

Mental Health Community Support Services Evaluation

Executive Summary

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Acronyms

Acronym	Definition
CALD	Culturally and linguistically diverse
COVID-19	Coronavirus Disease 2019
GBPRSP	Group-based Peer Recovery Support Program
HHS	Hospital and Health Service
HREC	Human Research Ethics Committee
IRHP	Individuals at Risk of Homelessness Program
IRSP	Individual Recovery Support Program
LGBTQI+	Lesbian, gay, bisexual, transgender, queer, intersex, and other orientations not listed
MHAODB	Mental Health, Alcohol, and Other Drugs Branch
MH CSS	Mental Health Community Support Services
MH NGOE NBEDS	Mental Health Non-Government Organisation Establishment National Best Endeavours Data Set
NDIS	National Disability Insurance Scheme
NGOs	Non-government Organisations
QCMHR	Queensland Centre for Mental Health Research
RBWH	Royal Brisbane and Women's Hospital
RE-AIM	Reach, Effectiveness, Adoption, Implementation and Maintenance
SEM	Socioecological Model
SG	Steering Group
TCFP	Individual Recovery Support – Transition from Correctional Facilities Program
UQ	The University of Queensland

Glossary

Acronym	Definition
RE-AIM Framework	The RE-AIM (Reach, Effectiveness, Adoption, Implementation, Maintenance) framework provides a practical means of evaluating health interventions. This framework was developed by Glasgow et al. (1999).
Socioecological Model	The Socioecological Model is a framework put in place to understand the multifaceted levels within a society and how individuals and the environment interact within a social system. This model was developed by Bronfenbrenner (1979).

Executive Summary

1. Background

Mental Health Community Support Services and Evaluation Commissioning

In Australia, it is estimated that 54% of people diagnosed with a severe mental illness do not receive adequate treatment (Whiteford et al., 2014). Severe mental illness is characterised by individuals experiencing a mental, behavioural and/or emotional disorder with episodic, recurrent, or persistent features that result in severe impairment (Baker et al., 2018; Parabiaghi et al., 2006). Causes of this treatment gap for individuals with severe mental illness are often due to poor integration and communication among mental health service providers, and a dearth of targeted and effective mental health programs (O'Donnell et al., 2020; Saxena et al., 2007). Community-based mental health care for people living with severe mental illness helps to address this concerning treatment gap by providing accessible and diverse services within individuals' own communities (Rosen et al., 2010).

In Queensland, prioritisation and investment in community-based mental health services for individuals with severe mental illness is a key aspect of the Connecting Care to Recovery 2016-2021 plan (Queensland Health, 2016). This included additional investment in Mental Health Community Support Services (MH CSS), which are non-clinical, holistic recovery-focused psychosocial wraparound support services delivered either one to one, peer to peer, or within a group, based on an individual's recovery needs (Queensland Health, 2016). There is an array of service offerings under Queensland's MH CSS programs including four core MH CSS programs across several of Queensland's Hospital and Health Services (HHSs) as well as specialist and state-wide MH CSS programs. The four core programs described below are in scope of this evaluation project:

- The **Individual Recovery Support Program (IRSP)** is an individualised program where psychosocial support is structured, purposeful and tailored to meet specific recovery needs and goals. The IRSP is also complemented by concurrent eligibility for the Group Based Peer Recovery Support Program.
- The **Group Based Peer Recovery Support Program (GBPRSP)** is intended for individuals linked from the IRSP and gives individuals access to group-based peer-led activities. Activities are led and self-managed by peer workers and aim to empower and support the person by working through group processes and sharing life experiences with others who have similar experiences.
- The **Individual Recovery Support -Transition from Correctional Facilities Program (TCFP)** is specifically delivered to individuals about to be released from a Queensland adult correctional facility who have been referred to the MH CSS program by a Prison Mental Health Service. This service offers non-clinical psychosocial wraparound support to a person at least 2 weeks prior to release from the correctional facility (when the date is known) and for up to 12 months post-release.
- The **Individual at Risk of Homelessness Program (IRHP)** is tailored specifically to individuals residing in a boarding house, crisis accommodation or hostel. This program offers non-clinical psychosocial wraparound support focused on breaking the cycle of homelessness and supports development of skills enabling individuals to transition to secure and stable tenancy and housing.

Individuals living with persistent severe mental illness aged 18 years and over (with a priority given to those not eligible for National Disability Insurance Scheme (NDIS)) are referred into MH CSS through recent or current access to mental health clinical care delivered by Queensland HHSs; this includes Community Treatment, Community Bed-Based, and Hospital Bed-Based services. The MH CSS programs are delivered through non-government organisations (NGOs) across Queensland's HHSs and are an integral service system component along a continuum of care within an individual's local community.

Across the four MH CSS programs that are funded in 14 HHSs across Queensland, 14 separate NGOs are contracted to deliver services. As part of the commissioning of these four MH CSS programs, Queensland Health's MHAODB committed that an independent evaluation would take place. The Mental Health Evaluation Stream at Queensland Centre for Mental Health Research (QCMHR) was engaged as the independent evaluators.

2. Aims

The aim of this evaluation was to determine the efficacy of the four MH CSS programs across all NGO and HHSs in Queensland using the Socioecological Model (SEM) and Reach Effectiveness Aim Implementation Maintenance (RE-AIM) framework; the factors that affect their efficacy (program level process and individual outcome level); and to provide recommendations as to how they can be improved as part of ongoing service improvement (Bronfenbrenner, 1979; Glasgow et al., 1999). Additionally, the evaluation will help inform future development and scope of these types of programs. It is important to note that the evaluation was not a review of the NGO performance.

3. Methods

Steering Group

As part of the evaluation, a MH CSS Evaluation Steering Group (SG) was established to provide guidance and feedback to the research team as they undertook the evaluation. Members used their expertise and lived/experience within the space of mental health services in Queensland to inform, guide, reflect, and improve the evaluation's design, methodology, data collection, and findings. The SG met monthly via videoconference and were specifically asked to provide feedback on the research plan, data collection methods, the interview schedules, and the early findings.

Ethics and Recruitment

Prior to recruitment, NGOs were part of an NGO Audit phase to gather information on preferred recruitment methods which informed the ethics application. Following the finalisation of the project methods, ethics approval (HREC/2021/QRBW/73074) was received from the Royal Brisbane and Women's Hospital in March 2021 and ratified through The University of Queensland (April 2021) before recruitment of consumers and NGO staff commenced. To allow for the recruitment and data collection of Queensland Health staff across the 14 HHSs, the team undertook 14 separate Site-Specific Agreements (SSA) and a Brisbane Diamantina Health Partnerships (BDHP) agreement. This process was lengthy and finally concluded in December 2021.

Following ethics approval, a range of methods (including phone/email/text/in-person communications) were used to recruit participants (consumers, NGO staff, and stakeholders) to ensure that as many people as possible were reached. HHS staff were not able to be recruited until all separate SSAs were approved and the overarching BDHP agreement was signed by all HHSs. Due to this arduous and burdensome process, this level of recruitment and data collection was not completed until early February 2022.

Data Collection

Demographic survey data collected from consumers during the recruitment process were analysed alongside routinely collected Mental Health Non-Government Organisation Establishment National Best Endeavours Data Set (MH NGOE NBEDS) data.

Past and current consumers of the four MH CSS programs were invited to take part in a semi-structured interview via email, text, poster and via conversations with NGO staff. NGO and HHS staff were invited via email. Following a purposive sampling process, $n = 70$ consumers, $n = 47$ NGO staff, $n = 18$ HHS staff and $n = 2$ broader stakeholders took part in an interview either face-to-face (majority consumers) or by videoconference (majority NGO and HHS staff). This equated to a representative sample of ~50 hours of consumer, ~45 hours of NGO staff, and ~20 hours of HHS and broader stakeholder, interview data. These qualitative data were also supplemented with observational data collected in the field during site visits.

4. [Analysis](#)

The evaluation provides a mixed-methods analysis of the four MH CSS programs with specific focus on service delivery between July 2019 to February 2022. The report outlines findings from the analysis of the quantitative and qualitative data collected, using RE-AIM as a guiding framework with a summary of key findings provided below.

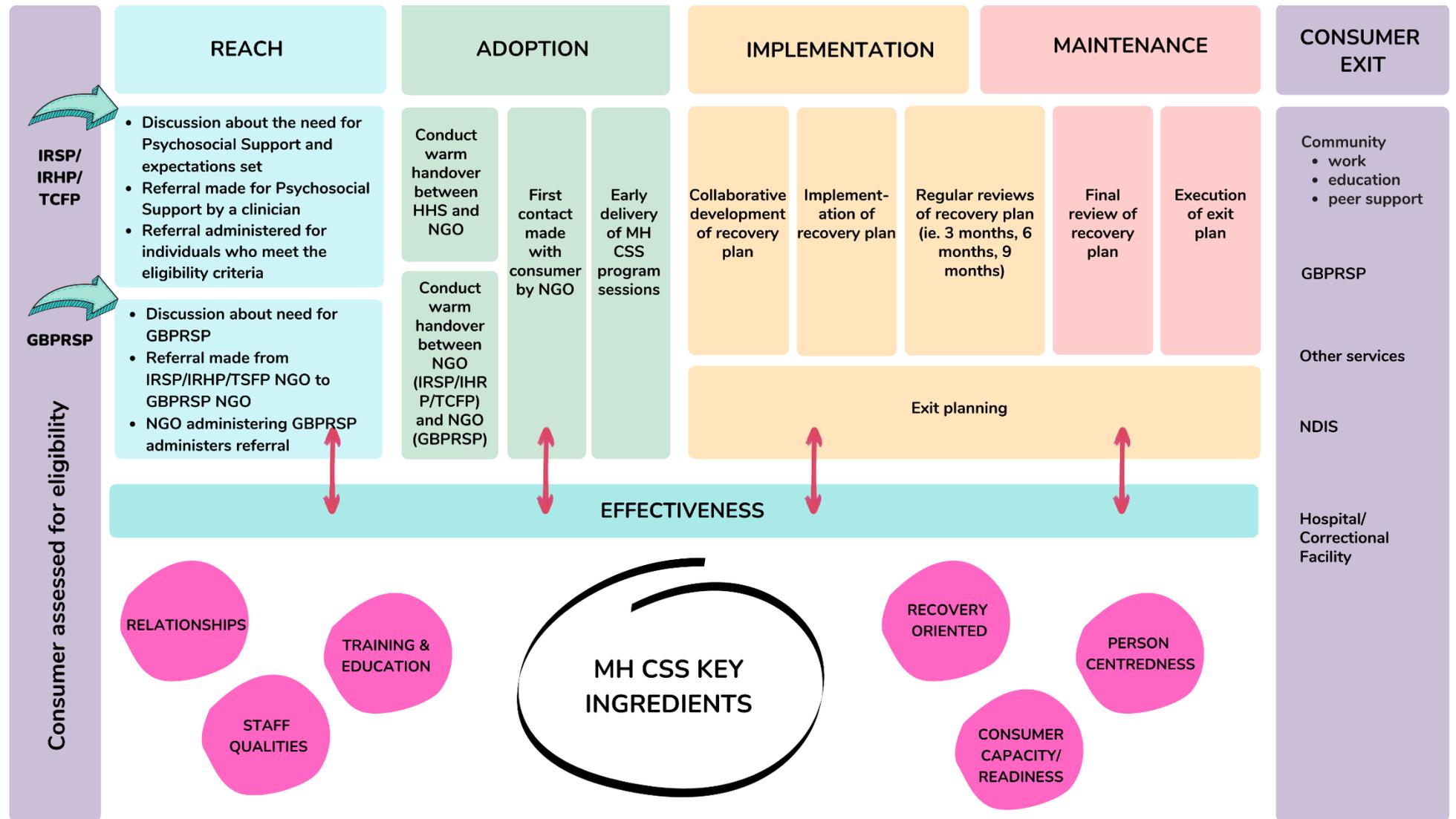
5. [Key Findings of the Evaluation](#)

It is clear from the extensive interviews with HHS staff, NGO staff, consumers, and other stakeholders that the MH CSS programs are vital in supporting people with severe mental illness in their recovery in the community, who would otherwise not be supported. They also support and facilitate *likely* eligible consumers to proceed with an NDIS application and/or provide interim support for those awaiting NDIS decision. Without the MH CSS programs, community mental health treatment teams would be further stretched, spending valuable time and resources on aspects of care for people with severe mental illness, more suited to a workforce skilled in delivery of psychosocial supports. For many consumers, this was the first time they had received any psychosocial support and attributed it to the reason that they were “still here”; be that living in the community (many independently) or indeed alive. Other observed outcomes of consumers engaging with the MH CSS programs included improved relationships, increased confidence, increased quality of life, and in some instances, a return to work (sometimes as a peer worker in this same space).

While there are many successes of the four MH CSS programs (most consumers had nothing but praise for the supports they received), it was identified that consumers had little idea of what to expect from psychosocial support and therefore did not know what level of supports they were entitled to receive. The evaluation found much variability in the MH CSS programs that are currently delivered across Queensland, ranging from best practice, through to those which are being delivered contrary to how they were intended (contractually or from program specifications). This was found to be true at each level and stage of the process and was expressed by staff (HHS and NGO) and consumers.

The MH CSS Best Practice Process Diagram (*Figure 1, page 10*) represents the different stages of the MH CSS programs that aligns to the RE-AIM framework and the resultant best practice from our evaluation. The following headings outline the variability at each stage of the MH CSS program, the key factors that underpin successful programs, and those that may require consideration for improvement. Lastly, the recommendations posed provide stakeholders with the opportunity to review their individual programs as a platform for learning and with the intention of developing meaningful improvements.

Figure 1: MH CSS Best Practice Process Diagram



Reach

Are the programs reaching the people they intend to and what are the barriers and facilitators? Are programs reaching their designated targets?

Eligibility Criteria

The MH CSS programs are reaching the people for whom they are intended, in that most consumers who adopt the program **do meet the inclusion criterion of having a severe mental illness and have been in contact with the HHS in the last 3 months**. While some more rural HHSs have included consumers who have diagnoses associated with moderate severity or impairment, the variability lies where HHSs/NGOs have interpreted consumers' eligibility for NDIS. For example, in some instances consumers who were deemed 'eligible' for NDIS (i.e., they would meet the threshold) were not accepted onto the MH CSS program. This contrasts with other instances where consumers who were identified as being eligible for NDIS and had applied, being able to access the MH CSS programs until their NDIS applications were approved.

It is important to note that some NGOs who deliver MH CSS programs are also NDIS providers and care coordinators. This could be viewed as a conflict of interest when clients exit from the MH CSS programs directly into the same NGO's NDIS services.

Recommendations:

- Clarify the inclusion/exclusion criteria for the MH CSS programs and ensure that all stakeholders are clear, including the NDIS eligibility nuance.
- Extend referrer options; consider extending the opportunity for General Practitioners (GPs) and private clinicians to be able to refer into the MH CSS programs for individuals who meet eligibility criteria.

Program Targets

Over the reporting period, the number of separate IRSP programs (14 in total) meeting their target number of consumers increased from 4 to 8. ***This inability for programs to meet targets was attributed to several factors including insufficient referrals being made (often due to lack of HHS staff awareness and understanding of what psychosocial support is), and inappropriate referrals being made by HHS staff (often due to insufficient information being provided on the referral)***. These issues meant that windows of opportunity to engage consumers in programs were often missed.

Recommendations:

- Psychosocial Support Training/Education; review and refresh knowledge about what is psychosocial support with the staff involved in referral and delivery of programs. Suggest embedding regular NGO delivered psychosocial support education/training for referring teams as part of comprehensive care and continuum of service that augments clinical mental health support.
- Consider the addition of variables into the MH NGOE NBEDS data collection process to enable more functional monitoring and evaluation, including:
 - The number of consumers referred to the MH CSS programs,
 - Additional demographic variables (i.e. ethnicity),
 - Individual level data, to track readmissions and/or rereferrals into MHCSS programs.

Governance and Relationships

The four MH CSS programs are part of a complex mental health care system in Queensland. The effectiveness of these programs depends on the establishment and maintenance of open, collaborative, and functional relationships. There is notable variation in the strength of these relationships across the HHSs and NGOs. Where the relationships between HHS and NGO staff are strong and functional, there is a shared purpose and commitment to collaboration for the best interest of the consumers, which in turn fosters open communication and streamlining of processes. However, where there does not appear to be a functional relationship between HHS and NGOs, this impacts governance, communication, and collaboration in delivery of the MH CSS programs. ***A key facilitator of programs meeting targets (and across the process), was a strong working relationship between the HHS and NGO, where there was a clear shared purpose and regular communication and co-coordination of care.*** This also equated to referring clinicians seeing the value of NGO delivered psychosocial support and having a refined referral pathway that was agile and responsive.

Recommendations:

- HHS and NGO Collaborative Governance; provide regular opportunity for communication and collaboration e.g., co-location of NGO staff in clinical teams, establish regular governance meetings, consumer review meetings, sharing good news stories.
- Facilitate the development of a community of practice for NGOs and HHSs to share best practice and training resources across the services.

Adoption

What proportion of consumers who are referred onto the programs take up the offer and what are the barriers and facilitators?

Due to limitations with the MH NGOE NBEDS data collection (i.e., no variable indicating the number of referrals), the evaluation team were not able to quantify the proportion of consumers who took up the program offer in comparison to the number who were referred. This information would support HHSs and NGOs to understand what part of the referral/adoption process might need addressing, if there were a notable disparity in the number of people adopting the program versus being referred.

HHS handover to NGO, NGO's first contact with a consumer, and early delivery

Factors that support the process of adoption are having a "warm" handover between the HHS and NGO, the NGO's actioning referrals with a timely first contact, HHSs and NGOs setting clear expectations with the consumer, access to the program (i.e. transportation), and flexibility of delivery setting. There was significant variation in the existence of these factors across the programs, with no one program exhibiting all key ingredients consistently.

Recommendations:

- Ensure that HHSs are providing warm handovers of consumers to NGOs, including the below components vital to this handover process:
 - Sufficient documentation and information being provided by the HHS referrer to the NGO about a referred consumer.
 - Open communication of the referral with both the NGO staff and the consumer themselves.
- Setting and management of clear expectations of the MH CSS program to the consumer, as established by the HHS staff and maintained by both HHS staff and NGO staff.
- Timely first contact from an NGO staff, as close to the HHS referral date as possible (a few days or within a week of discharge from HHS service), followed by a timely in-person first meeting that includes a member of the HHS referral team and the NGO staff performing intake.

NGO staff interpersonal factors

NGO staff should be *person-centred*, and where possible, should be *matched with consumers (according to their related lived experience, skillset, etc.)*. The *capacity/readiness of the consumer to engage in a recovery-oriented program* also needs to be considered. NGOs are best supported in meeting the latter two factors when there is a *collaborative working relationship* underpinned by functioning governance processes with the HHS clinical support or services, and when referred consumers are presented and discussed in regular meetings between the stakeholders.

N.B. Despite optimal delivery within all the above adoption sub-phases, that adoption of the program relies heavily on an individual consumer's capacity and readiness to engage in a recovery-orientated program.

Recommendations:

- Person-centeredness of early MH CSS program delivery, including:
 - Flexible delivery of the early MH CSS program sessions in a location/method as guided by the consumer themselves.
 - Matching the right NGO support worker to a particular consumer's needs.
 - More generally, wrapping the service around the consumer to meet their specific needs within the recovery-orientated program framework.

Implementation

Are the programs being delivered as intended and what are the factors that make them successful?

Recovery planning

Individual recovery planning (IRP) documentation were provided for review by the majority of NGOs. It was assessed that most NGOs' IRPs demonstrated the **key principles** that are outlined in the MH CSS Best Practice Process Diagram (*Figure 1, page 10*) including **goal setting, identifying progress review points, and exit planning**. Again, in practice, much variability was observed in NGOs' delivery with staff and consumers from some NGOs not being able to articulate/reflect that these key principles (goal setting, identifying progress review points, and exit planning) were taking place. Program duration was also highly variable, with some consumers reporting that they experienced programs of 3-6 months duration, while a small number reported they had in a program for 2 years. When consumers are not ready to engage, the NGO staff are unlikely to develop a recovery plan and/or follow one as intended. **When consumers have limited capacity, staff spend a lot of time at the start of the program attending to their basic needs** until such a time that their capacity improves- this invariably **leads to consumers requiring longer than 12 months on the program**.

Recommendations:

- The IRPs should be implemented within the first few sessions with the consumer, and they should follow a recovery-oriented framework and be guided by the consumer's goals and needs. The IRPs should be:
 - Regularly reviewed and updated.
 - Consumers should play a collaborative role in the management of the plan.
 - The exit planning done formally across the various MH CSS programs.
 - Outcome measures should be incorporated as part of regular reviews (i.e., 3 months, 6 months, 9 months, and 12 months at exit);
- Formalise a person-centred approach addressing the psychosocial needs of the individual to increase their right to autonomy, support their identification of their values, and to achieve goals.

NGO staff

In terms of staffing, programs were not delivered as intended when there was **inconsistent/or high turnover of staff, inadequate training, inadequate staff resourcing, and unhealthy staff-consumer boundaries**. Conversely, programs were delivered as intended when staff **were adequately trained, held person-centred qualities, had connection to community, and peer support workers were viewed favourably**. The evaluation also identified several important characteristics of NGO staff that facilitate the development of a **relationship** with the consumer and are aligned with positive engagement and outcomes for consumers. These are all related to how the staff approach the support they provide to the consumers and include **displaying empathy, being consistent and reliable, being non-judgmental, and acting as a trusted resource**.

Recommendations:

- Across the MH CSS programs (perhaps in co-collaboration of stakeholders), review the skills, experience and training required by recovery support staff at all levels, including peer workers.

Program phasing and resourcing

The intensity phasing of the programs was also found to vary significantly across the individual programs. While all programs identified that **consumers should get more time/support during the first 12 weeks**,

consumers found it difficult to articulate that in their experiences. This phrasing was **dependent upon adequate staff resourcing, a recovery-oriented delivery, and adequate review and exit planning.**

When asked what would improve the programs or what might facilitate their support of consumers, a common response was the ***inclusion of a discretionary fund*** that they could use for one-off items or processes, particularly for consumers with financial hardship. Examples given included being able to support with obtaining legal identification, bikes to support transport, or electronic devices (phones, tablets, etc.) to assist in communication.

Recommendations:

- Review of targets and staff resourcing to address the incongruency between NGOs not meeting targets and staff's reported inability to support the needs of the consumer.
- Review the practicalities of how the variability of the intensity of service (in terms of phases, complexity of need and rurality/location of services) can be better factored into program funding models.
- Consider the inclusion of a discretionary fund to support consumers in financial crisis or paying for items that would positively impact their recovery progress.

Maintenance

What skills do consumers develop as part of the programs that they take into other aspects of their life and what are the factors that facilitate this? Where did consumers exit to?

Exiting and application of developed skills

Where consumers engaged with the programs, they were able to identify skills that they learnt, developed, and applied in different contexts. For consumers **exiting from services, a large proportion moved onto NDIS support**, and many others accessed the corresponding **GBPRSP**. A true figure for this cannot be established as these data are not currently collected/reported. Some consumers exited into **independent living in the community** and where available, **some accessed other services**, and this was regularly facilitated by the consumer's support worker.

Recommendations:

- Assurance of a person-centred and recovery-oriented focus to support independence is grown and developed over the course of the program.
- Assurance of a 'warm exit' whereby consumers have an exit plan, the ability to follow-up with their NGO staff, and referral onto some form of support regardless of whether it is in the community or other services.
- Follow-up post program, which allows for open communication between the consumer and NGO staff following exit of the program, with clearly maintained expectations/guidelines on how this follow-up is managed.

Length of program and follow-up post-program

As mentioned previously, **for consumers with more complex needs and who lacked capacity to engage to the desired degree in the programs, the length of program was likely too short**, with many being re-referred or extended. This may also be due to consumers becoming attached to their support worker and resisting disengaging from that relationship. One clear request from **consumers who had exited the programs was that they would benefit from a follow-up(s) with their support worker or the NGO to check-in** and share their progress, or as a touch point and sounding board when they were feeling vulnerable.

Recommendations:

- The length of time needs to be flexible and person-centered in the sense that each person's recovery is an individual journey and thus requires individual and tailored lengths to suit.

Effectiveness

What does effectiveness of the programs or recovery look like/mean to the different stakeholders; how could this be measured and is there capacity to do so?

Outcomes (including outcome measures and observed outcomes)

At present, NGOs collect a **variety of outcome data** from consumers that align to the efficacy of the programs and their recovery, which shows that staff and consumers have the capacity to collect outcome measurement data. However, these **data are not standardised across programs/Queensland**, which means that **this evaluation project could not provide a measure of MH CSS efficacy at a program level based on outcomes data**.

It is also **unclear how the data collected are being used across the NGOs/HHS**, particularly in consumers' review of their individual recovery plan, which is a tool for support workers to facilitate discussions and adjust their support. That said, an important finding from the evaluation is that when asked how the program has contributed to their recovery, **a large proportion of consumers don't have the capacity to reflect on their own progress at a single time point** but can describe their journey and how far they have come. Through the evaluation, consumers were able to identify the following outcomes as a result of engagement with the MH CSS program: **ability to recognise need for support, achievement of goals, increased functional outcomes** (such as shopping, return to work, and other day-to-day activities) **and quality of life, improved relationships, increased confidence, and stabilisation or reduction in medication**. Where consumers were reportedly incapable of recognising progress, they were also likely to want to stay associated with the program past the contract criteria.

Recommendations:

- Standardisation of a set of outcome measures across the MH CSS programs to allow NGOs, HHSs and the MHAODB to regularly assess programs' performance and identify areas for development, improvement, and support.
- Outcomes measures should be:
 - Supported in the literature as efficient measurements of mental health outcomes.
 - Have acceptable validity and reliability.
 - Used to facilitate IRP and processes.
 - Collected regularly throughout a consumer's journey on a program (i.e., at 3 months, 6 months, 9 months, and 12 months at exit) to monitor program efficacy.
 - Supplemental to any data already captured by the HHS.
- Implementation of a follow-up measure post-consumer exit to assess long-term monitoring and evaluation.
- Training of staff to analyse and interpret these data.
- Results of the outcome measures are fed back into the program to inform and support ongoing person-centred and recovery-oriented IRP.

6. Additional Findings

Group Based Peer Recovery Support Program (GBPRSP)

Referrals and Access

The referral of consumers into the group-based programs should come from any one of the individual programs via the 'parent' NGO. The evaluation found that this is the case with the IRSP and the IRHP programs, and the degree to which the referrals are being made and the timing of those referrals varies greatly across the programs. ***The evaluation was not able to ascertain any referrals from the TCFP into the group programs.*** This is most likely due to a lack of understanding from NGOs that they *can* refer TCFP consumers into the GBPRSP (based on the intended pathway) and exacerbated through not being part of the existing governance meetings structures/ communication with HHS and referring NGOs (i.e., not involved in the 'relationship' key ingredient). In addition, it was raised by staff that this could also be due to safety concerns with TCFP consumers. ***Some HHSs indicated that they would like to be able to refer consumers directly into the GBPRSP.***

Some IRSP/IRHP consumers were able to access the group programs in parallel with the individual program and where the same NGO delivered both programs, the groups were used to support the IRP work. Others gained access to the groups after a period, while others exited out of the individual programs and into the GBPRSP. This was, of course, for those consumers who wanted to access groups, or for those who became ready to engage. These referrals tended to be most successful when the same NGO delivered both programs. Where the referral process requires a handover between NGOs, as with the individual program referrals, ***this required a strong working relationship between the two organisations, which was not always the case.*** There was also a ***proportion of consumers who would not engage with groups at all and classed themselves as 'not the type' or specifically did not want to spend time with other individuals with mental illness or did not feel safe in doing so.***

Recommendations:

- Provide clarification/guidance to all stakeholders around referrals into GBPRSP (facilitate relationships between NGOs where different NGOs deliver the programs).
- Review the feasibility/acceptability/need of the same NGO delivering the IRSP and GBPRSP at each location.

Program Offer

There is a large degree of variability in the delivery of the GBPRSP in terms on what is on offer to consumers. Some NGOs have fewer resources (e.g., cumulative funding, physical resources, access to transport) and/or consumers and so have a narrow suite of activities they can offer, whereas better resourced NGOs can offer a broad range of activities that cater to different consumer wants and needs. This was evidenced where larger NGOs offering multiple services with multiple funding streams combine resources to provide a broader offering to their consumers.

Recommendation:

- Ensure that the GBPRSP provides a broad offer (mental health and psycho-social/lifestyle content) to consumers and that they take place in accessible and safe places.

Individuals at Risk of Homelessness Program (IRHP)

Consumer complexity

It was observed that the **IRHP consumer group presented with more severe mental health issues, combined with a higher co-morbidities and substance use issues** than those commonly accessing the IRSP, and that the NGO staff servicing the IRHP program are required to manage these **complexities**. Examples include managing current psychosis, co-morbidities, ongoing legal issues where NGO staff **act as advocates** and facilitators for the consumers, and chronic homelessness. The evaluation has identified that IRHP is a specialised program when delivered as intended and the breadth of skills, experience and training required for support workers on this program is therefore likely to be greater than for the IRSP. It was observed however that some programs were being delivered in the same way as the IRSP, and therefore not catering to the specific needs of this complex consumer group.

Recommendation:

- IRHP is a specialised program – NGOs should therefore align the breadth of skills, experience and training required for support workers on this program.

Access to housing

Given the nature of the referrals for the IRHP group, it's not surprising to note that housing is a particular concern for the IRHP program however **the lack of access to appropriate and secure housing** was raised by the majority of support workers as being a constant challenge in delivering supports to consumers. In addition, it was observed that the criteria for consumers to meet to engage in the IRHP was interpreted differently by different HHSs and NGOs. Particularly, this was in relation to different housing situations that could/should be included as eligible for this program e.g. (housing instability vs sleeping rough, couch surfing, etc.).

Recommendation:

- Consider supporting the relationships between NGOs and Department of Housing/relevant organisations managing housing to address housing access concerns.
- Provide clarification/guidance to allow for consistent eligibility criteria for inclusion to the IRHP program (specifically around housing circumstances) across the state.

Transitions from Correctional Facilities Program (TCFP)

Consumer complexity

From the limited data collected for this specific program, and like the IRHP consumer group, **the TCFP consumers were observed to exhibit more severe mental health presentations** than those commonly accessing the IRSP. Additionally, as expected, there were unique factors associated to the delivery of the TCFP. These include the **additional complexities of need**, including **access to housing associated with having a criminal conviction**; a delay in recovery staff accessing consumers due to the **level of security clearance required** and **lockdowns/lockouts**; a **lack of appropriate group programs** to support the individual recovery plan process and to transition into; **release location not matching their home location** (i.e., different HHS and NGO offering- or not- TCFPs). Again, this is a specialist program requiring staff with a greater breadth of skills, experience and training required for adequately supporting consumers in this space.

Recommendation:

- TCFP is a specialised program – NGOs should therefore align the breadth of skills, experience and training required for support workers on this program.
- Consider supporting the relationships between NGOs and Department of Housing/relevant organisations managing housing to address housing access concerns.

Conflicting NGOs providing services

It was also reported by NGOs that there are **conflicts with alternate NGOs offering services within prison**. There are reportedly several other NGOs that access prison and offer services which leads to consumers “playing NGOs off each other” to see who they can get the most support from. This reportedly **impacts on the capacity for NGOs to receive referrals and to appropriately service TCFP consumers**.

Recommendation:

- Provide support to facilitate HHS and NGO relationships involved in the TFCPs, particularly addressing the conflicting services provided by alternate NGOs within the prison system.

Rurality

From the team's experiences of visiting most HHS locations, it was clear that there were unique factors impacting service delivery experience for staff and consumers in rural and regional areas*. To that end, the rural data were analysed separately from the metropolitan population. Some specific factors were identified as having a significantly larger impact on staff (HHS and NGO) and consumers in rural areas that should be considered regarding program function and funding in rural areas.

The **barriers associated with program delivery in rural areas are that NGOs are burdened with fewer resources, fewer staff, poorer access, greater workload, and fewer local clinical staff than other support services**. This is also exacerbated by the unique characteristics that come with living in a rural town such as **mental health stigma and lower mental health literacy**. To overcome some of these challenges, many support workers have resorted to upskilling themselves to provide the most helpful, up-to-date and accurate care that they can. Additional factors that help **rural support workers to be successful are that they are local people who understand the rural context** and where being a part of the 'in-group' is very important. Not every support worker will be from a rural background or have grown up in a particular area, but it is vital that they have an interest in the area and are assimilated.

**N.B. Please refer to the summary of the classification scale used to determine rurality, tabulated in the Rurality section of the Main Report.*

Peer Workforce

Throughout the evaluation, the concept and utility of a peer workforce (or staff who identify as having Lived Experience of mental illness) within the MH CSS programs, and community mental health services in general, arose as an important theme. **Consumers' ability to relate to a peer worker was assessed to be a substantial facilitator in engaging with the MH CSS programs**. Additionally, consumers found that engaging with **peer workers normalised mental ill health and provided an example of recovery being possible, or hope**. Most notably, several **consumers expressed interest in becoming peer workers themselves** after interacting and benefitting from the peer workforce, and that this provided them with aspirations of achieving a meaningful vocation and purpose.

In line with the variability seen across the other aspects of the MH CSS programs, the way that peer workers make up the staff and the level to which they are trained does vary significantly. While some NGOs have a clear structure and mechanism for training and supporting their peer workforce, many peer workers described **a dearth in training and support available**. This negatively impacts upon not only the delivery of the service (MH CSS programs) but also the peer worker's ability to cope with the challenges of their role and **has great risks to both the peer worker and the consumers they are working with**. As a result, both consumers and peer workers have described instances where **unhealthy relationships existed between peer workers and consumers**.

Inclusivity

Another additional finding centered on the **inclusivity of the MH CSS programs**, specifically referring to inclusivity of diverse consumers including those identifying as Aboriginal and/or Torres Strait Islander, Culturally and Linguistically Diverse (CALD), and/or LGBTQI+. Whilst significant efforts were made during recruitment to engage individuals from diverse population groups in the research, **challenges persisted particularly in recruiting consumers from CALD communities**. These challenges in recruitment highlight larger issues with the **inclusivity of various population groups in the MH CSS programs and mental health services in general**. The evaluation yielded mixed findings regarding suggestions of imbedding content

related to specific population groups into the MH CSS programs, for example Aboriginal and Torres Strait Islander peoples. The most common sentiment from consumers and NGO staff was that **the MH CSS program needed to be a safe space for all individuals, regardless of their various identities**. Another finding indicated **that consumers were supportive of the idea that their NGO staff were diverse**, and that the inclusivity of the MH CSS programs' consumers were reflected in the identities of the NGO staff.

Impact of COVID-19

An important point for consideration was the impact of the COVID-19 pandemic on the MH CSS programs' delivery and consumers. There were several consumers and staff from various NGOs that reported the COVID-19 pandemic did not impact on their accessing or delivery of the community mental health supports. Where there were changes in the delivery of the MH CSS programs, **a small number of consumers responded positively to their supports being delivered online**. Some organisations referenced the **additional funding** they were provided during COVID-19 as a benefit for **funding the purchase of devices** so the consumers could access the program remotely, **or other essential goods** (i.e., bikes for transportation).

Consumers and staff from various NGOs reported the COVID-19 pandemic did impact the MH CSS programs. Examples included **increased mental health concerns, increased employment instability, increased isolation, and reduced access to services**.

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