically referring a consumer to a different agency. [LHD manager]

LikeMind and CMO staff commented that while the most common source of referral is GPs, a range of other referrers include employment agencies, police, local schools (referring parents of students) and corrective services. All stakeholders recognised that many new consumers had heard about LikeMind through word-of-mouth.

6.3 The impact of COVID-19 and other recent developments

6.3.1 The impact of COVID-19

The COVID-19 pandemic has had a significant impact on the delivery of LikeMind services across the four sites. Each service had to be innovative and creative in their approach to service delivery.

Both metropolitan services closed their doors for a period of time during the first Delta wave of the lockdown. This lockdown commenced on 26 June 2021 and finished on 11 October 2021. During this time staff switched to a work-from-home model and consumer interaction changed from face-to-face to telephone and videoconference support. When Penrith LikeMind staff returned to work, Seven Hills staff had the option of working at the Penrith office whilst their office remained closed.

Both regional services kept the LikeMind doors open but instigated phone triage prior to booking in face to face-to-face appointments. In this way only the most vulnerable consumers received face-to-face appointments during the height of the pandemic restrictions while other consumers received telephone/video conference support.

During the first Omicron wave of the pandemic (from December 2021) all four services were open for business and many LikeMind staff members were able to return to the workplace. For consortium members, the return to the LikeMind offices was more variable with some CMOs maintaining a work-from home model for their staff. During this Omicron wave the number of walk-ins to the two metropolitan sites has waned.

> *I think there was…a lot of fear around and lockdowns and all that sort of stuff in public. I think there were less, sort of, people turning up unexpectedly. [LikeMind manager]*

COVID-19 also affected the way in which LikeMind and LHD staff interacted. Rather than LikeMind staff attending clinical review meetings, these were conducted through videoconference. This model of sharing information about shared care consumers remains but it is hoped that LikeMind staff will be able to return to face-to-face meetings with the LHD as soon as possible.

6.3.2 Head to Health

Established by the Australian Department of Health, the Head to Health initiative was originally conceived as an online and hotline service designed to assist individuals struggling with mental health issues. The mostly online resources include links to websites, online programs, digital resources, apps and online forums[6]. The hotline service links consumers with trained health professionals. Head to Health has recently been expanded to include Pop Up services to provide additional support during the COVID-19 pandemic.

These Head to Health Pop Ups are available across NSW and include shopfronts in Penrith and Seven Hills. The aim of the Pop Ups is to work with the consumer to develop a package

[6] https://www.headtohealth.gov.au/

of support services for their situation while keeping their GP informed if the consumer wishes. At the Pop Ups, consumers can talk to someone face to face or via telehealth services. They may receive services directly from Head to Health or be referred to another service if appropriate.

All participants felt that there is similarity between LikeMind and the Pop Ups, except Head to Health is funded by the Commonwealth and LikeMind by NSW Health. Participants from the LHDs felt that the creation of Head to Health Pop Ups served as a further duplication of services in an already crowded mental health service support system. They believed that, from a consumer perspective, this added an extra layer of choice which further complicated their decision making.

> *…it now means that there's two 1800 numbers in New South Wales that people call to find out where they go to get mental health support, and I think we're actually designing a system that's actually more complicated rather than less complicated. [LHD director]*

Participants from LikeMind had a very different perspective. While there was agreement that Head to Health represented a potential duplication of services, there was also a belief that LikeMind offered a superior service which Head to Health could link into.

> *I think the federal government did do some level of duplication of what the state was offering, but I strongly believe the state model is better. I think the state should ramp up what they've been delivering because I think if you were to compare the two, I think people would see that the LikeMind model is a better option. [LikeMind manager]*

Another LikeMind manager argued that Head to Health was limited because it was only a short-term service, "up to three months of service and they're essentially doing that immediate level support, care planning, engaging with appropriate services and referring on". In their opinion, "LikeMind has always done that. We've always service navigated. We've always linked people in. What we offer beyond that is longer term therapy". More cautious comments came from a LikeMind manager from one of the rural/regional sites.

> *I think they're [Head to Health] probably a good idea. I have no concerns about them starting – or the Federal Government starting up these programs. I think they're great and they're needed. I do have to wonder how State Government might feel about continuing to fund a state program like LikeMind, now the Federal Government is rolling out something similar. [LikeMind manager]*

6.4 The future

One of the final questions to participants related to whether they saw an ongoing role for LikeMind in its current structure or under a different arrangement. This prompted a variety of different opinions about the 'way forward' for LikeMind.

One LHD manager would like to see closer links to LikeMind, particularly between their acute care team and the LikeMind intake team. Ideally this would involve the LHD taking on the management of the LikeMind intake team. This would ensure clearer clinical governance between the two services.

> *I think the LHD and LikeMind need to come together a bit more to communicate to referring partners around whose roles and responsibility is what…we need to make a change and to work better together, because we are both here, both services are here, we need to find a way of how we're going to complement each other…we do have a partnership and we are the key primary partner with the LikeMind service. So whilst ever this model exists the way it is, we have a responsibility to find ways to work together. [LHD manager]*

One LikeMind manager believed that closer links between the two services could be supported by providing extra funding to support the role of a senior LikeMind clinician based in the LHD mental health team with a focus on service integration. There was also a feeling that any future funding to LikeMind should reflect a new model of care which focuses less on the co-location of LikeMind and LHD mental health services and more on the integration of services to promote referrals and shared care arrangements.

Clearer clinical governance and increased communication between the two services was also considered crucial to the future of LikeMind.

> *At a strategic level…we need written commitment from both services to making the shared-care arrangement work. [LikeMind manager]*

All LikeMind participants felt that there was a real need for the service as demonstrated by community demand and referral numbers. But this increased demand needed to be supported by future investment, particularly to support the LikeMind private practice model.

> *I'd absolutely suggest the enhancement around psychiatry…if the Ministry was serious about offering the additional consultation and support from a psychiatrist [we need] a salaried psychiatrist position, and at senior staff specialist rates. [LikeMind manager]*

There was also consensus about the need for LikeMind peer support staff to help consumers get to appointments and run peer support groups.

> *A peer worker here would be amazing, like, somebody who can support people to get to and from appointments or connect them in a warm way with other services, as they need them. [LikeMind manager]*

7 Discussion and recommendations

The NSW Ministry of Health established the LikeMind Pilot in 2015 as an integrated service with co-located mental health and other service providers in two metropolitan and two regional NSW locations. Approximately $27.5m has been invested in LikeMind to provide readily accessible community-based services for people with moderate to severe mental illness.

Since 2015, LikeMind has delivered more than 53,200 occasions of service to more than 22,000 consumers. Clinical and psycho-social support services have been provided to consumers across the four targeted service streams: mental health, primary health, drug and alcohol and vocational/social needs including linkages to employment and housing.

The current LikeMind Phase 2 evaluation formally covers the 20-month period from June 2020 to February 2022. Importantly, as CHSD completed the earlier evaluation of LikeMind (covering the period January 2015 to September 2018), this report provides a set of evaluation findings that have drawn on data collected over the whole 75 months during which LikeMind has operated.

The current funding arrangements between the LikeMind lead agencies and the Ministry are in place until 30 June 2022. The timing of this final evaluation report was agreed to ensure the Ministry, LikeMind service providers, and other stakeholders have empirical data and associated evaluation findings to support the decision-making processes that will occur in the coming months.

This final section of our report synthesises our evaluation findings and presents a set of recommendations to enhance the outcomes being achieved by LikeMind. These recommendations are based on a presumption that funding for LikeMind will continue.

7.1 A context for understanding the outcomes of the LikeMind Pilot

Co-location is an approach to facilitate service integration that usually involves shared space, equipment and staff; coordinated care between services; or a partnership between health providers and human services providers (Bayne et al., 2016). Leutz defines integration as the search to connect the health care system with other human service systems to improve outcomes (Leutz, 1999).

There is a strong body of evidence to support the benefits of integrated and co-located community-based mental health services for consumers (Blackmore et al., 2018; Lee-Tauler et al., 2018), service providers (Dawson et al., 2020; Knight et al., 2018) and the broader health system (Jackson et al., 2007). The literature also identifies a range of challenges associated with such initiatives (Clarke and Burns, 2017; Fernandez et al., 2017; Flatau et al., 2010). The decision to establish LikeMind in 2015 reflected the broad evidence base and was consistent with the ten year NSW Strategic Plan for Mental Health (NSW Mental Health Commission, 2014a).

The LikeMind Phase 1 and Phase 2 evaluations have analysed a significant volume of data. This includes a longitudinal analysis of program data, interviews with more than 80 LikeMind stakeholders over six years and data from LikeMind consumers collected through focus groups and a consumer survey. Based on this considerable body of evidence, the evaluation has been able to meaningfully assess the impact and outcomes of LikeMind and produce a set of findings regarding the extent to which it has achieved its objectives.

7.1.1 Enablers and barriers to service integration

The academic literature identifies a set of service attributes that have been shown to contribute to the successful implementation of integrated mental health services. Many studies have also identified barriers to successful implementation of such models. Some of the key enablers and barriers can be characterised as underlying principles, while others are more practical in nature - both are relevant to LikeMind and are useful to highlight when considering its outcomes. The enablers and barriers particularly relevant to LikeMind include:

Enablers

- Social and professional skills, face-to-face interaction, managing differing work cultures and culture change were important success factors (Haggarty et al., 2012).
- Trust and respect are key to the success of joint working and requires time for workers to develop. Joint training helps workers to understand each other's roles and responsibilities (Cameron and Lart, 2003).
- Ongoing joint governance and management, clear on-site leadership, and a well-designed evaluation strategy are needed to ensure success over time as well as the patience of clients, staff and participating organisations (Nepe et al., 2011).
- Services should be established as a full-time endeavour with ongoing joint service management and onsite leadership (Waghorn et al., 2009).

Barriers

- A lack of focus on new governance structures, which meant that agencies kept their old lines of governance and culture (Lawn et al., 2014).
- A missed opportunity when practical 'moving in' issues were prioritised early on rather than governance and collaboration issues (Lawn et al., 2014).
- Where there was disagreement about working culture, with each profession wanting the other to change its organisational culture (Kharicha et al., 2005).

7.2 Evaluation findings – key implementation issues

Challenges with service integration, workforce issues, and more recently COVID-19 have had a significant impact on the implementation of LikeMind. These issues were outlined in the previous section in the context of a set of key stakeholder interviews. They are discussed below in the broader context of the evaluation findings.

7.2.1 Service integration

Service integration is probably the most fundamental aspect of the LikeMind model of care. It represents the 'value add' that LikeMind seeks to achieve by enhancing CMO service delivery and linkages with public health and other services. In establishing the LikeMind pilot, it was intended that co-locating mental health service providers in community accessible premises with shared service protocols would lead to improved outcomes for consumers. Assessing the extent to which LikeMind agencies function together as an integrated service is therefore a core aspect of the evaluation.

In our initial evaluation reports, we reported that the most significant obstacle facing effective service integration between LikeMind services was an ongoing tension between the lead agencies and participating LHDs. At that time, most LHD staff felt that the mental health needs of their consumers were best met when services were provided directly by the LHD. In their view, being part of a co-located, CMO led consortium represented an obstacle, rather than a benefit to LHD staff. In contrast, staff employed by LikeMind and the other consortium CMOs were highly supportive of the initiative. From their perspective, the model was sound and increasingly meeting its objectives of providing a fully integrated service.

At the time of the LikeMind Phase 1 final evaluation report in 2019, we identified an important improvement in the dynamic between the LHD and LikeMind staff particularly at Seven Hills and Penrith. The improvement had resulted largely from the appointment of several senior LikeMind staff with extensive experience in the mental health sector. This had led to LikeMind and LHD staff working more co-operatively and becoming better placed to identify opportunities for co-management of clients and a more integrated service delivery model. Similar improvements were also evident but to a lesser extent at Orange. At Wagga Wagga, the LHD had not been co-located at the LikeMind site, but attended on an as-required basis. The LHD considered this to be advantageous for their clients as the environment of the LikeMind office was less clinical and allowed their clients to link with the various wrap-around services offered by LikeMind.

During the last two years, there has been a number of significant developments in this area. The LHD mental health teams at Seven Hills, Penrith and Orange have all ended their co-location arrangements with LikeMind. Similarly, while consortium members continue to be co-located on a fractional basis, their physical presence at LikeMind sites has decreased primarily as a result of COVID-19. Challenges relating to attracting private practitioners have also persisted.

Not surprisingly, the evaluation has found that no longer being co-located has resulted in a significant reduction in the level of service integration between lead CMOs and LHDs. The opportunity for staff to interact informally has been largely removed and some of the formal mechanisms implemented to promote integration are no longer practical.

At the same time, the evaluation has found that not being co-located has significantly improved the dynamic between lead CMOs and the LHDs. Despite the improvements described above, the prevailing view from LHDs was that the efforts to develop integrated

service models should be structured around LHD led clinical services being integrated with CMO led psycho-social support and other wrap around services. The tensions arising from this view have largely disappeared as a result of LHDs no longer being co-located. LHDs no longer feel a sense of having the LikeMind model imposed on them and are comfortable operating in an environment where the two organisations collaborate effectively but function largely independently.

Within this environment, the evaluation has also found that the well-established collaborative relationships between the lead CMOs and the LHDs have been maintained. Seven Hills, Orange and Penrith all have SLAs in place and Wagga Wagga has a MOU with LikeMind. These agreements define organisational roles and responsibilities, agreement on co-contribution to the activities of the consortia and clear referral pathways. For example, at Orange the LHD acute and community mental health teams have a strong commitment to the SLA that drives clinical governance and helps identify potential gaps in service delivery.

Overall, it is clear that LikeMind has evolved and now operates as a well-established partnership between the lead CMO, LHDs and other consortium members. It has not, however, evolved into an integrated service delivery model as was initially envisaged.

7.2.2 Workforce and private practice issues

A range of issues associated with the LikeMind model of care have continued to be critical in the way that LikeMind services have responded to internal and external influences. Two significant challenges have been workforce and private practice issues.

The key workforce challenges relate to high levels of staff turnover and the lack of experience and/or qualifications of LikeMind frontline intake and assessment staff. These staff are in many ways the cornerstone of the LikeMind model. The triage decisions they make in determining whether or not a prospective consumer requires further assessment by LikeMind or other services, and the type and urgency of the response is critical. However, attracting and retaining appropriately skilled intake staff has been a significant challenge at each LikeMind service.

The recruitment of a senior clinician to provide clinical leadership and support for the LikeMind intake and assessment clinicians is one response that has been successful at the two metropolitan LikeMind services. While staff turnover still remains an issue, both Penrith and Seven Hills have been able to maintain a full complement of intake and assessment clinicians.

This is not the case in the regional sites where both LikeMind services have continued to struggle to attract appropriately skilled and experienced staff. Unfortunately, in recent times, these staff shortages have occurred at the same time as a significant increase in the demand for mental health services related to COVID-19. This has put extra pressure on existing intake staff creating the potential for staff burnout.

The issue of recruitment in regional areas has been well documented in this and previous evaluation reports. Less attractive award rates offered by CMOs and a perceived lack of

available local candidates with relevant work experience are part of the recruitment problem. This is compounded by the fact that LikeMind often loses its more experienced staff to LHDs where staff can enjoy improved award rates and working conditions.

In relation to private practice services, there continues to be difficulties in attracting and retaining GPs, psychiatrists and psychologists. This has resulted in a high turnover of clinicians and gaps in service provision at each of the four LikeMind services. Consequently, those clinicians that do work with LikeMind are extremely busy and typically have long waiting lists.

Both regional LikeMind service have trialled offering salaried positions for in-house GPs, social workers and psychologists. While this was successful initially, staff retention for these positions has become an issue at both sites.

To some extent, the rise in the use of telehealth services facilitated by the Commonwealth Better Access Program was a surprising boon for the LikeMind private practice model during the pandemic. Firstly, this initiative provided LikeMind consumers with access to mental health services delivered remotely by a GP, psychologist, social worker or occupational therapist. Secondly, it facilitated the recruitment and commitment of psychologists due to the flexibility it offered them in being able to support LikeMind consumers remotely.

Despite this, the uncertainty in recruiting skilled and experienced LikeMind staff and the failings of the private practice model has negatively affected the relationship between the LHD mental health teams and LikeMind. The impact of COVID-19 and other recent developments

A range of Commonwealth and state policies have been introduced since the commencement of LikeMind that have had an impact on the mental health service delivery system. Like many organisations since the onset of the COVID-19 pandemic, LikeMind services have had to be innovative in their approach to service delivery.

COVID-19 has significantly changed the mode of delivery of LikeMind services, particularly at the two metropolitan sites. Staff have worked from home as required and a large proportion of services have been delivered through telephone and videoconferencing at different points in time since 2019.

Other effects of the pandemic have included a rise in LikeMind service use, a cancellation of group peer-to-peer support activities and a reduction in face-to-face meetings between LikeMind, LHD and consortia staff. For many consortium members the effect of the pandemic continues with many service providers not yet returning to the LikeMind offices.

The increased use of telehealth services has benefited the private practice model at LikeMind services as psychologists can now be reimbursed under the COVID-19 Temporary MBS Telehealth Services. This has also had the unexpected positive effect of seeing an increase in attendance rates by clients accessing psychological services. As mentioned

above, this increase in MBS activity could also potentially reflect well on a private practitioner's longer-term commitment to LikeMind.

Another recent development that could have an impact on LikeMind is the launch of Head-to Health pop-up sites in Penrith and Seven Hills. This has created an additional option for consumers seeking mental health support by creating an extra layer of choice.

7.3 Evaluation findings - LikeMind outcomes and achievements

The LikeMind program logic (Figure 1, Section 2) summarises the inputs, outputs and outcomes that underpin the LikeMind model. The expected outcomes of LikeMind are grouped under three headings: outcomes for consumers; outcomes for service providers and outcomes for the broader health system.

7.3.1 Outcomes for LikeMind consumers

The clinical profile of consumers highlights that LikeMind has been successful in delivering services to consumers with moderate to severe mental illness in a co-located community setting and across the four target streams. More than 60% of LikeMind consumers reported levels of severe psychological distress at initial assessment. This proportion decreased to less than 40% at follow-up[7] highlighting that LikeMind consumers achieved demonstrable clinical improvement. This analysis was not possible in our earlier evaluation reports due to low rates of follow-up K10 assessments.

Previous research has identified that benefits for consumes are more likely to relate to factors such as not needing to re-tell their story, improved communication between providers and less stigma. These factors may not be reflected in ratings on clinical tools (Calkins et al., 2013; Nepe et al., 2011). For this reason, information has been collected directly from LikeMind consumers at key points throughout the evaluation.

Consumers have consistently reported positive outcomes being associated with LikeMind dating as far back as focus groups conducted in 2018 and as recently as a consumer survey completed in February 2022. The recent consumer survey found very high levels of satisfaction across all LikeMind sites in relation to: 'access to services', 'experiences with staff' and 'overall satisfaction with the service'.

Data collected during focus groups in the early stages of the implementation (prior to COVID-19) identified that access to multiple co-located service-providers contributed to positive consumer experiences. It is difficult to assess the impact that LHD services no longer being co-located has had on consumer experiences of the service. In the recent consumer survey, a minority of consumers reported value in being able to access multiple service providers in one location. However, because the majority of consumers had not accessed multiple services at LikeMind in the first place, the LHD no longer being co-located did not emerge as an issue.

[7] Follow-up K10 assessment data available for 497 consumers.

Overall, the above findings are significant and provide clear evidence that LikeMind has delivered meaningful mental health outcomes for a significant number of consumers at each of the four sites.

Recommendations to enhance LikeMind outcomes at the consumer level

- LikeMind services should actively promote routine collection of the YES survey;
- The direct involvement of consumers across all aspects of LikeMind should be actively encouraged to ensure that co-design principles are a core component of service delivery. This could occur by:
  - Developing strategies/guidelines/requirements for LikeMind consumers to be included in program, consortium governance and quality improvement processes.
  - Recruiting and implementing appropriate minimum training requirements for peer workers with a lived experience of mental illness to support the recovery journey of LikeMind consumers;
  - Re-introducing group peer-to-peer sessions as soon as practicable given COVID-19 restrictions;
- LikeMind services should continue to develop community engagement activities to raise public awareness of the support they can offer individuals experiencing mental illness;

7.3.2 Outcomes for service providers

Provider level outcomes have been evaluated in terms of how efficiently resources have been targeted and whether effective staffing structures and partnership arrangements have been maintained. Despite lack of progress in genuine service integration, important formal and informal links between LikeMind and LHD staff have developed.

Prior to COVID-19, each of the LikeMind services (including Wagga Wagga where the LHD was not co-located) had been operating with an increasing level of co-operation between LHDs and lead agencies. However, based on the information collected during staff interviews and supported by the recent consumer survey, we have found that level of integration between LikeMind services has diminished over the latter stages of the evaluation.

Despite the services no longer being co-located, the informal and formal links between LikeMind and LHD staff have continued. In many instances, these professional relationships have developed and been maintained over a long period of time and a degree of trust has developed between the two services. When LikeMind staff participate in clinical review meetings with LHD mental health teams to discuss shared care arrangements, a degree of capacity building takes place with both teams benefiting from each other's knowledge and experience.

LikeMind provides an important opportunity for less experienced staff to gain professional experience in a clinical environment. LikeMind has been described as a 'training ground for provisional psychologists' where LikeMind intake staff would 'move on' to working for the LHD or other organisations after completing their registration. There is no doubt that

LikeMind has provided an important opportunity for provisional psychologists to develop their careers.

Recommendations to enhance LikeMind outcomes at the service provider level

- New funding agreements should be negotiated based on agreed structural and service delivery arrangements that include:
    - The co-location of LHD mental health services not being a requirement of the LikeMind model;
    - The co-location of CMO consortium members being a feature of the LikeMind model for some CMOs, but not a formal requirement for all CMOs;
    - Specific measures to promote a shared care culture that includes formal and informal service integration outside a co-located environment between all consortium members including LHDs. This should include LikeMind staff participating in clinical reviews with the LHD mental health community teams and senior LikeMind and LHD staff meeting regularly to discuss the partnership and opportunities for service integration;
    - The new funding agreements should be set at a level that will allow:
        - Lead CMOs to attract and retain appropriate staffing levels including both senior clinicians and intake and assessment staff;
        - Recognition that ongoing challenges with the recruitment of GPs and mental health practitioners are likely to persist;
        - Lead CMOs to adjust their approach to service delivery as required to respond to changing circumstances associated with COVID-19;
- LikeMind Service Plans and associated documentation should be updated as required to reflect the new funding agreements.
- The LikeMind V2 MDS should continue to be collected routinely to support ongoing monitoring and evaluation activities. This should include:
    - A focus on improving the infrastructure to support the ongoing collection of the LikeMind V2 MDS;
    - Greater emphasis on ensuring collection of the two clinical tools (K10 and PWI) to allow clinical outcomes to be reliably and accurately assessed;
    - Co-located CMOs making better use of LikeMind client information systems;
- Service level agreements should be developed with all consortium members specifying each organisation's responsibility to the LikeMind model of care including approaches to encouraging integrated service delivery. The SLAs should include:
    - Clearly defined governance arrangements consistent with the agreed model of care;
    - A commitment from all consortium partners to promoting a culture of shared care that includes the involvement of consumers across all aspects of LikeMind services;

- The requirement for lead CMOs to hold regular consortium meetings attended by all stakeholders including the LHD;
- All consortium members having a clear understanding and participating in the collection of the LikeMind V2 MDS as required;

7.3.3 Outcomes for the health system

At the system level, data from multiple sources confirm that LikeMind is delivering accessible community-based services to its target population. Feedback from consumers throughout the evaluation has confirmed that LikeMind is a welcome addition to the mental health service delivery system in each community. Feedback from providers indicates that LikeMind is meeting previously unmet need for services. This is particularly important given the increased demand for services that have arisen as a result of COVID-19.

However, LikeMind services are not being delivered as an integrated 'one-stop-shop' approach as envisaged when the model was developed. Rather, services are being delivered largely independently with well-established mechanisms to facilitate inter-service collaboration. At its most functional, LikeMind can be described as an effective and well-regarded collaboration with co-location arrangements in place between the lead and some partner CMOs.

A range of policy developments at both the state and national level have influenced the internal and external environment in which LikeMind operates. Many of these have been a direct response to the COVID-19 pandemic. Examples include the introduction of new services (such as Head to Health), the extension of existing services (such as the Better Access Program), and a raft of changes in the way in which mental health services are delivered. The evaluation has found LikeMind has been able to quickly and effectively adapt to this rapidly evolving policy and service delivery environment.

The evaluation has found that LikeMind has been very successful in developing brand recognition in each of the four local communities in which it operates. The appointment of community engagement officers has been identified in previous research as essential in promoting brand recognition (Yap et al., 2017). Each LikeMind service has employed staff to raise community awareness of the service. Feedback from multiple LikeMind stakeholders, including consumers has confirmed that LikeMind is very well regarded and has been a welcome addition to the mental health service system.

The scope of the evaluation did not allow the impact of LikeMind on the use of services such as emergency department and hospital inpatient units to be formally assessed. However, anecdotal evidence suggests that LikeMind has not had a material impact on the use of acute mental health services. A recent Australian study also found that decreases in inpatient admissions, length of inpatient stays and emergency department attendances were not significantly reduced following the introduction of a similar model (Beere et al., 2019). Further research in this area would provide a stronger evidence base on this issue in relation to LikeMind services.

Recommendations to enhance LikeMind outcomes at the system level

- The LikeMind model of care should be re-defined with a clear and compelling vision that:
  - Reflects the aims and objectives (particularly related to co-location) that have evolved since its initial inception;
  - Recognises the challenges in integrating different organisational and professional cultures;
  - Reflects changes in the strategic direction and policy context of mental health service delivery at both a Commonwealth and state level.
- LikeMind services should actively explore opportunities for formal and informal links with existing and new community-based services including:
  - Head to Health services, particularly in Penrith and Seven Hills where pop-up clinics have been established;
  - GPs and other community services not currently involved in the consortium;
  - Other mental health and social services established in response to COVID-19.
- Efforts to recruit GPs and private mental health practitioners to LikeMind should persist. Notwithstanding the recognised funding challenges, these efforts should include:
  - efforts to incorporate private practitioners into the LikeMind culture;
  - incorporating non-financial incentives for private practitioners being associated with LikeMind;
  - Identifying opportunities for private practitioners to become more involved in LikeMind governance processes.
- The LikeMind Program Logic should be updated to reflect the re-defined LikeMind vision. The revised Program Logic should:
  - Provides a clear summary of the different elements of the program and how they fit together, demonstrating the 'theory of change';
  - Clearly document the nature of the consortium approach that underpins the LikeMind model;
- Continue monitoring and evaluation activities to demonstrate the outcomes achieved by LikeMind and to assess changing areas of need for this client group.

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Appendix 1 CHSD Evaluation Framework

EVALUATION HIERARCHY	What did you do? PROGRAM / PROJECT DELIVERY	How did it go? PROGRAM / PROJECT IMPACT	Can you keep going? PROGRAM / PROJECT SUSTAINABILITY	What has been learnt? PROGRAM / PROJECT CAPACITY BUILDING	Are your lessons useful for someone else? PROGRAM / PROJECT GENERALISABILITY	Who did you tell? DISSEMINATION
Level I Impact on, and outcomes for, consumers (people with mental health issues, families, carers, friends, communities)						
	Direct service and support, linking and coordination of services, and facilitation of decision-making	Impact on people with mental health issues, Carer and family impacts	Sustainability assessment	Capacity building assessment	Generalisability assessment	Dissemination log
Level 2 Impact on, and outcomes for, providers (service providers, professionals, organisations)						
	Capacity building within services Governance Direct care Information Professional development	GPs CMO staff Others	Sustainability assessment	Capacity building assessment Implications for organisations providing services for people with mental health issues	Generalisability assessment	Dissemination log
Level 3 Impact on, and outcomes for, the system (structures, processes, networks, relationships)						
	Capacity building within systems Governance Direct care Information Professional development	System level impacts, including external relationships, impact on the health system	Sustainability assessment	Capacity building assessment Implications for services for older people with dementia	Generalisability assessment	Dissemination log

Appendix 2 Key stakeholder interview questions

Service provider questions

1. What is your role in the LikeMind service?
2. How has not being co-located impacted on the way that services are delivered?
3. Do you think that LikeMind has been meeting the mental health needs of the community?
4. What do you see as being the major successes of LikeMind?
5. Are LikeMind services more effective for some clients than others?
6. Has LikeMind created opportunities for clients to use a more appropriate range of services?
    a. For example, do clients now access a greater number of services?
    b. Has it been possible to make use of private practice services?
7. How effective are the current partnership arrangements between LHDs and CMOs?
8. How integrated is service delivery within LikeMind?
    a. Do LikeMind partners consult with each other about clients?
    b. Do LikeMind partners refer clients?
9. Do you see that there is an ongoing role for LikeMind in its current structure or under a different arrangement?
10. How has COVID-19 affected the way you consult with clients and deliver services?
11. Additional questions or comments.

LHD Mental Health Director's Questions

1. The LikeMind pilot has been operating since 2015? How would you describe the current operating arrangements for the pilot?
2. How effective are the current partnership arrangements between LHDs and CMOs?
3. LikeMind services are not co-located with the lead CMO in the LikeMind office. Has this impacted on the capacity of the way that the consortium has been able to deliver mental health and other services?
4. What do you see as being the major successes of LikeMind?
5. Do you see that there is an ongoing role for LikeMind in its current structure or under a different arrangement?
6. Additional questions or comments.

Appendix 3 Consumer survey

Information about you

Q1 What is your gender?
(please tick one option only)

- ☐ Male
- ☐ Female
- ☐ Non-binary/gender diverse
- ☐ Prefer not to say

Q2 What is your postcode?
(please enter your four-digit postcode)

Q3 What is the main language you speak at home?
(please tick one option only)

- ☐ English
- ☐ Other, please specify

Q4 Are you of Aboriginal and/or Torres Strait Islander origin?
(please tick one option only)

- ☐ Neither Aboriginal or Torres Strait Islander
- ☐ Yes - Aboriginal
- ☐ Yes - Torres Strait Islander
- ☐ Yes - Aboriginal and Torres Strait Islander

Q5 What is your age group?
(please tick one option only)

- ☐ 18-24
- ☐ 25-34
- ☐ 35-44
- ☐ 45-54
- ☐ 55-64
- ☐ 65-74
- ☐ Over 74

Information about your use of LikeMind services

Q6 How were you referred to LikeMind
(please tick one option only)

- ☐ Self-referred
- ☐ Referred from my GP
- ☐ Referred from a mental health service
- ☐ Referred from another service
- ☐ Other, please specify

_____

Q7 How long have you been receiving support from LikeMind?

(please tick one option only)

- ☐ Up to 2 weeks

- ☐ 2 to 4 weeks
- ☐ 1 to 3 months
- ☐ 4 to 6 months
- ☐ 6 months to 12 months
- ☐ Over 1 year

Q8 How many times have you used LikeMind services?
(please tick one option only)

- ☐ 1 to 2 times
- ☐ 3 to 5 times
- ☐ 6 to 10 times
- ☐ More than 10 times

Q9 What is the main type of contact you have had with LikeMind?
(please tick one option only)

- ☐ Mostly telephone/video contact
- ☐ Mostly face-to-face contact
- ☐ About the same amount of telephone/video and face-to-face contact
- ☐ Other, please specify

_____

Q10 Which LikeMind office do you have the most contact with?

- ☐ Penrith
- ☐ Seven Hills
- ☐ Orange
- ☐ Wagga Wagga

Q11 Which of the following services have you received?
(please tick all that apply)

- ☐ Mental health services delivered by LikeMind
- ☐ Mental health services delivered by community mental health
- ☐ Alcohol and other drug services
- ☐ Employment assistance/support
- ☐ Housing assistance/support
- ☐ Disability services/support
- ☐ Other (please specify)

_____

Please turn over…

	The following questions relate to the services you have received Please indicate your level of agreement or disagreement with each of the following statements. Please tick one box only for each question.					
Question		**Strongly disagree**	**Somewhat disagree**	**Neither agree or disagree**	**Somewhat agree**	**Strongly agree**
Q12	**The location of LikeMind is convenient for me**	☐	☐	☐	☐	☐
Q13	**I didn't have to wait long for my first appointment**	☐	☐	☐	☐	☐
Q14	**I didn't have to wait long for follow-up services**	☐	☐	☐	☐	☐
Q15	**Information was given in a way that I could easily understand**	☐	☐	☐	☐	☐
Q16	**I felt respected and well treated by staff**	☐	☐	☐	☐	☐
Q17	**Staff kept me informed about my treatment and progress**	☐	☐	☐	☐	☐
Q18	**Staff worked well together to coordinate my care**	☐	☐	☐	☐	☐
Q19	**Staff referred me to the services I needed most**	☐	☐	☐	☐	☐
Q20	**Overall, I was satisfied with how my mental health needs were addressed**	☐	☐	☐	☐	☐

The following questions relate to your overall experience of LikeMind

Q21 Some additional services such as employment or housing support are provided within the LikeMind hub. Do you think that being able to access different services at one location makes it easier for you?

(please tick one option only and provide any additional comments in the box below)

- ☐ Yes
- ☐ No
- ☐ Unsure

Q22 Would you recommend LikeMind to others?

(please tick one option only and provide any additional comments in the box below)

- ☐ Yes
- ☐ No
- ☐ Unsure

Q23 Has COVID-19 had an impact on the way you have accessed LikeMind services?

(please tick one option only and provide any additional comments in the box below)

- ☐ Yes
- ☐ No
- ☐ Unsure

The final three questions provide you with an opportunity to make any additional comments you may have about LikeMind

Q24 What do you like most about LikeMind?

Q25 Do you think there are any ways in which LikeMind services could be improved?

Q26 Do you have any final comments about LikeMind?

End of Survey: Thank you for completing the survey

Appendix 4 Summary of changes between LikeMind MDS V1 and V2

	Change	Additional information
V2 item number	**Initial assessment data set**	
0.1 0.2.1 0.2.2	Addition of items: Outcome of triage assessment, Why was LikeMind not suitable, Why was LikeMind not suitable (other)	These items capture information about all persons who present to LikeMind. The items will enable the evaluation team to quantify how many people are assessed (triaged) and reasons why LikeMind was not appropriate for persons who do not become LikeMind clients. Note that LikeMind sites may have differing triage assessment processes and the 'process' itself is not relevant for the MDS, only the outcome of the assessment.
1.3	Addition of data item 'Episode identifier'	This will enable accurate identification of clients who return to LikeMind for subsequent episodes of care
1.13	'Source of income' – a new option has been added 'No income' with a code set value '8'	Change as per recommendation from lead agencies
1.14	'Relationship status' – the option 'Never married' has been renamed to 'Single'. An 'Other' category has also been added (with code set value '6')	Change as per recommendation from lead agencies
1.15	Removal of 'Number dependent children' and addition of 'Does the client have dependent children?' with options 'No' and 'Yes'	Knowing whether a client has dependent children may help to understand their domestic circumstances
na	Removal of 'Carer residency status' and 'Relationship of carer to client' data items. The item 'Carer availability' has been renamed to 'Does the client have a carer?'	Change as per recommendation from lead agencies
1.17	'Type of accommodation' – three new options have been added: • 'Emergency temporary accommodation' (code set value '8') • 'Specialist homelessness services including short term, crisis or transitional housing' (code set value '9') • 'Homeless' (code set value '10')	Change as per recommendation from lead agencies
na	'Living arrangement' has been removed	Change as per recommendation from lead agencies
1.18	'Referral source' – the option 'No written referral' has been renamed to 'self-referral' and the following options have also been added: • 'Acute mental health service' (code set value '9') • 'LHD acute team' (code set value '10') • 'LHD case management team' (code set value '11') • 'LHD other' (code set value '12') • 'Community development event' (code set value '13') • 'Drug and Alcohol service' (code set value '14') • 'CMO (Different organisation)' (code set value '15') • 'CMO (Same organisation)' (code set value '16') • 'Community Housing Provider' (code set value '17') • 'National Disability Insurance Scheme (NDIS) funded provider or National	Change as per recommendation from lead agencies

	Disability Insurance Agency (NDIA)' (code set value '18')	
1.20.1 – 1.20.5	'Primary presenting issue(s)' – the options have been reduced by collapsing some of the sub-categories. There are now 23 options (instead of 66) as follows: • Anxiety symptoms • Depressive symptoms • Suicidal thoughts/behaviour • Stress related • Psychosis symptoms • Deliberate self-harm • Borderline personality straits • Anger issues • Other mental health issue • Sexual assault/abuse • Physical health • Vocational assistance • Alcohol or other drugs • At risk of social isolation • Homelessness or at risk of homelessness • General violence • Grief • Trauma • Legal issues (in general) • Developmental issues (cognitive) • Emotional dysregulation • Difficulty with personal relationships • Other	Change after considering recommendation from lead agencies. Note that up to five presenting issues can still be recorded - by only allowing one presenting issue, it may be difficult to show that clients are presenting with 'complex needs'
na	'Service provider' has been removed as it is not required (LikeMind intake and assessment clinicians always perform the initial assessment)	Change as per recommendation from lead agencies
1.21	'Discipline of service provider' – the option 'Aboriginal mental health worker' has been added (code set value '11')	Change as per recommendation from lead agencies
na	'Primary diagnosis' and 'Secondary diagnoses' have been removed. This item is now only required at the end of the episode (i.e. on the Exit data set)	Change as per recommendation from lead agencies
1.22.1 – 1.22.5	'Main outcome(s) of session' – the options 'Refer to another service within LikeMind' and 'Formal referral to other service in conjunction with current treatment at LikeMind' have been removed. The option 'Follow up consortia' has been renamed to 'Follow up another LikeMind service provider'. The following options have been added: • Refer to external service – referral accepted (code set value '7') • Refer to external service – referral not accepted (code set value '8') • Refer to another LikeMind service – referral accepted (code set value '9') • Refer to another LikeMind service – referral not accepted (code set value '10')	This item will enable the evaluation to quantify both internal and external referrals made and whether the referrals were accepted.
1.23	Addition of new item 'Modality of session' with response options: • Face-to-face (code set value '1') • Phone (code set value '2')	Change as per recommendation from lead agencies

	• Online (e.g. Zoom, Skype) (code set value '3')	
1.26.1 – 1.26.9	Removal of the RAS DS and the addition of the 'Personal Wellbeing Index'	Change as per recommendation from lead agencies. Note that it is crucial for analyses of client outcomes that this tool (and the K10) are completed at least TWICE.
na	Removal of the K10 total score	The total score is derived by summing the ten individual item scores
	Occasion of service data set	
2.3	Addition of data item 'Episode identifier'	This will enable accurate identification of clients who return to LikeMind for subsequent episodes of care
2.5	'Service provider' – the option 'LikeMind Peer worker' has been added to the list for each of the four sites. In addition, the list of specific organisations has been replaced with a more generic list. Each site has the following generic options: • LikeMind (split into four categories as appropriate for each site) • LHD • PHN • CMO – on site • CMO – off site • Other	Change after considering recommendations from lead agencies
2.6	'Discipline of service provider' – the option 'Aboriginal mental health worker' has been added (code set value '11')	Change as per recommendation from lead agencies
na	'Private practice' has been removed	Change as per recommendation from lead agencies
na	'Primary diagnosis' and 'Secondary diagnoses' have been removed. This item is now only required at the end of the episode (i.e. on the Exit data set)	Change as per recommendation from lead agencies
2.7	'Funding source' – the options 'Mental Health Nurse Initiative (MNHI)', 'Rural Primary Health Services (RPHS)' and 'ATAPS' have been removed	Change as per discussions with lead agencies
2.8.1 – 2.8.5	'Main service(s) provided' – seven additional options have been added as follows: • Cultural support (code set value '26') • Consultation with parent/carer, with client consent (code set value '27') • Liaison with other service providers within LikeMind (code set value '28') • Liaison with other service providers outside LikeMind (code set value '29') • Case review (code set value '30') • Legal, justice, corrections services (code set value '31') • Discharge plan (code set value '32')	Change as per discussions with lead agencies
2.9	'Main outcome of session' – this item is no longer a multiple response field and options 3-7 have been removed and replaced with: • Change of Care Plan – step up (referral to more acute service(s) required) (code set value '9') • Change of Care Plan – step down (can begin preparation for discharge) (code set value 10')	Change as per discussions with lead agencies
2.10	Addition of new item 'Modality of session' with response options: • Face-to-face (code set value '1') • Phone (code set value '2')	Change as per recommendation from lead agencies

	• Online (e.g. Zoom, Skype) (code set value '3')	
2.11	Addition of new item 'Client present' with response options: • Yes (client is present, via any modality) (code set value '1') • No (client is not present, however the activity is specific to the client's care) (code set value '2')	Change as per discussions with lead agencies
na	'Other services recommended' and 'Additional support provided' data items have been removed	Change as per recommendation from lead agencies
2.13.1-2.13.10 and 2.14.1-2.14.9	Addition of the two clinical assessment tools Personal Wellbeing Index (PWI) and K10	Change as per discussions with lead agencies
	Exit data set	
3.3	Addition of data item 'Episode identifier'	This will enable accurate identification of clients who return to LikeMind for subsequent episodes of care
3.4	The additional information for the 'Date of assessment/service' data item has been updated to 'The date of the final assessment/service (i.e. episode end)'	Clarification of data item
3.6	'Source of income' – a new option has been added 'No income' with a code set value '8'	Change as per recommendation from lead agencies
3.7	'Relationship status' – the option 'Never married' has been renamed to 'Single'. An 'Other' category has also been added (with code set value '6')	Change as per recommendation from lead agencies
na	Removal of 'Number dependent children'	Change as per recommendation from lead agencies
na	Removal of 'Carer residency status' and 'Relationship of carer to client' data items. The item 'Carer availability' has been renamed to 'Does the client have a carer?'	Change as per recommendation from lead agencies
3.9	'Type of accommodation' – three new options have been added: • 'Emergency temporary accommodation' (code set value '8') • 'Specialist homelessness services including short term, crisis or transitional housing' (code set value '9') • 'Homeless' (code set value '10')	Change as per recommendation from lead agencies
na	'Living arrangement' has been removed	Change as per recommendation from lead agencies
3.10	'Service provider' – the option 'LikeMind Peer worker' has been added to the list for each of the four sites. In addition, the list of specific organisations has been replaced with a more generic list. Each site has the following generic options: • LikeMind (split into four categories as appropriate for each site) • LHD • PHN • CMO – on site • CMO – off site • Other	Change after considering recommendations from lead agencies
3.11	'Discipline of service provider' – the option 'Aboriginal mental health worker' has been added (code set value '11')	Change as per recommendation from lead agencies
na	'Private practice' has been removed	Change as per recommendation from lead agencies

3.12.1-3.12.5	Primary and secondary diagnoses – this is now one data item (with up to five responses) and can either be a formal diagnosis (as determined by qualified practitioner) or a clinical indication as determined throughout the episode by a non-qualified practitioner	Change as per discussions with lead agencies
na	'Main outcome(s) of session' has been removed	Change as per recommendation from lead agencies
na	'Other services recommended' and 'Additional support provided' data items have been removed	Change as per recommendation from lead agencies
3.14	Addition of new item 'Modality of session' with response options: • Face-to-face (code set value '1') • Phone (code set value '2') • Online (e.g. Zoom, Skype) (code set value '3')	Change as per recommendation from lead agencies
3.16	'Mode of discharge' – the option 'Final Outcome Assessment completed' has been removed and this item is now single-response only. Two additional options have been added: • Cease current treatment – client admitted to hospital (code set value '7') • Cease current treatment – client refused further treatment (code set value '8')	Change after considering recommendations from lead agencies
3.18.1 – 3.18.9	Removal of the RAS DS and the addition of the 'Personal Wellbeing Index'	Change as per recommendation from lead agencies. Note that it is crucial for analyses of client outcomes that this tool (and the K10) are completed at least TWICE.
na	Removal of the K10 total score	The total score is derived by summing the ten individual item scores

Appendix 5 Kessler Psychological Distress Scale (K10)

The Kessler Scale (K10) Worksheet Please tick the answer that is best for you:	All of the time 5	Most of the time 4	Some of the time 3	A little of the time 2	None of the time 1
1. In the past 4 weeks, about how often did you feel tired out for no good reason?	☐	☐	☐	☐	☐
2. In the past 4 weeks, about how often did you feel nervous?	☐	☐	☐	☐	☐
3. In the past 4 weeks, about how often did you feel so nervous that nothing could calm you down?	☐	☐	☐	☐	☐
4. In the past 4 weeks, about how often did you feel hopeless?	☐	☐	☐	☐	☐
5. In the past 4 weeks, about how often did you feel restless or fidgety?	☐	☐	☐	☐	☐
6. In the past 4 weeks, about how often did you feel so restless you could not sit still?	☐	☐	☐	☐	☐
7. In the past 4 weeks, about how often did you feel depressed?	☐	☐	☐	☐	☐
8. In the past 4 weeks, about how often did you feel everything was an effort?	☐	☐	☐	☐	☐
9. In the past 4 weeks, about how often did you feel so sad that nothing could cheer you up?	☐	☐	☐	☐	☐
10. In the past 4 weeks, about how often did you feel worthless?	☐	☐	☐	☐	☐

Appendix 6 Personal Wellbeing Index (PWI)

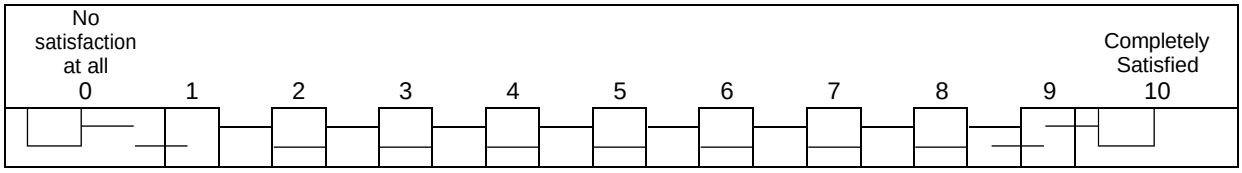
Instructions for Written Format (i.e. test items answered in written questionnaire)

The following questions ask how satisfied you feel, on a scale from zero to 10. **Zero** means you feel no satisfaction at all and **10** means you feel completely satisfied. "

Test Items

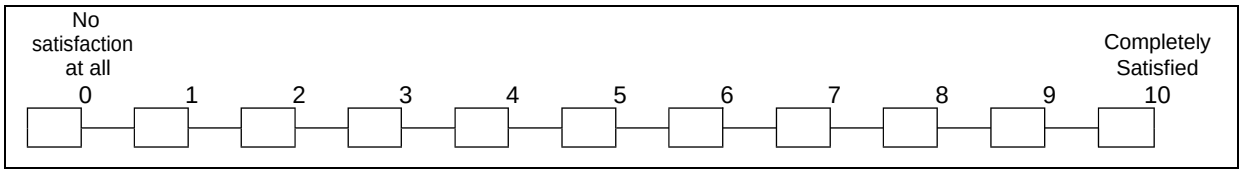
Part 1 [Optional Item]

1. "Thinking about your own life and personal circumstances, how satisfied are you **with your life as a whole?"**

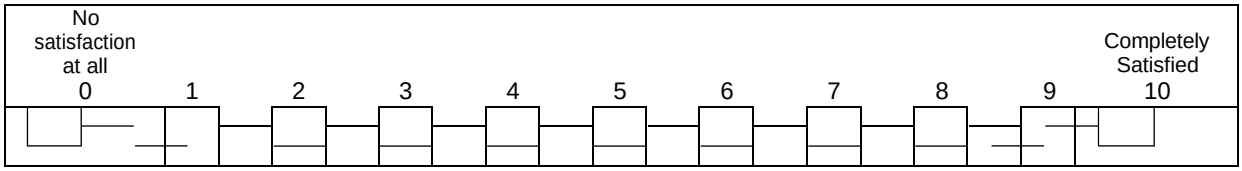


Part 2

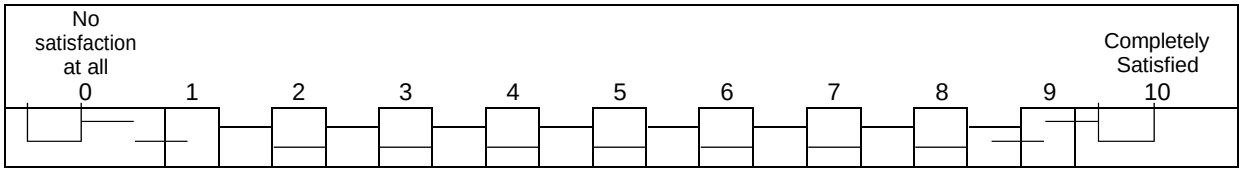
1. "How satisfied are you **with your standard of living?"**



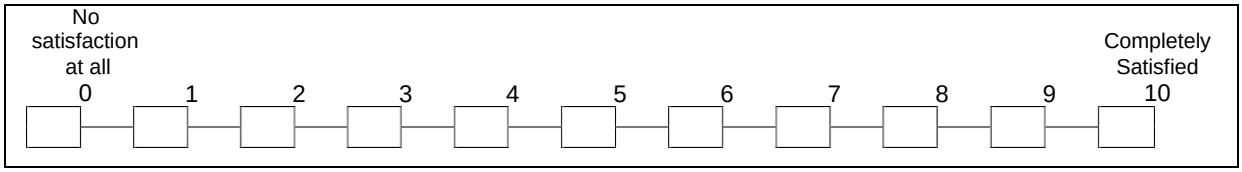
2. "How satisfied are you **with your health?"**



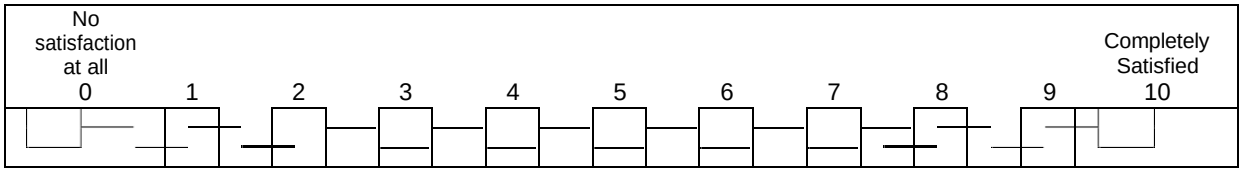
3. "How satisfied are you **with what you are achieving in life?"**



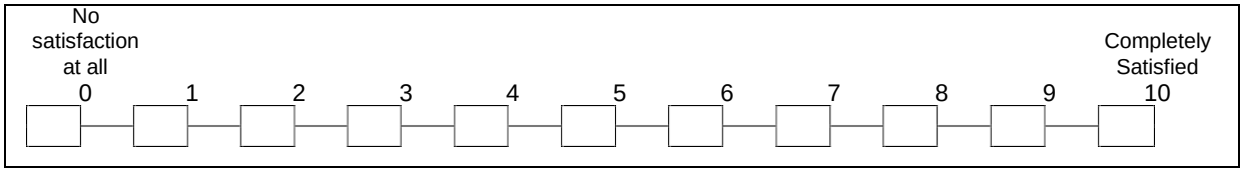
4. "How satisfied are you **with your personal relationships?"**



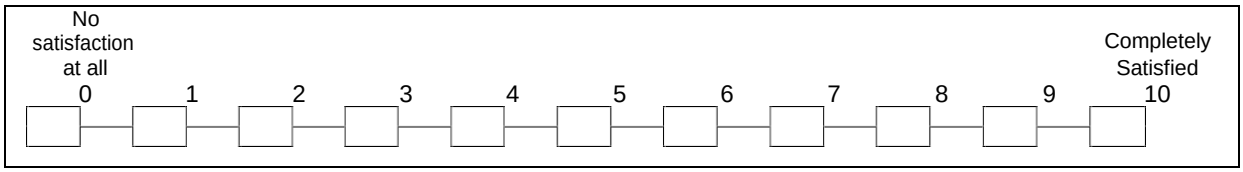
5. "How satisfied are you **with how safe you feel?"**



6. "How satisfied are you **with feeling part of your community?"**



7. "How satisfied are you **with your future security?"**



Appendix 7 YES Survey Results

YES Survey Summary Results

Uniting

01/01/2019 - 31/12/2021

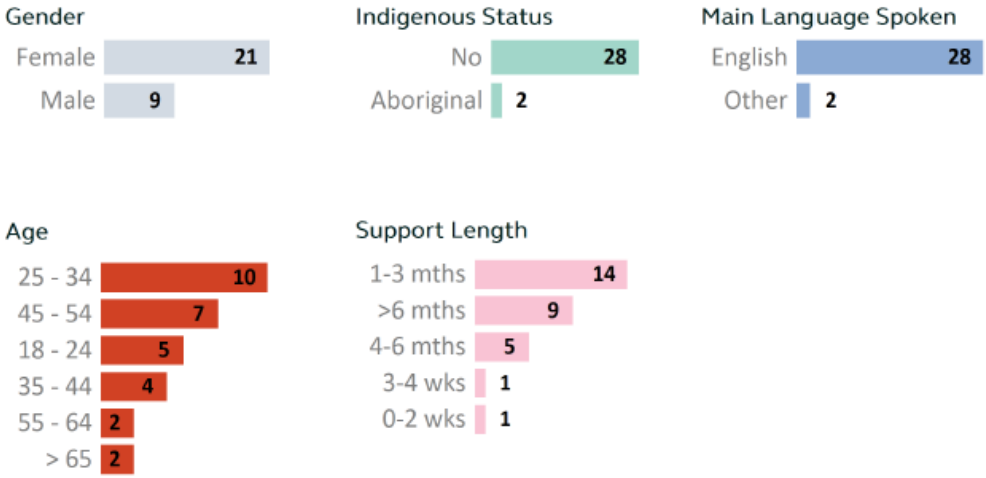
LikeMind Penrith

Return Rate

30 valid returns[1]

Domain Summary••

Demographics



1. Results based on less than 10 returns per quarter should be interpreted with caution and will impact significance ratings.
2. Total score for each domain is 100. Scores 85 and above are considered good.

YES Survey Summary Results

Uniting

01/01/2019 - 31/12/2021

LikeMind Penrith

Domain Breakdown

Respect	On average, people rated this service (out of 5)	Clinical services were rated (out of 5)	Average of all UR services (out of 5)	Rating compared to last period[3]
You felt welcome at this service	4.9	4.9	4.8	—
Staff showed respect for how you were feeling	5.0	4.9	4.9	▲
Your privacy was respected	4.9	4.8	4.8	▼
Staff showed hopefulness for the future	4.5	4.8	4.8	▼
Staff made an effort to see you when you wanted	4.4	4.7	4.7	▼
You were listened to in all aspects of your care and treatment	4.8	4.7	4.7	▲
Safety & Fairness				
You felt safe using this service	4.9	4.8	4.8	▼
You believe that you would receive fair treatment if you made a complaint	3.3	3.6	3.8	▼
The facilities and environment met your needs	4.8	4.6	4.6	▼
Participation				
You had access to your treating doctor or psychiatrist when you needed	3.4	3.3	3.2	▼
Your opinions about the involvement of family or friends in your care were respected	3.4	4.0	4.0	▼
Staff worked as a team in your care and treatment	4.5	4.5	4.5	▲
You had opportunities for your family and carers to be involved in your care	3.4	4.1	3.8	▼
Staff discussed the effects of your medication and other treatments with you	4.1	4.6	4.5	▼
You had opportunities to discuss your progress with the staff caring for you	0.5	2.4	2.4	▼
Individuality				
Your individuality and values were respected	4.7	4.9	4.8	▼
There were activities you could do that suited you	2.4	3.3	3.6	▼
Info & Support				
Information given to you about this service	4.2	4.3	4.3	▲
Explanation of your rights and responsibilities	4.0	4.4	4.3	—
Access to peer support	3.2	3.3	3.6	▼
Development of a care plan with you that considered all your needs	3.9	4.2	4.2	▲
Impact				
The effect the service had on your hopefulness for the future	3.8	3.9	4.0	▲
The effect the service had on your ability to manage your day to day life	3.7	3.8	3.9	▲
The effect the service had on your overall wellbeing	3.7	4.0	4.1	▼
Overall, how would you rate your experience of care within this service in the last 3 months	4.0	4.2	4.3	—

3. The period 1/01/2016 - 31/12/2018 where there were 32 surveys returned. Comparisons are not shown for periods with less than 10 returns.

YES Survey Summary Results

Uniting

01/01/2019 - 31/12/2021

LikeMind Penrith

Client Feedback

My Experience Would Have Been Better If
More suggestions for certain aspects of treatment
Staff were more keen to listen to me carefully, understand situation & then develop a care plan. Not a single care plan fits to all. It felt like a single therapy is given to everyone regardless of their situation.
If i could see someone at Seven Hills.
Given a physical plan of issues to deal with/ treatment for upcomming sessions.
Always had telephone appointments available from the beginning b4 covid dince I have a disability.
N/A - all that was provided i could not fault.
If the councillor had the same experience, the loss of a young child. I believe that a better rapport would have been achieved; this is something that i have experienced with a number of councillors. The councillor was good though.
N / A
It was overall excellent
The parking is full all of the time, not great parking otions available.

The Best Things About This Service Were
Staff always assisting and scedulling around day - day life
Its good to have someone who is interested in your wellbeing. Taking the time to learn as much about you as they can
the understanding of my situation, which resulted in good advice and hope for the future
friendly and professional staff
staff respected and warmly welcomed me
Convenience, friendly staff, free.
The privacy, friendliness, didn't feel that I was a patient with a problem, rather a person. Flexibillity especially withh UNI schedules. How welcomming in everyone is and it always felt like I didn't have as many issues when I walked in, my issues didn't define me.
The friendliness of the staff.
the support, constructive advice.
Practical exercises to assist with managing anxiety.
Very friendly staff.
The easily accessible, friendly organised staff, options available.
Getting in touch & follow up on appointments.
People.
Convenience of location.
The staff who worked with me. Particularly Danielle and Glenyis who I had the most contact.
The links to services that i required to maintain my wellness!
This is an excellent service
Friendly staff, supportive, non-judgemental, easy to talk to anddid all they could do, accomodate my work hours and when i was available for appointments.
Flexibility, rfeliable and overall very helpfu.
The friendly and welcomming staff, very attentive and caring. The facillities are very well kept and tidy.

YES Survey Summary Results

Uniting

01/01/2019 - 31/12/2021

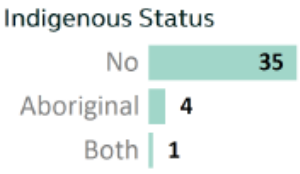
LikeMind Seven Hills

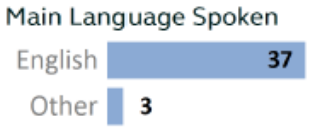
Return Rate

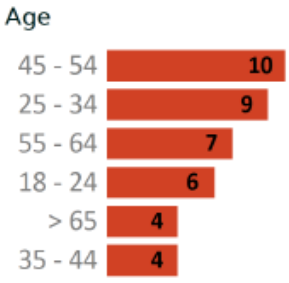
40 valid returns[1]

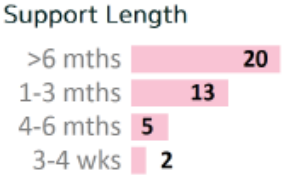
Domain Summary••

Demographics









1. Results based on less than 10 returns per quarter should be interpreted with caution and will impact significance ratings.
2. Total score for each domain is 100. Scores 85 and above are considered good.

YES Survey Summary Results

Uniting

01/01/2019 - 31/12/2021

LikeMind Seven Hills

Domain Breakdown

Respect	On average, people rated this service (out of 5)	Clinical services were rated (out of 5)	Average of all UR services (out of 5)	Rating compared to last period[3]
You felt welcome at this service	4.8	4.9	4.8	▼
Staff showed respect for how you were feeling	4.8	4.9	4.9	▼
Your privacy was respected	4.7	4.8	4.8	▼
Staff showed hopefulness for the future	4.7	4.8	4.8	▼
Staff made an effort to see you when you wanted	4.6	4.7	4.7	–
You were listened to in all aspects of your care and treatment	4.6	4.7	4.7	▼
Safety & Fairness				
You felt safe using this service	4.9	4.8	4.8	▼
You believe that you would receive fair treatment if you made a complaint	4.0	3.6	3.8	▲
The facilities and environment met your needs	5.0	4.6	4.6	▲
Participation				
You had access to your treating doctor or psychiatrist when you needed	3.6	3.3	3.2	▲
Your opinions about the involvement of family or friends in your care were respected	3.7	4.0	4.0	▼
Staff worked as a team in your care and treatment	4.6	4.5	4.5	▲
You had opportunities for your family and carers to be involved in your care	3.8	4.1	3.8	▼
Staff discussed the effects of your medication and other treatments with you	4.7	4.6	4.5	–
You had opportunities to discuss your progress with the staff caring for you	0.4	2.4	2.4	–
Individuality				
Your individuality and values were respected	4.9	4.9	4.8	–
There were activities you could do that suited you	3.3	3.3	3.6	▲
Info & Support				
Information given to you about this service	4.5	4.3	4.3	▲
Explanation of your rights and responsibilities	4.3	4.4	4.3	–
Access to peer support	3.5	3.3	3.6	▲
Development of a care plan with you that considered all your needs	4.1	4.2	4.2	▼
Impact				
The effect the service had on your hopefulness for the future	4.0	3.9	4.0	▲
The effect the service had on your ability to manage your day to day life	4.0	3.8	3.9	▲
The effect the service had on your overall wellbeing	4.1	4.0	4.1	▲
Overall, how would you rate your experience of care within this service in the last 3 months	4.4	4.2	4.3	▲

3. The period 1/01/2016 - 31/12/2018 where there were 41 surveys returned. Comparisons are not shown for periods with less than 10 returns.

YES Survey Summary Results

01/01/2019 - 31/12/2021

LikeMind Seven Hills

Client Feedback

My Experience Would Have Been Better If
If my key issues been resolved e.g. sleeplessness
I had help paying off an ambulance fee that a collegue said LikeMind would help/cover it, but they didn't
Could see a Psychologist a lot earlier at Seven Hills
My experience with Like<Mind has been great
If there were more people that understood me properly Group activities like headspace Parramatta did, like "chil space" and a kitchen so if we were waiting we could get a coffe/tea or biscuits.
lyt was a bit closer to where I live
My phne number didn't get mixed into another clients data file. Could be serious privacy issue.
There were more group sessions
No it is good
There was more parking avcailable
I don't think my experience could have been better
Nothing All was good
It was easier to get parking. It has been stressful, wondering if i could get parking
Parking poor and stressful at times
Face to face

The Best Things About This Service Were
Talking through the issues raised and attempt to resolve for a better outcome
Its local for me so i don't have to travel too far which is very convenient
Attitude
Socializing with other careers & supporting each other
Kindness, Listening, Knowledge
Staff were friendly, welcoming and understanding
Being in an accessable area / location
Everything
Talking about how felt about life
The staff, always welcoming and supportive
So far, being able to talk to someone.
Some of the courses have been exceptional
Staff is nice
Appointments with Mikayla are always helpful
Taslking to the Clinician
The workers have been amazing and very helpful
Short wait time, sometimes
Stuff
Admin team, very warm and compationate. Charles is the best Psychologist i've had in over 10 years.
Support given byt staff
Caring well trained staff
Feeling radiated Easy to make / cancel appointments Friendly office staff, lovely facillities
Staff was nice
The service is free, I probably wouldn't have continued to attend because of financial constraints. The quality of care
Provide mental health support information.