phn
HUNTER NEW ENGLAND AND CENTRAL COAST
An Australian Government Initiative

PRIMARY HEALTH NETWORK

Older Australians Mental Health Pilot Programs

EVALUATION REPORT

20 March 2024

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CONTENTS

This report is an abridged version of the formal evaluation report *Evaluation of Aged Care Mental Health Services – Final Report (June 2023)* commissioned by the HNECC PHN from ARTD Consultants.

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BACKGROUND

In recent years the Hunter New England and Central Coast (HNECC) regions have recognised the increasing need to provide better mental health care for older Australians, especially those in Residential Aged Care, who have been identified as being underserved by mental health services.

Interventions to prevent and mitigate mental health issues as part of a stepped care framework is required to service a large region of over 1.2million people who live in small rural and remote communities, in regional towns, and in densely populated urban centres including the Central Coast, Newcastle, Tamworth and Armidale (Figure 1).[1].

National statistics indicate that 52% of permanent aged care residents experience symptoms of depression, and 45% of newly admitted residents have symptoms of depression.[2] Moreover, mental health services do not normally form part of RACFs' service offerings, leaving a gap in addressing these issues.

As a result, the PHN has commissioned providers to deliver pilot programs of services within RACFs with a view to scaling services to serve RACFs across the PHN region in the future. Five interventions are being piloted in RACFs and evaluated; four are new interventions and one is an expansion of existing mental health services to focus on RACF contexts (For program description, see Appendix 1):

- Older Person's Peer Support Service (new)
- Bereavement Counselling Service (new)
- Animal Assisted Therapy (new)
- Music Therapy (technology assisted service) (new)
- Primary Mental Health Care Psychological Service (expansion of existing services).

There are additional pilot programs that were excluded from the scope of the evaluation due to their nature. Due to a different lens to psychological intervention, remote monitoring and roles of other allied health professionals, they were not suitable to compare.

Implementation of the programs began in July 2021, though exact starting dates depended on the readiness of the pilot programs. Concurrently, COVID-19 restrictions were implemented throughout July and August 2021.

FIGURE 1. THE PHN SERVICE AREA AND RELATION TO NSW

PURPOSE AND SCOPE

The third-party evaluation, conducted by **ARTD Consultants**, comprised a process and outcomes evaluation of the package of interventions with the aim of determining the feasibility of scaling the approach to cover all residential aged care facilities (RACFs) in the Hunter New England and Central Coast Primary Health Network (HNECC PHN or the PHN) region. Specifically, the evaluation sought to:

- provide insights into the efficiency, effectiveness, appropriateness and value of a range of interventions commissioned in Residential Aged Care Facilities as

[1] HNECC PHN (2021), Hunter New England and Central Coast Population Health Snapshot 2021.

[2] Mental Health Australia (2019), *Submission to the Royal Commission into Aged Care Quality and Safety.*

outlined in the HNECC PHN Mental Health Aged Care Strategy 2020-2023. [3]
- compare interventions, to determine those providing value for money
- provide evidence and recommendations to support future regional service development aligning with the overarching mental health strategic objectives and the Quadruple Aim framework
- help build the capabilities of the PHN (namely in the Health Intelligence and Performance Team) to undertake value for money (VfM) assessments.

This evaluation applies a Rubric Matrix approach. Rubrics are used in evaluation studies to consistently apply evaluative criteria, particularly where multiple activities, programs or elements are being evaluated alongside each other. This typed of evaluation enables a transparent and easily communicated assessment of program performance incorporating both qualitative and quantitative data.

Rubrics can also address objectives unique to individual programs. This enables a fair activity-level assessment while also allowing a holistic assessment of the program that includes an analysis of gaps in delivery.

METHODOLOGY

A set of VfM rubrics have been developed in a workshop with the HNECC PHN, defining five VfM criteria of equity, economy, efficiency, effectiveness and cost-effectiveness, together with sub criteria (aspects of performance) and standards (levels of performance) for each criterion. Collectively, these rubrics define what excellent, good/, adequate, and poor VfM would look like for the pilots. The rubrics articulate an agreed basis for making evaluative judgements from mixed methods evidence (qualitative, quantitative and economic), and can be applied to the pilots individually and collectively. (See Appendix 2 – Rubic Questions formulated)

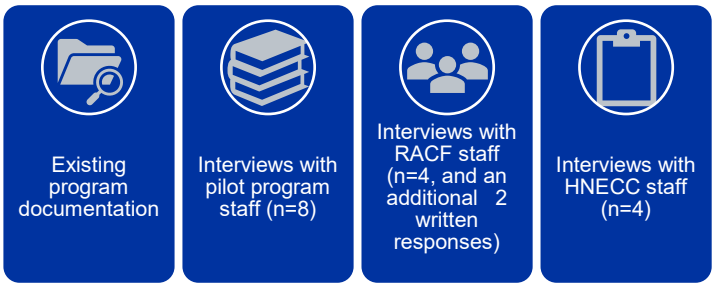
The approach to economic evaluation and answering the value for money key evaluation question reflects the intent of the pilots. The value of pilot programs is that they are an opportunity to innovate, adapt, learn and provide proof of concept for a (relatively) modest investment.[4] If successful, the pilot programs improve outcomes for small cohorts taking part just the one time. However, their principal value is that the learning they lead to can inform to a sustainable, scalable approach.

In this evaluation, an agreed criteria set out in the cost-effectiveness rubric shown in Appendix 3 to assess the extent to which pilots provide proof of concept for an alternative model of care that can:

- be taken to scale
- be accessible and acceptable to older people in RACFs, and to the RACFs themselves
- be delivered sustainably, at an acceptable, affordable cost
- strengthen referral pathways for older people's mental health care
- improve the availability of low intensity and low to moderate intensity psychological services that respond to local needs
- meaningfully increase PHN aged care mental health service coverage and reach in the aged care sector
- help improve population health.

Given the early stage of the pilots and the nature of outcome data available, full economic analysis (e.g. cost-utility analysis to estimate cost per quality-adjusted life year gained, or cost-benefit analysis to estimate net present value of interventions) was out of scope.

The visual below outlines the **data collection methods** used to gather evidence addressing each of the key evaluation questions and inform the evaluation provided in this final report. Consideration and limitation are discussed in findings.



[3] https://hneccphn.imgix.net/assets/src/uploads/resources/Mental-Health/Aged-Care-Mental-Health-Strategy-2020-23.pdf

[4] See www.julianking.co.nz/vfi/pilot-roi.

FINDINGS

The following sections present rubrics for each of the VfM criteria, along with definitions of performance for each of the levels within each criterion. Assessment against each of the rubric criterion will be made using evidence from the evaluation activities and the answers to each of the evaluation questions.

FIGURE 2. OVERALL RUBRIC SCORECARD

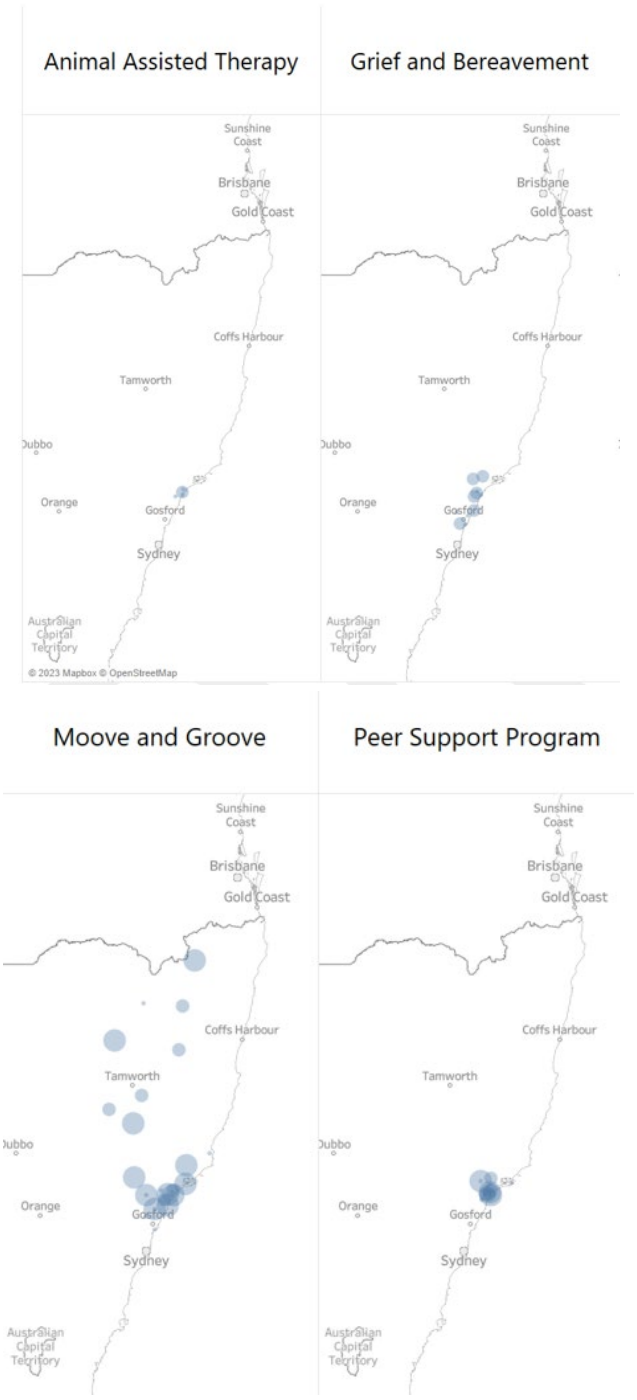
	Older Person's Peer Support	Grief & Bereave-ment Counsell-ing	Animal Assisted Therapy	Moove and Groove	PMHC Psycho-ogical Services	Overall
Equity	Good	Good	Good	Good	Good	Good
Econo my	Good	Excellent	Excellent	Excellent	Excellent	Excellent
Efficie ncy	Good	Good	Good	Excellent	Excellent	Good
Effecti ve-ness	Good	Good	Good	Good	Good	Good
Cost-effectiv e-ness	Good	Good	Adequate	Excellent	Excellent	Good

RUBRIC SCORECARD – EQUITY

All the pilot programs are reaching their intended target groups and reporting reduced psychological distress in residents. Program self-reported documentation shows engagement by size (Figure 3) and the location of RACFs engaged (Figure 4)

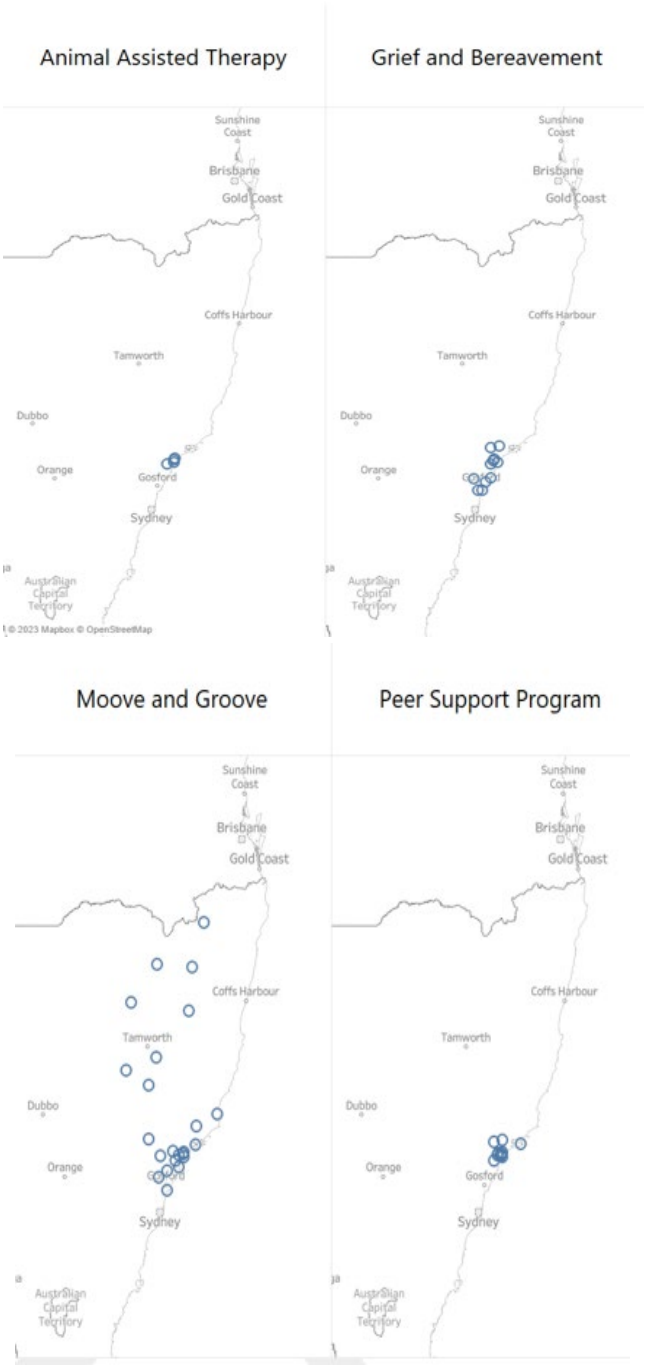
Older Person's Peer Support	Grief and Bereavement Counselling	Animal Assisted Therapy	Moove and Groove	Primary Mental Health Care Psychological Services
Good	Good	Good	Good	Good

FIGURE 3. RACF ENGAGEMENT – BY RACF SIZE



Source: The location of RACFs engaged in self-report by the pilot providers. Note: The size of the dot indicates the number of residential places at the RACFs. The larger the dot, the greater the number of residential places.

FIGURE 4. RACF ENGAGEMENT – BY RACF LOCATION



Source: The location of RACFs engaged with each program is self-reported by the pilot providers.

The design and procurement process for the pilot programs ensured that their target groups were clear from the outset. Target groups may have changed for some programs over the evaluation period, but the PHN's flexibility in reporting has ensured this process remained equitable.

There was no clear evidence that the pilot programs were equitably reaching LGBTQIA+ consumers and those from CALD backgrounds, as they are not required to report on the breakdown of consumer demographics. However, it appeared as though pilot providers were considering how to deliver their programs equitably to these populations.

There needs to be greater focus on reaching remote and regional populations for the programs to meet the criteria for 'excellent'. This was seen as a key challenge for pilot programs as their limited FTE capacity makes travelling long distances prohibitive. One pilot provider looked for efficiencies by scheduling meetings with several remote RACFs in one day.

RUBRIC SCORECARD – ECONOMY

Available evidence indicates that the PHN is a good steward of resources. It has documented policies and procedures for procurement, which it adheres to. The procurement practices to select pilots that are relevant and fit-for-purpose, with capacity to deliver at an appropriate price. The contracting processes has ensured pilots are accountable for use of resources and minimise wastage, and data systems to monitor outputs and service user demographics.

Older Person's Peer Support	Grief and Bereavement Counselling	Animal Assisted Therapy	Moove and Groove	Primary Mental Health Care Psychological Services
Good	Excellent	Excellent	Excellent	Excellent

Most pilot programs are excellent stewards of resources. Some pilot providers indicated that there have been some difficulties with data entry. Older Person's Peer Support reported difficulties with data entry within the PHN system due to the additional workload and the detailed information that needs to be uploaded after each client visit. With support from the PHN, they are now retroactively entering data from each of their client visits.

Though there is limited outcomes data available for some programs, all pilot programs are currently set up to collect some outcomes data. Interviews and administrative data suggest that pilot providers are collecting additional information in the form of consumer interviews, RACF feedback surveys and consumer case studies.

RUBRIC SCORECARD – EFFICIENCY

The majority of stakeholders interviewed reported strong relationships, trust and communications between them and other stakeholders (including the PHN, pilot programs and RACFs). These strong relationships have facilitated a cohesive and well-integrated approach to service delivery on the whole.

The PHN and the pilot programs all reported learnings that had been identified through program delivery as well as demonstrating adaptations. As a result, pilot programs have reported service improvements.

Older Person's Peer Support	Grief and Bereavement Counselling	Animal Assisted Therapy	Moove and Groove	Primary Mental Health Care Psychological Services
Good	Good	Good	Excellent	Excellent

RUBRIC SCORECARD – EFFECTIVENESS

The programs show meeting or exceeding the expectations of increasing aged care mental health workforce capability in consumer and community engagement and improving older people's and carers' experience or satisfaction. Whilst all pilot programs are rated 'good' on the rubric, they are also partially meeting criteria under the 'excellent' rubric.

Older Person's Peer Support	Grief and Bereavement Counselling	Animal Assisted Therapy	Moove and Groove	Primary Mental Health Care Psychological Services
Good	Good	Good	Good	Good

The visibility of referral pathways; linkages to the aged care mental health ecosystem and network; and awareness of PHN aged care mental health services have increased at different rates across the pilot programs. Pilot providers indicated as the pilot programs become more established within the sector, they would expect more referrals. Moove and Groove reported that RACF staff movement between facilities was resulting in word-of-mouth referrals.

Some pilot providers reported improving early intervention and prevention of higher clinical needs in interviews and administrative data. Some pilot providers also noted that their services were increasing staff confidence in early intervention. For example, Grief and Bereavement Counselling reported that 65% of participants indicated increased knowledge. Additionally, some pilot providers have reported the improvement in RACF staff and clinicians' experience of aged care mental health services.

RUBIC SCORECARD - COST-EFFECTIVENESS

Administrative and anecdotal interview data indicates that all pilot programs are contributing to the improvement of population health within the participating RACFs to some extent.

Older Person's Peer Support	Grief and Bereavement Counselling	Animal Assisted Therapy	Moove and Groove	Primary Mental Health Care Psychological Services
Good	Good	Adequate	Excellent	Excellent

Whilst all pilot providers showed proof of concept or an alternative model of care that can be taken to scale, there are differences between pilot providers in terms of the sustainability of their service delivery. This is likely due to differences in stages of implementation and delivery. Those that are more established (Moove and Groove and Primary Mental Health Care Psychological Services) have delivered their service to a greater number of clients (see Table 1). While pilot providers that are not as established may not initially appear to be good investments, a pilot's benefits may exceed the costs when taken to scale.[5]

RESPONSES TO EVALUATION QUESTIONS

For detail responses to evaluation questions, see Appendix 4.

[5] www.julianking.co.nz/vfi/pilot-roi

TABLE 1. NUMBER OF CLIENT PER PROGRAM

Program	Total clients	Data Source
Animal Assisted Therapy	12	PHN FOLIO
Grief and Bereavement Counselling	312	PHN FOLIO
Moove and Groove	481	PHN FOLIO
Older Person's Peer Support	99	PHN FOLIO
Psychology Service - HealthWISE	40	PHN FOLIO
Psychology Service - Coast and Country Primary Care	121	PHN FOLIO
Psychology Service - Hunter Primary Care	173	PHN FOLIO

Source: PHN FOLIO Quarter 1 22/23 to Quarter 3 22/23. Note: Comparisons of metrics such as cost per client are not appropriate as the programs are at different stages of delivery.

EVALUATION RECOMMENDATIONS

Recommendation 1: Consider facilitating engagement between pilot providers and RACFs utilising existing relationships and networks.

Recommendation 2: Continue to maintain and develop clear guidelines, templates and professional development opportunities for providers.

Recommendation 3: Maintain quarterly meetings with pilot program providers to ensure that information is shared amongst stakeholders in a timely manner, thus encouraging continuous improvement from learning and feedback.

Recommendation 4: Continue the funding of the PHN project lead, such as a Commissioning Coordinator, to ensure that pilot providers are supported during the design, implementation and ongoing delivery of their services.

Recommendation 5: Consider whether future funding should be performance-based, and whether it should be based on overall resident outcomes or RACF engagement with providers.

Recommendation 6: Continue engagement with and regular updating of HealthPathways to ensure visibility of referral pathways.

Recommendation 7: Consider attending professional development training opportunities.

Recommendation 8: Involve communities in rural and remote areas during procurement processes to ensure that their needs are met and to encourage early engagement.

OUTLOOK - WHAT'S NEXT?

The PHN will continue to develop services to improve the mental health outcomes of older Australian. From 2024 to 2026, the PHN aims to increase equity of access and support a diverse workforce to provide care to people over 65.

Besides promoting innovative and digital health care, we intend to support training in primary care and aged care. For example, increasing awareness on current and emerging trend relating to psychotropic medication(s) and non-pharmacological approaches to mental health and wellbeing.

If you have any questions, would like to provide us with feedback, or need assistance, please reach out to info@thephn.com.au

APPENDIX 1 – PROGRAM DESCRIPTION

The **Older Person's Peer Support Service** provides a Consumer Peer Support Worker and Carer Peer Support Worker to support RACF residents and their families/ carers. It is an evidence-based intervention delivered by people with lived experience. The Peer Workers deliver the service for between 6- and 16-weeks using recovery-orientated practice. They play a key role in supporting people during their transition to RACFs.

The **Bereavement Counselling Service** (Grief and Bereavement Counselling) is an evidence-based intervention to address the loss and grief that contribute to mental ill-health. It offers those engaged with the program confidential discussions about loss and its impacts, helping them to express their grief and feel supported. Following implementation of the counselling within RACFs, the program staff identified a significant need for support not only for residents, but also for RACF staff and residents' families. As a result, this program is delivered via group sessions to RACF staff and family/ carer groups in addition to sessions for RACF residents.

Animal Assisted Therapy (AAT) is an evidence-based intervention that creates a bond between the RACF resident and an animal through interaction and play, building on the social, emotional and physiological benefits associated with this relationship. Residents are matched with a volunteer and their dog depending on set criteria and individual preferences, in order to deliver the best outcomes. The pilot provider is delivered by Delta Therapy Dogs and works with a clinical delivery partner.

The Music Therapy (**Moove and Groove**) program provides individualised audio and visual content to RACF residents through headphones. Depending on residents' individual preferences this can include music and health and wellbeing content, and is available in more than 30 languages. Following an initial pilot stage, Moove and Groove can be delivered in a personalised or group setting, and individual residents can choose to opt in and out of the program.

The **Primary Mental Health Care Psychological Services** (PMHC Psychological Services) are existing services delivered to people over 65 years old living in RACFs across the PHN region. These providers are Coast and Country Primary Care Mental Health Clinical Services for the Central Coast region, HealthWISE Mental Health Services for the New England region and Hunter Primary Care Psychology Services for the Hunter and Manning region. These organisations provide evidence-based psychological interventions.

APPENDIX 2 – KEY EVALUATION QUESTIONS

Based on a combination of initial interviews with PHN staff and pilot providers, along with the outcomes of workshops with PHN staff, a set of evaluation questions was developed to guide the project:

1. How well were programs established?
    a. Were there sufficient resources to deliver on their objectives?
    b. How did the program design process work to meet the needs of older people and the aged care system?

2. How did programs fit within the broader context?
    a. Compared to traditional programs, how well aligned was the stepped care approach to broader mental health and aged care policies (including state and Commonwealth policies)?
    b. How well aligned were the pilots with a stepped care approach?
    c. Have the low intensity services supported referrals to other mental health services?
    d. Has the delivery of programs enabled the PHN to build relationships with services?
    e. Has the delivery of programs enhanced capacity and capability of pilot providers, RACFs and the PHN?

3. What happened during and after programs were delivered in terms of outcomes?
    a. How well were programs delivered?
    b. To what extent do the pilots represent value for money?
    c. How appropriate were programs in meeting the needs of older people and the aged care system?

4. What can we learn from the delivery of the package?
    a. What are the circumstances in which programs are most effective?
    b. Were there unexpected consequences of delivering the package of programs?
    c. What factors should be considered in scaling up or expanding the programs?

APPENDIX 3 – COST EFFECTIVENESS SCALE RUBRIC

GENERIC STANDARDS

Standard	Definition
Excellent	Meeting all expectations (may be exceeding some), bearing in mind the realities of the context. There may be room for incremental improvements.
Good	Generally meeting expectations, allowing for minor exceptions. Still ome room for growth.
Adequate	Meeting minimum requirements, but not all expectations. Showing acceptable progress overall. Significant room for growth.
Poor	Not meeting minimum 'bottom line' requirements or not showing acceptable progress. Urgent improvements needed.

An additional set of scale were used for the following criteria: equity, economy, efficiency, effectiveness and cost-effectiveness. Additional information is available upon request separate to this report.

APPENDIX 4 – RESPONSES TO EVALUATION QUESTIONS

1. How well were programs established?

Pilot programs were mostly well established within the sector, and learnings from their ongoing implementation and delivery were being integrated into program delivery. The pilot programs are at different stages of implementation. There have been significant delays across pilot providers, which are attributable to the ongoing impact of COVID-19 on the aged care sector as well as high staff turnover and burnout.

1a. Were there sufficient resources to deliver on their objectives?

Stakeholders defined 'resources' as funding, staffing and time. There were system-wide constraints on certain resources, largely related to staffing and ongoing COVID-19 impacts, that were reported by most stakeholders.

Funding was generally seen to be adequate for the pilot providers to meet their contracted requirements, though some programs are yet to meet their target number of sessions. Pilot providers mentioned that any scaling of the programs would require additional financial resourcing to meet the needs of RACF residents.

Stakeholders from all programs identified a skilled workforce as foundational to the success of the pilot programs. For programs needing a large number of staff or volunteers to deliver, this was particularly challenging. A small number of pilot provider stakeholders raised the administrative burden of resourcing on staff, though recognised that this process was becoming more efficient over time.

Flexibility in time frames was identified as important by both pilot providers and PHN staff. This was especially important where there were unexpected occurrences, including COVID-19 and its ongoing impacts. The PHN acknowledged that the pilot programs were at different stages in their implementation and could be expected to mature over time.

1b. How did the program design process work to meet the needs of older people and the aged care system?

For older people and the aged care system the need identified is for additional mental health services,

particularly those designed to prevent and mitigate mental health issues as part of a stepped care framework. Mental health services do not normally form part of RACFs' service offerings, leaving a gap in addressing these issues. The pilot programs were commissioned under the HNECC PHN (Hunter New England and Central Coast Primary Health Network) Mental Health Aged Care Strategy 2020-2023 to address this gap. Though the programs are at different stages of delivery, the design process has been flexible and clear. This has facilitated successful implementation across all programs, therefore meeting the need for mental health services in RACFs.

The design process also included the development and refinement of a program logic with the PHN that reflects the inputs, outputs and intended outcomes of the pilot programs. The PHN also created an outcomes matrix that links proposed data collection methods with the program logic and evaluation questions.

The program design process was also supported by the strong relationship between program managers and the PHN that stakeholder reported. Stakeholders described the relationship as involving timely and constructive communication, which facilitated opportunities for ongoing learning and flexibility where needed. This was important for the pilot programs as they developed and matured. The PHN's flexibility in the design and implementation process has ensured effective service delivery for older people and the aged care system more widely.

My observation about the way in which this project has unfolded – that it is a really good example of how these funding models can grow small and then incrementally evolve. […] I think that's a really good model. We've been really happy with how it's evolved, […] I think it's been a really innovative way to do it. – Pilot provider interview

2. How did programs fit within the broader context?

Programs mostly continue to positively fit within the broader sector context by providing alternative and early intervention support for residents within RACFs. The pilot programs align with a stepped care approach that itself aligns with the broader mental health and aged care policies of the state and Commonwealth.

Awareness of the pilot programs has increased as they mature in the sector and become more widely known through word-of-mouth. A small number of pilot providers noted constructive and ongoing engagement with RACF staff, providing opportunities for capacity building and improved wellbeing in their roles.

2a. Compared to traditional programs, how well aligned was the stepped care approach to broader mental health and aged care policies (including state and Commonwealth policies)?

Pilot programs appear to align well with broader state and Commonwealth mental health and aged care policies. There are 8 Aged Care Quality Standards[6] that government-funded aged care providers are required to comply with. These standards include ensuring that aged care residents are able to access appropriate services and supports for their emotional and psychological wellbeing. The data suggests that the pilot providers are aligning with this standard by providing additional mental health services to residents.

The pilot programs also appear to be well aligned to the Quadruple Aim framework that guides the HNECC PHN. The pilots appear to be improving the patient experience and improving the care and experience of the provider. They also appear to be working toward improving population health outcomes and providing value for money, though this may become more apparent over time as the pilot programs mature and pilot providers learn from service delivery.

2b. How well aligned were the pilots with a stepped care approach?

A stepped care approach is defined as "an evidence-based, staged system comprising a hierarchy of interventions, from the least to the most intensive, which can be matched to the individual's needs".[7]

The PHN stepped care approach to delivering services to RACF residents matches services to need. Stepped care generally focuses on those with mild to moderate needs. The pilot programs are geared toward early intervention, to reduce numbers of residents entering the mild to moderate group and to complement existing interventions available for RACF residents. Residents

[6] www.agedcarequality.gov.au/sites/default/files/media/acqsc_aged_care_quality_standards_fact_sheet_4pp_v8.pdf

[7] www.health.gov.au/sites/default/files/documents/2021/04/primary-health-networks-phn-primary-mental-health-care-guidance-stepped-care.pdf

with severe and persistent or complex needs are out of scope for stepped care PHN services.

In general, the pilot programs appear to be well aligned with the stepped care approach, offering RACF residents more choice in the mental health interventions and services they can access.

2c. Have the low intensity services supported referrals to other mental health services?

Most pilot providers were not aware of supporting referrals into other mental health services, though they did acknowledge that they do not always see the longer-term impacts of their service unless they make repeat RACF visits. This may mean that there are impacts of the pilots that are not recorded, including additional referrals. There have been a small number of specific examples where additional treatment has been sought as a result of the service provision.

The HealthPathways portal is one way for pilot providers to create awareness of their program. It is an online health information portal for GPs and other primary health clinicians that provides information on how to assess and refer patients to local specialists and services. It was expected that pilot providers would upload and maintain their information on HealthPathways. This was also a deliverable in the FOLIO database, where providers were asked to provide a narrative on their use of HealthPathways.

2d. Has the delivery of programs enabled the PHN to build relationships with services?

There has been a high level of engagement between the PHN and the pilot providers throughout the implementation and delivery of the programs. Pilot providers have reported responsive and supportive communication from the PHN, backed by quarterly update meetings and reporting.

The role of Commissioning Coordinator has been instrumental in the ongoing provision of programs. The pilot providers also noted that the PHN's flexibility in providing support and feedback was appreciated and important to ensure the programs remained successful.

In general, there were some who identified reporting as a substantial additional workload and indicated that there was a steep learning curve and upskilling required for data entry in the Primary Mental Health Care Minimum Data Set. Animal Assisted Therapy and Older Person's Peer Support both reported that they were currently working to identify ways to make the reporting more efficient.

The relationship between pilot providers and RACFs has been variable. Some providers indicated that there were limited opportunities to foster and maintain a relationship with RACFs, depending on the size and location of RACFs. RACFs in more remote areas of the PHN take longer to reach, often meaning face-to-face engagement is limited.

Similarly, there can be less face-to-face relationship building with individual staff members in larger RACFs, a situation that is exacerbated by high staff turnover rates. The strength of the relationship also depended on the existing relationships between the pilot providers and the RACFs. In interviews, pilot providers did recognise the value of building rapport and relationships with RACFs.

Staff members from RACFs engaged with the Moove and Groove program indicated that they were satisfied with their relationship with the pilot provider, describing them as "responsive", "accommodating" and "efficient".

2e. Has the delivery of programs enhanced capacity and capability of pilot providers, RACFs and the PHN?

Generally, across all pilot providers, the stakeholders working or volunteering indicated that they were satisfied with the training available from the pilot provider, with one describing it as "comprehensive". They felt supported in delivering the programs to RACF residents.

As one example, Animal Assisted Therapy offers professional development meetings to its volunteers as well as comprehensive training before any RACF engagement. On the other hand, the Grief and Bereavement Counselling program provider indicated that it was building capacity with a range of stakeholders.

3. What happened during and after programs were delivered in terms of outcomes?

Available evidence from interviews and administrative data suggests that the pilot programs are all successfully delivering services consistent with the intent of stepped care. Most are demonstrating the ability to deliver an equitable service to populations across the Central Coast, Newcastle, Tamworth and

Armidale regions. Resource constraints and a strained workforce are limiting the full potential of service delivery.

It should be noted that it was harder to identify and record the longer-term outcomes of the pilot programs where there is not a strong relationship between the provider and the RACF.

3a. How well were programs delivered?

Programs were delivered well most of the time, given the circumstances. As discussed, Pilot providers were unable to engage with RACFs fully when there were COVID-19- related lockdowns and area-specific shutdowns. Pilot providers also indicated that they were limited by the funding allowances, including the number of staff hours that could be allocated to program delivery (measured in terms of full-time equivalent (FTE) staff).

Pilot providers considered equitable delivery in the design and implementation stages. The providers of the Older Person's Peer Support, Animal Assisted Therapy and Grief and Bereavement Counselling programs acknowledged some limitations relating to the time taken to travel to more regional locations.

The majority of RACFs engaged were within the metro areas of the Central Coast or Hunter regions, likely due to the longer travel times between the pilot providers and the more remote locations. Moove and Groove and the Older Person's Peer Support Program were engaging with larger RACFs in comparison to the other pilot providers. There was not a significant amount of crossover, with only one RACF engaging with two pilot providers, as per Figure 3 and Figure 4.

3b. To what extent do the pilots represent value for money?

The approach to economic evaluation and answering this key evaluation question reflects the intent of the pilots. The value of piloting programs is that they are an opportunity to innovate, adapt, learn and provide proof of concept for a (relatively) modest investment.[8] If successful, they improve outcomes for small cohorts taking part just the one time. However, their principal value is that the learning they lead to can inform a sustainable, scalable approach.

As per Table 1, the pilot programs are generally meeting expectations, though there is room for improvements.

3c. How appropriate were programs in meeting the needs of older people and the aged care system?

Considering the stakeholder interviews and administrative data, the pilot programs appear to be largely appropriate in meeting the needs of older people and the aged care system. The stepped care approach offers more services to meet the demands of RACF residents. Some programs are also reporting improvements in staff welfare and increasing capability within the aged care system.

The pilot programs are collecting Kessler Psychological Distress questionnaire data where feasible. However, while this data was made available, in aggregate, for the evaluation, there were too few data points to make meaningful inferences on outcomes.

4. What can we learn from the delivery of the package?

The design and delivery of the pilot programs demonstrated the need for and importance of offering alternative mental health programs for older people in aged care.

Some of the pilot programs appear to be achieving better outcomes. This may be due to the time that has elapsed since implementation, meaning that there has been a longer time to observe outcomes. It is clear that the effectiveness of the pilot programs depends on engagement with RACFs and the number of resources available to support delivery.

As the programs mature, they are learning from their experiences and being supported by the PHN's flexibility in reporting and expectations. RACF engagement and stakeholder flexibility should both be considered in scaling up programs.

4a. What are the circumstances in which programs are most effective?

Programs were often most effective when the RACFs and pilot providers engaged well with each other. This engagement is impacted by the facility's location, size and staffing.

[8] See www.julianking.co.nz/vfi/pilot-roi.

When a facility was remote, this made it harder for providers to visit and engage in person with staff and residents. With limited FTE capacity, they were more likely to use virtual alternatives to avoid expensive travel time. In interviews, RACF staff expressed that in-person training and engagement was preferred where possible.

I would like to think that they would actually come to the facility, I know COVID has got a lot to do with that. […] I always find with education, if it's more one-on-one and they can actually show us how to plug [the device] into the TV rather than give us a diagram; I think that makes it easier for all the other staff members that are here as well. So if we actually had some one-on-one face to face education, I think that would be an improvement. – RACF staff interview

According to pilot providers, the size of an RACF impacted engagement in that there tends to be less engagement with RACF staff in facilities with larger resident populations. This is because these larger RACFs are more likely to have more staff and multiple levels of management, which can mean that providers do not have a regular RACF staff contact.

Related to this is staff retention. The high staff turnover in the sector impacts on an RACF's engagement with a program. Most pilot providers reported aged care staff turnover have a large impact on their ability to foster relationships with RACFs. One pilot provider indicated that their program worked most effectively when they were able to engage in the broader body of staff.

4b. Were there unexpected consequences of delivering the package of programs?

There have been a small number of unexpected consequences of delivering the package of programs, both on an individual pilot provider basis and more widely.

RACFs have reported improved staff wellbeing, which was not the key focus of pilot providers during the planning stages. This is most notable in the Grief and Bereavement Counselling program, which has found that much of its service delivery pivoted towards staff group sessions. These changes in programs and slight adjustments in targeted groups meant that the PHN had to be flexible in its reporting requirements and the support it provided.

The Moove and Groove pilot provider noted feedback from RACFs included improved staff wellbeing: 92% of their survey responses report an improvement in the quality of life of staff. This improvement was also reported in interviews with RACF staff.

4c. What factors should be considered in scaling up or expanding the programs?

There are several factors identified through interviews and in administrative data that should be considered in scaling up or expanding the programs.

Firstly, pilot providers were keen to express the need for additional funding, staffing and other resources if demand was to increase or the service was to be expanded. Some pilot providers felt that it was already hard to attract volunteers and staff to support their program and that this would be exacerbated if the program were scaled up.

Another consideration is the geographical location of RACFs and the time it takes to travel to more remote facilities. It can be challenging for providers to travel longer distances with limited FTE funding.

Additionally, capacity building within the sector and further training could be considered. The pilot providers indicated that they were continuing to learn and develop their programs as they mature in the network and collect feedback from residents.

A consideration highlighted in interviews with pilot providers was the possibility of a loss of information as RACF staff migrate to other positions, which is common in the sector.

In the initial round of interviews, pilot providers indicated that the reporting requirements were quite challenging and time consuming. In the more recent interviews, some providers said they had found efficiencies in reporting the required data. Others indicated that they were continuing to learn and implement ways to make reporting more efficient for them.

The PHN also indicated that reporting was generally a learning curve, and that it had noticed improvements over time. Reporting requirements should be considered if programs are expanded as the amount of reporting will increase.

There are also considerations about how the performance of pilot providers and future funding should be measured. The outcomes of services delivered to older people needs to be reported on consistently across pilot providers.

Finally, the ongoing impacts of COVID-19 should be considered, as well as the impacts of potential future pandemics and climate-related disasters. These events demand a certain amount of flexibility from pilot providers, and considering the large geographic region the PHN covers, they may significantly influence future success.

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