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Project Synergy (Phase 2) Implementation Evaluation:

Final Report Part A (Summary)

Implementing the Monitoring and Evaluation Framework for the development and trialling of the InnoWell Platform, as part of *Project Synergy* (Phase 2, 2017–2020)

Prepared for InnoWell

June 2020

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The Social Policy Research Centre is based in Arts & Social Sciences at UNSW Sydney. This report is an output of the evaluation of Project Synergy (Phase 2, 2017–2020), funded by InnoWell.

Suggested citation:
O'Shea, P, Bates, S, Katz, I, Gendera, S (2020), *Project Synergy (Phase 2) Implementation Evaluation: Final Report Part A (Summary).* Sydney: UNSW Social Policy Research Centre.

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Abbreviations

CALD	Culturally and linguistically diverse
CIS	Consulting and Implementation Services
CRC	Cooperative Research Centre
DoH	Department of Health
eMH	electronic (digital) Mental Health
LEAB	Lived Experience Advisory Board
LEAF	Lived Experience Advisory Function
LHD	Local Health District (NSW only, Local Health Networks elsewhere)
MEF	Monitoring and Evaluation Framework
NCCP	National Community Consultation Program

1 The evaluation of Project Synergy

InnoWell has contracted an evaluation team from the Social Policy Research Centre at UNSW Sydney to conduct the evaluation of Project Synergy (Phase 2, 2017–2020), which includes the development and trialling of the InnoWell Platform (previously known as 'Synergy Online System'), as well as the National Community Consultation program. The evaluation is based on the *Monitoring and Evaluation Framework for Project Synergy* (MEF; CIS, 2018) prepared by Consulting and Implementation Services through a process of co-design with InnoWell, service providers and the Lived Experience Advisory Board (now Lived Experience Advisory Function).

This report is a summary of the findings from the evaluation. The full report (Part B) presents the findings with supporting data.

The report is the output of a partnership between the evaluation team and InnoWell (including the R&D team subcontracted from the University of Sydney), the Lived Experience Advisory Function (LEAF; members with lived experience of mental ill-health), and health service providers. The evaluation itself was subject to co-design, and the findings have been validated with InnoWell and LEAF.

1.1 Evaluation questions

The evaluation was designed to answer the following question:

Using a co-design approach, to what extent has Project Synergy enhanced mental health service access and quality?

The *Monitoring and Evaluation Framework* (CIS, 2018: 12), prepared as part of Project Synergy, identifies five domains and specific questions related to each domain – relating to policy, process, outcomes, impact and value.

Policy	To what extent has Project Synergy maintained alignment and consistency with the broad mental health policy agenda and context?
Process	To what extent have the collaborative approach and methodologies used in Project Synergy been well-conducted?
Outcomes	To what extent did Project Synergy have an effect on access to and quality of mental health service delivery?*
Impact	To what extent did Project Synergy provide learnings that have informed and influenced policy and practice in mental health services; and To what extent has an impact on the everyday lives of people with lived experience of mental ill health using InnoWell Platform-enabled services been observed?
Value	To what extent did Project Synergy deliver value, in relation to the total investment by all stakeholders in the project?

*Clinical outcomes are outside of the scope of this evaluation.

1.2 Scope of the evaluation

Phase 2 of Project Synergy (2017-2020) involved the co-design and trial of the InnoWell Platform across different mental health services that provide supports for different conditions and different demographics.

Within the evaluation period, the InnoWell Platform was customised and configured to the population and settings for a number of health services (hereinafter referred to as trial sites). Each is subject to an impact evaluation study by the InnoWell R&D team (this is different to the one clinical trial which aims to validate the InnoWell Platform scientifically, clinically and analytically). InnoWell describes this as a technology-enabled solution, in that the process of service mapping, co-design and configuration of the Platform to the health service leads to more outcomes than the Platform achieves alone. The scope of the evaluation includes the co-design and development of the core InnoWell Platform, the trial of the InnoWell Platform in the health services (trial sites) where all steps of the trial were completed, as well as the National Community Consultation Program (NCCP) that was delivered to support Project Synergy during this period.

Trial	**Focus of service**	**Go Live date***
Open Arms	Veterans and their families in Sydney (with other sites planned in the future)	February 2019
North Coast PHN (headspace cluster)	Young people in Tweed Heads, Lismore, Coffs Harbour, Port Macquarie, and Grafton (not included in the evaluation as co-design was not complete at the time of the evaluation)**	Port Macquarie – February 2019 Coffs Harbour – May 2019 Lismore – May 2019 Tweed Heads – July 2019
The Butterfly Foundation's National Helpline (EDHOPE)	To provide support for people experiencing eating disorders and body image issues	July 2019
Kildare Road Medical Centre	General population accessing mental health supports through GPs	January 2020.

* The 'go live' date is the date consumers were able to start using the Platform in the health services. Note that co-design activities commence earlier than this, including service mapping and user testing.

** Note that during the validation exercise, it was noted that the Grafton site now wants to engage in the trial process. (Project Synergy).

1.3 Approach and methodology

Our approach throughout this evaluation has been to minimise the burden on health services and consumers of health services. Therefore, the evaluation has:

- Prioritised the use of existing data
- Where appropriate, amended existing data collection to address data requirements

- Collected new data through interviews, workshops and surveys with InnoWell teams and stakeholders where required.

The evaluation was conducted in parallel to the ongoing development of the InnoWell Platform and the implementation of the trials.

The evaluation involved a number of different methods including:

- **A desktop review of the policy and literature**, focusing on (1) the use of technology to support mental health services, and (2) the role of co-design in developing mental health services and how to measure its' success.

- **Workshops** with the InnoWell team and LEAF Working Group to understand the InnoWell Platform and co-design.

- **A review of documentation** about the project governance, Project Synergy, the InnoWell Platform and trial sites**.**

- **Interviews and focus groups with stakeholders** about their experience with Project Synergy, the trials and the NCCP. A total of 42 individuals participated in interviews or focus groups, including six from service providers, 18 from Project Synergy (including nine working directly with trial sites), nine from LEAF (seven from the Working Group and two Panel members), and nine other stakeholders (including steering committee members and two with experience of other e-health projects).

- **A survey of co-design participants** (n=51) about their experience in collective engagement and collaboration across different aspects of the project (informed by the literature review).

- **A review of Platform data** for the trial sites in scope of this evaluation.

1.4 Context of the evaluation

There are a number of factors which need to be taken into account when reading this report.

- Much of the conceptualisation of the Platform and approach to Project Synergy were completed under Project Synergy Phase 1 (2014-2016), the precursor project funded through the Young and Well Cooperative Research Centre (CRC). Phase 1 is outside the scope of this evaluation – no comment can be made on the acceptance or co-design of the approach prior to the commencement of Phase 2.

- The evaluation was adjusted to the progress made in Phase 2 of Project Synergy. Some of the trial sites commenced later than expected, therefore data from the Platform development and use in each trial location varies. While the R&D team reported that co-design had occurred with all demographic groups, the Platform had not been implemented in all services. A decision was made by InnoWell that this evaluation would only include health services where the Platform had been co-designed and trialled in the health service.

Therefore, this evaluation does not include sites across the variety of demographics or life-course as originally intended.

- Each trial site implements the InnoWell Platform differently which influenced how the process of implementation impacted on services. For example, some sites use the Platform for triage purposes to determine who can be treated within their primary care model and who needs secondary care (which may be outsourced).

- At the time of the evaluation, no data was available about the demographics of service users in each trial site to establish a benchmark for uptake of the Platform by consumers in the health service. Therefore, the findings of the evaluation are based on stakeholder's perceptions rather than quantitative measures. At the time of reporting, the number of consumers using the Platform in each site was too low to allow for detailed statistical analysis about the factors that may be associated with Platform use. The data could not be analysed across all sites together due to the different way the Platform had been implemented in each health service.

- To reduce burden on consumers, we relied on Platform use data to understand how the Platform is being used by consumers of different services. However, due to the number of consumers using the Platform, detailed analysis of their characteristics and how they used the Platform (through Google analytics) could not be undertaken at this time.

- In the absence of a standard measure of co-design, the evaluation team developed a survey instrument, informed by prior literature, to capture whether co-design has been implemented as intended. However, we note that this instrument is novel and will need to be tested further.

- This evaluation focuses on the process of co-design rather than the outcomes of the trials themselves which will be reported on separately by the R&D team. The original design of this evaluation intended to incorporate outcomes reported elsewhere; however, the trials have been extended for 12 months and as such this information is not available to this evaluation.

- Many of the challenges faced by InnoWell to date are faced by the adoption of any new technologies in service systems. At this point, it is very difficult to disaggregate whether these are inevitable 'teething' issues faced by new technology uptake in any domain, or whether there will be significant challenges to the uptake of the InnoWell Platform in the medium and long term.

2 Key findings

2.1 Policy alignment

Evaluation question: To what extent has Project Synergy maintained alignment and consistency with the broad mental health policy agenda and context?

2.1.1 Alignment with mental health reform agenda

Overall, Project Synergy aligns with the government's mental health reform agenda, supporting key initiatives including early intervention and prevention (including suicide prevention), holistic, integrated and stepped care, improved service delivery, lived experience participation, person centred practice, and ongoing policy reform.

- Project Synergy aligns with the policy of **early intervention and prevention**. The Platform is particularly useful where the service configures the Platform to identify, escalate or triage consumers who require early intervention, and supports this with early response. Early intervention and prevention are limited to those consumers who engage with the Platform, which is contingent on health services using the Platform, consumers being invited to use the Platform, and the experience being positive. There was some evidence of **improvements in service delivery;** participation in Project Synergy provided an opportunity for health services to review and consider how they support consumers through a process of service mapping.

- **Lived experience participation** was strongly supported centrally in Project Synergy through the LEAF and through the design and implementation of the National Community Consultation process. It was reported by some participants in the evaluation that lived experience participation varied across trial sites; the co-design processes that included people with lived experience increased the awareness of the importance and effectiveness of lived experience participation.

- While Project Synergy is implementing many aspects of mental health reform, participants were unclear of its potential to contribute to **ongoing policy reform,** at least until the trials were completed and the clinical outcomes known. There have been many learnings in the process of building the InnoWell Platform in Project Synergy, and there is an expectation that these learnings will inform further policy and service reform. Nevertheless, Project Synergy was perceived by some evaluation participants to be a lower priority for policy makers now than it had been when first initiated by the Department of Health. The policy impetus for fundamental system reform was also viewed by evaluation participants to be low. However, as one participant noted, there is already a noticeable shift towards greater acceptance of technology enabled service reform in response to COVID-19.

2.1.2 Alignment with other policy drivers

In addition to mental health reform, Project Synergy shows alignment with other policy drivers, including co-design and digital health.

- **Co-design** has been the underlying philosophy of Project Synergy, bringing together researchers, technicians, clinicians and people with lived experience to develop and implement

a health information technology for mental health. There is strong evidence of collaboration, shown in project documentation, and participants expressed significant goodwill in the co-design process. One of the challenges highlighted by participants, has been the different perspectives and understandings of what co-design is and conflicting interests and views. This includes what co-design involves (and does not involve), what can be co-designed, and when co-design is appropriate compared with other forms of collaboration or consultation. Participants highlighted that many lessons were learned about the nature of co-design, the processes involved, and the resourcing requirements during Project Synergy, and these have the potential to inform policy and further research in this area.

- The InnoWell Platform was perceived by most participants in the evaluation as primarily a form of health information technology (or **digital health**), that puts consumers in control of and manage their health information, allows services to manage health information, and provides links to tools that can help a consumer improve their wellbeing. Participants felt strongly that there are many advantages to the use of digital health solutions in the provision of mental health services, including as an assessment tool for triage, as a non-confronting way for people with mental health challenges to give and receive information with health professionals, and as a way to increase the reach of health services to rural and remote areas. Some participants highlighted that the implementation of the Platform was intended to bring about system transformation in health services. There was some evidence of this, with some trials reporting changes in intake practices to use the InnoWell Platform for assessment and triage and this may have increased reach and access in some areas.

- The landscape of health information technologies in the mental health space is complex and many participants believed that it is unclear where the Platform sits in relation to other technologies, and whether similar technologies exist to compare it to. Health information technologies must align or work within health services and their program delivery requirements, such as the minimum data set and other clinical requirements, as well as meet strict requirements on the security of personal information. This was addressed through service mapping workshops in each of the trial sites.

- The perception from some participants was that this was another technology, rather than system or business transformation, that did not necessarily work well with existing processes and technologies. However, other participants asserted that health services were wedded to existing systems and processes rather than thinking about fundamental changes to meet the needs of consumers. Notably, service models are rapidly changing in response to COVID-19 which is likely to greatly increase the use of digital health approaches (Australian Government DoH 2020).

2.1.3 Sector alignment

Mental health services are provided by both Commonwealth and States and Territories, either directly or by contracting third parties to deliver services on their behalf (in the case of Commonwealth funding, this is managed through 31 Primary Health Networks). Health information technologies need to align to this sector and their needs, and also the funding context.

- **Funding of mental health programs**, especially those that are commissioned by government, are often relatively short-term – between 1–3 years in duration. Program funding is fragmented and often has limited resources available for operational overheads, such as the purchase of digital health solutions. This was perceived by some participants to be a key barrier to the uptake of the Platform in services.

- The **needs of the mental health sector** are based on the services they are funded to provide – programs can and do change, as do the way they are commissioned (in terms of the contractual reporting requirements). Participants highlighted that services have multiple systems that manage health information, track contractual reporting requirements, and manage case file information – some of which are provided by the funders themselves. Some participants in the evaluation highlighted that services are not open to having an additional system that clinicians are required to use. In addition, how services operate is also often related to the culture of professions within the service rather than the needs of consumers; this extends to the willingness to share health information (Keeley, Bullen, Bates, Katz, & Choi, 2015).

2.1.4 Overall policy alignment

- Project Synergy meets a number of mental health policy objectives, including providing links to e-mental health (eMH) solutions; incorporating lived experience into the co-design of the Platform and user testing, communication and promotion of the Platform; and placing the user at the centre and in control of their care, managing their mental health in partnership with their health professional, (while also enabling others to support them).

- There is continued support for and promotion of eMH solutions at a policy level; our analysis suggests that the InnoWell Platform is a tool that auspices and supports service provision, rather than provides an eMH intervention alone. For this reason, it may not necessarily fit one objective neatly; yet in principle, it meets many of the standards of good mental health care.

- There are some inherent tensions in eMH policy itself. In particular, there is a tension between providing a 'joined up' service experience for consumers, where information is passed on to different providers as the consumer progresses through the system, versus the market-based approach to service and Platform funding, which inevitably leads to fragmentation and difficulties for consumers who might access several providers being required to use and provide input for multiple systems. These issues are being addressed in different ways in the trial sites, but are broader contextual factors that may impact on the uptake and use of the InnoWell Platform and are outside of Project Synergy's control.

- The evaluation has found that Project Synergy, and the uptake of the InnoWell Platform, may be constrained in the absence of broader support and integration with other policies and programs; for example, short-term funding of health services, restrictions on expenditure on overheads, and fragmented service landscape. The trial of the Platform in a General Practice is different in that it provides mental health consumers an opportunity to use the Platform at their first point of contact with health services – who can then potentially use to the Platform to support access to other health services.

- Project Synergy aims to embed co-design throughout the development and trial of the InnoWell Platform. Project Synergy reports that user testing has been adapted from methods used in marketing and software development.[1] Although in this case, user testing also involves how the Platform is used within the service context (not just stand alone). It is unclear the extent to which co-design will be used beyond Stage 2 of Project Synergy and the trials included in this evaluation.

- The InnoWell Platform supports the stepped care model, promoted by the National Mental Health Commission, through the triage and management of service users according to their individual needs which may change over time. Currently, the trials (within the scope of this evaluation) are limited to single health services – the Platform may therefore be more useful to mental health consumers where stepped care is provided within a single service, as opposed to when stepped care requires consumers to change services (this is contingent, for Commonwealth funded services, on how each of the 31 PHNs commission mental health services under the stepped care model).

2.2 Process of collaboration

Evaluation question: To what extent has the collaborative approach and methodologies used in Project Synergy been well-conducted?

This section reports on the extent to which participants perceived the collaborative approach and methodologies used in Project Synergy had been well-conducted and differentiated the project. This relates to the strategic management of the project, the co-design of the InnoWell Platform, the co-design of the trials, the effectiveness of trial partner and site engagement, and the quality and usefulness of the national community consultation.

2.2.1 Strategic management

- Project documentation demonstrates that **lived experience** was incorporated in all levels of governance for Project Synergy, from the Steering Committee that provides oversight, through to the executive team at InnoWell. However, as one participant highlighted, there was a lack of diversity in other areas, such as Aboriginal representation on the steering committee. LEAF uses a diversity matrix to ensure representation and diversity, and recruited members to address any gaps in lived experience.

- Within InnoWell itself, merging the cultures between R&D, lived experience and the commercial nature of the organisation was acknowledged by participants as being one of the greatest challenges, and something that improved over time.

2.2.2 Co-design of the InnoWell Platform

- Co-design has been evident across the duration of the project, although participants highlighted it has not been without challenges and reality has not always matched intent. The way lived experience was incorporated changed over time in both the way it was

[1] See MJA 211 (7 Suppl): Chapter 2. (doi: 10.5694/mja2.50349).

organised, in particular, through the change from LEAB to LEAF and the associated working group, and the way it functioned.

- Some evaluation participants noted that it was difficult to see where and how they could influence the project, particularly given this was Phase 2 of the project and the Platform was already well developed; this left some people feeling that they were being consulted rather than included in the design process. It was felt that this was addressed with changes to the organisation of lived experience within the project (from LEAB to LEAF); most LEAF Working Group participants felt they had a greater contribution to the development cycle of the Platform, although there still appeared to be some issues with engagement with LEAF Panel members. Overall, the lesson learned by InnoWell is that it is crucial to be transparent about what is in scope and what is not in scope in the co-design process, and to be clear about the decision-making processes.

- Many participants of the evaluation, across different groups, indicated there were different understandings of what co-design means and how it should be practised; this was more fully understood and collectively articulated over time. The changes demonstrated organisational learning and agility; the value of the expertise lived experience brought to co-design increased over time as the understanding and value of co-design grew across the Project. This was evidenced in the work of LEAF integrating lived experience and appropriate language across organisational processes and communications, including induction packages for new staff.

- How different disciplines within InnoWell collaborate has also improved overtime. Early in the process, roles and responsibilities were unclear across the different disciplines; this has progressed to more collaborative approaches over time. Participants of the co-design survey developed for this evaluation, attribute stronger, more effective working relationships to: the smaller LEAF Working Group, more regular meetings, clearer roles and expectations, and a more collective understanding of what co-design is. The co-design survey showed that most respondents who participated in co-design felt the process was effective and worthwhile.

2.2.3 Co-design in the trial sites

- While some collaboration at the trial sites was evident, the inclusion of people with lived experience in co-design was reported to have less impetus at some trial sites as it did at the core of the project. While this was largely attributed to the difficulty in reaching and recruiting people with lived experience locally and providing resources to support their engagement, at some trial sites people with lived experience were reported to have been excluded from initial design forums. For example, it was considered important by some participants in the evaluation to first co-design with service staff to map the service and tailor the Platform to meet their specific program needs; people with lived experience were then included in subsequent consultations. The exclusion of people with lived experience in the initial design meetings would appear to undermine co-design ethos. However, when people with lived experience were included in the design processes, service providers and Project Synergy staff valued their contributions, and some thought they could/should have been included sooner.

- At one trial site, evaluation participants perceived the co-design process, and in particular the need to continually engage senior management of the health service, made the implementation process longer – particularly when those stakeholders were busy and took time to respond. This was exacerbated when stakeholders that had been engaged left and new people needed to be brought up to speed. This illustrated some of the practical challenges in co-design processes that had implications on the timing (and consequently resourcing) of the trials.

- There were also concerns expressed by some participants about the limited changes that could be made to the Platform at individual trial sites, highlighting that perhaps expectations were not managed or articulated as well as they should have been at the beginning or through the co-design process. Feedback from trials was incorporated into a pipeline of improvements for the Platform overall and some adjustments were made to accommodate service needs.

- Overall, it was acknowledged that InnoWell staff learned a lot through the co-design process at the trial sites, in terms of both Platform configuration and the co-design process.

2.2.4 Effectiveness of trial partner and site engagement, and clinician education

- Fewer health sites engaged in the trials than were anticipated. Most were engaged through existing relationships in the sector. At the time of writing, some health services were not willing to engage longer-term, particularly when the timing of trial or purchase arrangements did not coincide with service funding arrangements and they could not afford to purchase the software independently. However, one stakeholder highlighted that discussions with the InnoWell team had led them to strategically review their information technology needs.

- The trials were subject to a number of delays which caused some frustration with service providers. Many of the delays were due to the lack of embedded systems and processes within InnoWell, associated with being a new organisation. Prior to Therapeutic Goods Administration (TGA) registration, an additional contract was required between the health service and the University of Sydney, this added to delays. This has now been resolved through tripartite agreements between the University of Sydney, InnoWell and the health service. One participant highlighted that health services did not always have legal counsel in house, adding to the timeframe for entering into agreements. Following the introduction of the tripartite agreement, they added that the duration of the contracting process had halved.

- While health services signing up to the trials appeared to be engaged at an executive level, this did not always filter down to clinical staff; evaluation participants suggested that clinicians were not using the Platform as much as anticipated, with many suggesting that the Platform was a significant cultural shift in the way front line staff worked. Some participants in the evaluation also had concerns about the tone of the Platform appearing to be more problem than strengths focused, and that negative feedback might be demoralising to some users (note the presentation of results is different depending on whether it is the clinical tool, where clinicians need to know what the priorities are, or the health and wellbeing version of

the tool). It is concerning, however, that these matters were not resolved through the co-design process.

- The number of clinicians and consumers using the Platform was reported anecdotally as low. While figures are available on its use for each trial site, they are difficult to interpret without understanding the capacity of the service to take on new consumers, how the service tried to engage consumers to use the Platform, the number of consumers and clinicians invited to use the Platform, and the expected uptake. Each organisation decided to use the Platform in different ways; only one health service, part of a previous trial and not within the scope of the evaluation, had mandated the use of the Platform. However, during the report validation process, it was reported to the evaluation team that this was changing rapidly, in part due to COVID-19, and in part due to experiences in using the Platform.

2.2.5 Quality and usefulness of the National Community Consultation Program

- The National Community Consultation Program (NCCP) was delayed after a false start and recommenced in late 2018 (LEAF NCCP: End of Phase 2 Summary Report). While too late to influence the design of the Platform, it was still considered worthwhile with the key question being: 'How might digital products and engagement change the way people experience their mental health care and wellbeing?' (Muller 2019).

- The NCCP was conducted face to face during various organised and special purpose events and through an online forum (*Bang the Table*). The process and each engagement were co-designed with the LEAF Working Group to identify optimal methods of engagement with different communities. This process built the capacity of LEAF and also recognised the contribution of people with lived experience by reimbursing them for their time. This helped to raise the expectation that lived experience is recognised and valued part of any mental health project.

- The NCCP was perceived by some stakeholders to help not only build the credibility of the Platform in the community, but also provide access to the community that may have otherwise been closed to researchers. Participants were keen to see how their contributions were used, or receive feedback.

- The *LEAF NCCP: End of Phase 2 Summary Report* states that Phase 2 NCCP 'learned about different user journeys, in particular how different communities and populations groups gain access to digital mental health. What barriers they face when they are seeking access and what makes them trust a service or consider an online solution'.

- This report indicates that all Platform related feedback and learnings were delivered to the Product Development team who include it in the product development re-engagement working group. NCCP data has also been used by an internal language and tone co-design working group, to inform the co-development of a language style guide, along with a check of all current content.

- Learnings about process were discussed at the LEAF Working Group to further NCCP planning. Some examples of process learnings include, consulting peer workers, recognising

the importance of language, changing the digital strategy such as translating into other languages to increase reach.

2.2.6 Overall process of collaboration

- The data collected indicates that LEAF participants overwhelmingly agree that the collaborative approach and methodologies used in Project Synergy have been well conducted. LEAF Working Group members reported that there had been some issues earlier on in the process they described this a learning opportunity and that they were pleased with how the Working Group now operated and in their level of participation and influence. Working Group members told us that they felt part of the wider Project Synergy Team and their views were sought and valued by Innowell staff.

- The uptake of collaborative methodologies has been contingent on the leadership and organisational support for the trial. Where there was strong leadership and support for the trial, the uptake of collaborative methodologies has been good and the feedback and involvement of participants was positive; the process was considered to be useful for tailoring the Platform to the individual service. In trial sites where there was less consistent support for the trial (for a range of factors, including change in leadership, lack of internal consultation, and lack of initial support from staff to implement the change) the collaborative methodologies were much slower, less attended and less consistently attended. This also had implications for subsequent Platform use.

- The data collected to date shows that implementation of the Platform, and collaborative design methodologies, require substantial leadership, change management processes, understanding, resourcing and ongoing training and education concerning the purpose and potential gains/benefits at all organisational levels.

- The data suggests that the technology solution needs to be implemented with three groups in mind: service/organisation (KPI, reporting systems, service delivery model, e.g. to manage intake and assessment); the clinicians and staff (in the way they deliver mental health care, monitor outcomes, assess risks); and the mental health consumers (in how they use technology, wish to remain engaged with a service/ an assigned clinician, concerns consumers have about sharing their data and privacy, if they experience or/see a personal gain/benefit to completing comprehensive assessments). The data also suggests that meeting the diverse needs and inherent tensions between the groups can prove challenging to the implementation of the InnoWell Platform in the future, or e-technology more widely.

- The implementation of the Platform will impact on the delivery, resourcing, and administration of mental health service in the respective trial services. In trial services where one or more of these factors were present – leadership, buy in from staff, service model alignment – staff/clinicians see the Platform as supportive to their work and to the wellbeing and care of the mental health consumer.

2.3 Experience using the InnoWell Platform

Evaluation questions: To what extent did Project Synergy have an effect on access to and quality of mental health service delivery?

This section looks at consumer and health service staff experience of using the Platform. Clinical outcomes are outside of the scope of the evaluation.

2.3.1 Consumers

- Uptake of the Platform is reported anecdotally by participants as low. This is likely to be for a number of reasons, including but not limited to:
    - Delays in implementing the trials
    - Differences in how the service implements the Platform
    - Service capacity to support new clients (one service is at capacity and is therefore not taking on new clients)
    - Consumers access to IT resources (computer/phone or access to Wi-Fi)
    - Performance issues with the Platform.
- Despite the lower than expected number of consumers using the Platform at the trial sites included in this evaluation, the Platform data shows attrition of users between the time of invitation, registration on the Platform (in some cases as links expired), and then completion of the different assessments required. We are unable to determine whether this is a natural level of attrition, or due to other factors. At the time of reporting, data was not available on the manner or length of subsequent engagement.
- It is difficult to ascertain user experience of the Platform as, at the time of reporting, there was no feedback mechanisms for users to share their experience. This was discussed early in the evaluation process as something that was likely to happen; however, there was no evidence of this to date. Health services consulted also highlighted that they would like more information about consumer experience with the Platform.
- The initial levels of uptake may have simply been a reflection of any new technology being implemented in service delivery. All new technologies have fast adopters and others who take up the technology later on. This is particularly the case when the technology is not mandated.

2.3.2 Health service staff

- Health service staff reported variations in the use of the Platform from one service to another and also within services.
- There were some examples where health professionals found that the Platform confirmed something they may have known or suspected about the service user. Some found the

Platform helped facilitate the conversation with the service user as it helps the service user to come to the realisation themselves.

- Some health service staff reported they found the tools on the Platform useful and have incorporated them into the client's care-plan. Some service users found using the Platform transformative, whereas others thought it was just an added extra to offer service users. The difference in these views appeared to depend on how their service used the Platform and how embedded it was in practice and across the service.

- Some barriers to health service staff using the Platform included: not fitting the service model; pushback about using another online system; concerns about risk to service users coming to a realisation of mental health issues while using the Platform without direct support at hand, despite potentially accessing services earlier than without the Platform; that the Platform requires time to learn and implement; and lack of support or mandate to use.

2.3.3 Results from user testing

Prior to the service 'going live', people with lived experience, clinicians, and other service staff including managers and administrators, were involved in user testing which was used to make improvements to and configure the Platform for the specific health service.

- Participants involved in the evaluation identified many benefits to the Platform, including: being able to store information in one place, being able to share information with their GP, seeing the dashboard (although not everyone liked this), being able to prioritise their needs and access non-clinical care options, having more control of their care, and not having to repeat their story.

- There were also aspects that were not liked, including: difficulties for some people navigating the Platform, being deficit focused, being confronting (the dashboard potentially making people feel worse, the instruments being unsuited to completing alone at home), and feeling worried about confidentiality.

- Recommendations included: making the language more recovery oriented and strengths focused, improving tracking, increasing flexibility, and listing good results before bad ones for the dashboard seen by the consumer.

2.3.4 Overall effect on access to and quality of mental health service delivery

There are benefits of a streamlined and early comprehensive assessment of consumers accessing a service for the first time. There were reports that the Platform had enabled the early identification of high-risk mental health consumers who were new to the service and were subsequently offered more immediate care. As the uptake of the Platform has been lower than expected and there was no mechanism to capture service user experiences, it is not possible to make any definitive conclusions about equity of access or consumer experience.

2.4 Impact on health services

Evaluation questions: To what extent did Project Synergy provide learnings that have informed and influenced policy and practice in mental health services. To what extent has an impact on the everyday lives of people with lived experience of mental ill health using InnoWell Platform-enabled services been observed?

One component of Project Synergy was to work with health services to map services. This was used to inform how the Platform would be configured for the service, but also provided an opportunity to stop and reflect on the way it organised and delivered services. This had a number of positive impacts on health services including:

- Incorporating lived experience into health service design
- Conducting a more holistic review of health information technology needs
- Changing intake processes, supporting triage and follow-up and reducing the time associated with each step
- Allowing information to be provided prior to the first consultation to enable service to start working with the service user sooner.

2.4.1 Overall impact on health services

- There is yet limited evidence on the impact of the InnoWell Platform on practice in most trial sites – either because the Platform has not been implemented (trial sites that chose not to engage), the implementation and assessment of its impact is not complete, or changes are being undertaken to the Platform and its implementation (e.g. how and to whom the Platform is being offered).
- Selected trial sites reported a direct impact of the collaborative methodologies on their service. For example, one service examined reflected on the intake and access pathways of new clients, and redesigned and streamlined their processes as a result of being involved in Project Synergy.
- Another stakeholder saw the value of products such as the InnoWell Platform, but was in the process of identifying their own system requirements that addressed their specific needs.

2.5 Overall perceived value of Project Synergy

Evaluation question: To what extent did Project Synergy deliver value, in relation to the total investment by all stakeholders in the project?

The value of Project Synergy is multifaceted:

- Over the duration of Project Synergy, much has been learnt about co-design and incorporating lived experience in the design of the Platform and how it is implemented in different services. This has been a learning curve for InnoWell as an organisation; it has

shown great agility in adapting in response to experience and to emerging findings. While the intent was always to embed co-design throughout the project, this has improved considerably by learning from experiences over the life of the project. In particular, the LEAF is currently working well and lived experience is being incorporated across many aspects of the project, although there is still opportunity to improve. The co-design process was seen not only as key to the design of the Platform, but also as a point of difference and a 'selling' point for the project and the Platform.

- In terms of the trial sites, implementing the Platform has been in many ways a useful process for the health services and has opened up opportunities for other areas of improvement. That said, there needs to be a cultural shift in the way health information technologies are used in the provision of mental health care, and consolidation of IT systems in organisations to remove the many frustrations clinicians have of needing to switch between multiple systems. In an ideal world, the health services would have a system that manages case notes, reporting requirements and enables consumers to control their own care; in reality, there are multiple systems, with some overlap and potentially some gaps. In the service environment health services operate in, with short-term funding cycles and low operational budgets, it is unlikely that they will invest significantly in health information technologies themselves. Some funders (including PHNs) also provide software to be used for certain services, adding to the systems being used. The perceived value of the InnoWell Platform is therefore undermined by the requirement to use other systems to collect and report data.

- In terms of consumers, the evaluation was not provided with sufficient data to draw any conclusions about the value to their treatment and their outcomes.

- It should be noted that the capacity of LEAF has grown and it may be that LEAF members are able to take these learnings to other services and initiatives more broadly.

- Overall, most stakeholders believed that InnoWell offers an improved service experience for consumers who engage with the Platform, and that the Platform offers the potential for a more consumer focused and evidence-based e-mental health service. However, the Platform has had a mixed response particularly by practitioners, many of whom have, at least initially, perceived it as adding another administrative burden to their work.

- The co-design process is key to the success of InnoWell. Many lessons were learned during the trial about co-design which are relevant for a range of e-mental health solutions and mental health programs more generally. However, there was consensus that co-design is a 'journey' and there are still lessons to be learned.

2.6 Opportunities for future co-design and e-mental health solutions

The knowledge developed through Project Synergy, about co-design and the development of e-mental health solutions, is valuable and when shared, will no doubt be able to contribute to reform and improvement in this space. The project has benefited from adequate resourcing, including the LEAF, and it must be highlighted that this success is in part due to resourcing and in part due to the

commitment to and leadership of the lived experience function as a core and integral component of the Project.

The key lessons for future co-design relate to:

- Being clear about what co-design means, what co-design is best suited to, and best way to conduct co-design for all parties involved
- Being clear about expectations and decision rights
- Adequately resourcing co-design as an integral part of the project – not just in terms of remuneration, but also in terms of additional time required

References

Australian Government DoH (2020) COVID-19 Bulk Billed MBS Telehealth Services. 30 March 2020. MBS Factsheet https://www.health.gov.au/sites/default/files/documents/2020/04/bulk-billing-incentives-australian-government-response-to-covid-19-covid-19-bulk-billed-mbs-telehealth-services_0.pdf

Ian B Hickie, Tracey A Davenport, Jane M Burns (2019) Project Synergy: co-designing technology-enabled solutions for Australian mental health services reform MJA Supplement October 2019 211(7)

Keeley, M., Bullen, J., Bates, S., Katz, I., & Choi, A. (2015). Opportunities for information sharing: Case studies (Report to). Social Policy Research Centre, UNSW Australia, Sydney

Muller, S. (2019) National Community Consultation Program InnoWell, Updated March 2019