Australian Healthcare Associates

Evaluation of the Community Mental Health Transition to Recovery Programs

Final Report

November 2012

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List of Acronyms and Terms

AHA	Australian Healthcare Associates - the consultants that conducted the evaluation
AOD	Alcohol and other drugs
CALD	Culturally and Linguistically Diverse
FaHCSIA	Department of Families, Housing, Community Services and Indigenous Affairs
HREC	Human Research Ethics Committee
HSD	Health Service District
ICD-10	International Classification of Diseases (ICD)
NGO	Non government organisation
PHaMS	Personal Helpers and Mentor Support
PICF	Participant Information and Consent Form
PMHS	Prison Mental Health Service
PRA	Psychiatric Rehabilitation Australia
QH	Queensland Health
RAS	Recovery Assessment Scale
RFQ	Richmond Fellowship Queensland
RRP	Resident Recovery Program
RSA	Recovery Self Assessment
SSA	Site Specific Assessment
TFCF	Transition from Correctional Facilities Program
TRP	Transitional Recovery Program
TTR	Transition to Recovery
TTR program	The TTR program is delivered by the NGO sector. When the evaluation began, funding for the TTR program was provided by the Queensland Department of Communities. Following the recent restructure, the TTR program is now funded by Queensland Health. QH funds and provides a range of mental health services. These are situated in acute settings as well as the community.
VET	Vocational Education and Training

1 EXECUTIVE SUMMARY

1.1 Background

The *Community Mental Health Transition to Recovery (TTR) Program* is an initiative of the Queensland Government that aims to increase access to support services and community-based accommodation for people with a mental illness. First funded in 2007-08, the Program is aligned to an international shift towards client empowerment and community care in mental health practice. The TTR Program comprises three separate programs:

- Transition from Correctional Facilities Program
- Transitional Recovery Program
- Resident Recovery Program.

In December 2010, Australian Healthcare Associates (AHA) was appointed by the Queensland Government Department of Communities, Child Safety and Disability Services, to undertake an evaluation of the TTR program.

1.2 Evaluation Objectives

The evaluation objectives were to:

- Profile the clients who receive support through each of the transition programs
- Determine the cost and client outcomes of these TTR community programs versus acute mental health services in terms of:
  - Establishment and ongoing costs for each program
  - Indicative program costs per person while in the program
  - Outcomes for clients while in the program
  - Comparative cost-benefits of providing community based mental health programs in addition to public mental health services, compared to public mental health services alone
- Identify the outcomes for the target groups of each of the programs. Outcomes may include, but are not limited to:
  - Promotion of health and personal safety
  - Development of relationships and social connections (including participation in social/community activities)
  - Promotion of living skills including self care, domestic skills, community living skills
  - Obtaining stable employment, volunteering or undertaking vocational activities
  - Transition to sustainable housing
- Describe any unintended outcomes of the three transition programs
- Examine the perceptions of carers/significant others and service providers in relation to the outcomes achieved for clients with a mental illness who participate in the three transition programs
- Examine the effect of the three Transition Programs on usage of Public Mental Health Services by clients supported by these programs.

1. Executive Summary

1.3 Methodology

A mixed methods approach was used to collect qualitative and quantitative data. Methods included:

- Analysis of Queensland Mental Health Data and financial reports from TTR service providers
- Client and staff surveys
- Interviews with clients, staff and other stakeholders
- Client case studies
- Profiling service providers, i.e. staffing, service models etc.

The evaluation findings have been derived from these information sources, and have been contextualised through review and consideration of national and international literature.

1.4 Summary of findings

Service Model Implementation (Chapter 5)

- Overall, the TTR programs have been implemented largely as planned.
- Barriers to program implementation included:
  - The complexity of health and social needs of the client population (particularly for the Transition from Correctional Services program). Although a known factor, it still impacted on the way the programs were implemented.
  - Difficulties accessing services such as housing, AOD and other support services.
- Service providers reported that following the introduction of the Queensland government's *Growing Stronger Initiative*, the Commonwealth Government's Medicare Locals and Queensland post-election changes, processes related to assessment, referral and discharge within the TTR programs were negatively impacted.
- While a recovery focus was seen as important in all programs, there were mixed views about the value of the formal recovery training provided during the establishment phase. All programs recognised the value of internal training, mentoring and ongoing professional development.
- The establishment and support of reference groups was seen by all programs as an important mechanism for informing stakeholders about the program aims, for facilitating appropriate referrals, and for improving linkages to community supports.
- Improving referral practices was identified as an important focus for ongoing development by all programs.

Staffing Profile (Chapter 6)

- The structure of the teams that deliver the TTR programs varied between service providers. Several programs used Community Development Workers and Peer Support Workers.
- Relative to the broader Queensland NGO mental health sector, TTR staff was well qualified.
- Many staff had competencies in dual diagnosis.
- The range of recovery-focussed professional development courses undertaken by TTR staff demonstrates a commitment to a recovery-oriented approach by the service providers.

1. Executive Summary

Client Profile (Chapter 7)

- The TTR program reached the appropriate target population (i.e. those with moderate to severe mental illness aged over 18 years).
- Within each program, there was considerable variability in the duration of support provided to clients. This is consistent with the flexible nature of the support provided under the TTR program.
- The average duration of support provided to clients from commencement up to exit, was:
  - Lower than expected for clients in the Transition from Correctional Facilities program (average 4.8 months compared with 9 months expected)
  - Lower than expected for clients in the Transitional Recovery Program (average 15.4 months compared with 18 months expected).
  - Similar to that expected for clients in the Resident Recovery Program (average duration of support was 8.1 months).
- Staffing issues in one organisation had a significant impact on client numbers.

Client Outcomes (Chapter 8)

- Positive client outcomes have been demonstrated across a number of recovery domains as a result of the TTR program. These include improvements in mental health, physical health, social connectedness, employment status and, for some clients, housing.
- QH mental health service usage data supported qualitative reports of improved mental health status:
  - TTR clients were found to have lower rates of inpatient admissions for mental health issues, and fewer bed days compared with a comparison population that had not participated in the TTR program.
  - TTR clients had double the rate of community mental health service usage, compared to the comparison group, suggesting that TTR clients were able to better manage their mental health without the need for non-elective hospital admissions arising from crisis situations.
- This pattern of service usage is consistent with findings from the national and international literature which shows that recovery programs tend to lead to a reduction in acute service usage and a concurrent increase in community mental health service usage.
- A notable barrier to the achievement of program outcomes was difficulties accessing services on completion of the program. A lack of appropriate housing was a particular issue.
- A key element of program success was the strong and trusting relationship developed between clients and their support worker; however a potential negative consequence of this relationship was the development of dependency by the client on their support worker. This was a frequently reported issue.
- Due to the time-limited nature of the program, early exit planning was found to be very important. Careful exit planning may help to reduce the likelihood of dependency developing by focusing on developing sustainable supports beyond the duration of the TTR program.

1. Executive Summary

Cost Analysis (Chapter 9)

The analysis set out in this report indicates that overall the TTR program resulted in additional net costs to Queensland Health. The total cost to QH is comprised:

- Direct costs of delivering the three TTR programs
- Less: Savings associated with reduced inpatient service usage by TTR clients, during the two year period after exit from the TTR program
- Plus: Additional costs associated with increased usage of community-based specialised mental health services by TTR clients, during the two year period after exit from the TTR program.

It is difficult to accurately estimate this total cost to QH. Specifically, it was challenging to identify:

- The change in usage (increase/reduction) of other QH services by TTR clients; a Control Group has been used for this purpose.
- The costs/savings associated with these changes; Australian Institute of Health and Welfare AIHW) data has been used for this purpose.

Given these challenges, the cost data shown in the following table should be regarded as indicative only. Full details of the calculations and the related caveats and limitations are included in chapters 8 and 9 of this report. It is suggested that further work is required to confirm these findings and refine the insights provided in this report.

Cost per Client	TFCF	TRP	RRP
Direct Cost: TTR program *(refer Table 9.4)*	$6,035	$126,345	$9,240
Savings: Reduced inpatient service usage *(refer Table 9.5)*	($11,387)	($11,387)	($11,387)
Cost: Increased community service usage *(refer Table 9.5)*	$22,037	$22,037	$22,037
Total QH cost per client	**$16,685**	**$136,995**	**$19,890**

The direct cost shown above is the average cost per client, based on clients' TTR service usage from commencement to exit from the TTR program. The indicative savings and costs identified are based on clients' changed usage of other QH funded services, during the two year period after exit from the TTR program.

The Transitional Recovery Program provides full time community accommodation and 24 hours per day psychosocial recovery support to clients, over a period of 12 months or more. Its cost per client ($126,345) is therefore significantly greater than the other two programs ($6,035 and $9,240), which involve relatively short term flexible and responsive support to assist clients to plan and achieve their agreed personal recovery goals.

1.5 Conclusions

The *Community Mental Health Transition to Recovery (TTR) Program* is viewed positively by clients, staff and other stakeholders involved with the program. The Program has been implemented largely as intended, and is supported by a well-qualified and committed workforce.

1. Executive Summary

The Program has resulted in a range of positive outcomes for clients in a number of important recovery domains. A notable outcome is the improved management of mental health issues, as evidenced by a shift in service usage away from the acute mental health sector to the community sector. Although there are a range of barriers identified throughout the evaluation, strategies to minimise the impacts of the barriers have meant that services are assisting a range of clients with high support needs as was the original intention of the TTR program.

These findings support an accumulating body of evidence in the national and international literature that recovery-oriented approaches to mental health can have impressive results in terms of client outcomes. This evaluation found that the TTR program leads to a decrease in the costs of in-patient service usage and an increase in community service use costs. It may be valuable however to consider a wider ranging economic evaluation that takes into account a broader range of areas of a person's life, where improvements in their mental health or housing situation may translate to improvements or cost savings, such as through the person gaining employment or returning to education.

2 BACKGROUND

This chapter outlines the underpinning evidence that supported the development of the Transition to Recovery Program and the objectives and scope of the evaluation.

2.1 Impact of severe mental health disorders

Mental illness is an important public health concern in Australia. It covers a wide range of disorders and often has far reaching implication for individuals, families and society as a whole.[1] The prevalence of mental illness is high, with almost 45% of Australians aged 16-85 having experienced a mental disorder sometime in their lifetime.[2] Results of the 2007 *National Survey of Mental Health and Wellbeing* (NSMHWB) indicated that in the 12 month period prior to the survey:

- one in five (20%) Australians aged 16-85 experienced one or more of the common mental disorders (anxiety disorders, affective disorder, substance use disorders)
- one in seven (14.4%) Australians had an anxiety disorder
- one in twenty (6.2%) had an affective disorder; and
- one in twenty (5.1%) had a substance use disorder.[3]

The results also indicated differences by gender and age. Women were more likely to have experienced a mental illness in any given year and reported higher levels of anxiety disorder (17.9% compared to 10.8% for men). In contrast, men were twice as likely to have a substance use disorder (7.0% compared to 3.3% for women).[4] Prevalence of mental illness is greatest among 16-24 year olds, with a reported prevalence of more than one in four (26.4%) in any one year.[5]

The Fourth National Mental Health Plan suggests that '...an estimated 3% of Australian adults have severe disorders...about 50% have a psychotic illness, primarily schizophrenia or bipolar affective disorder. The remainder mainly comprise individuals with severe depression or severe anxiety disorders.'[6]

People experiencing mental illness and substance use disorders have markedly poorer psychological and physical health than the general population. 'Over half (57.2%) of people with any drug dependence and one quarter (27.4%) with any harmful drug use reported high to very high levels of psychological distress. Among people with alcohol dependence one in three (38.7%) experienced high

[1] Australian Institute of Health and Welfare, *Australia's Health 2012,* Australia's Health Series No.13. AIHW, Canberra, 2012.

[2] AIHW, *Australia's Health 2012.*

[3] Mental Health Statistics Fact Sheet, http://www.health.gov.au/internet/mentalhealth/publishing.nsf/Content/10416BD24115D987CA25731E00123DEA/$File/MH%20stats%20factsheet%20April%2009.pdf

[4] T Slade, A Johnston, M Teesson, H Whiteford, P Burgess, J Pirkis & S Saw, *The Mental Health of Australians 2: Report on the 2007 National Survey of Mental Health and Wellbeing*, Department of Health and Ageing, Canberra, 2009.

[5] MG Sawyer, FM Arney, PA Baghurst, JJ Clark, BW Graetz, RJ Kosky, B Nurcombe, GC Patton, MR Prior, B Raphael, J Rey, LC Whaites & SR Zubric, *The Mental Health of Young People in Australia*, Mental Health and Special Programs Branch, Commonwealth Department of Health and Aged Care, Canberra, 2007.

[6] Department of Health and Ageing. *Fourth National Mental Health Plan – An agenda for collaborative government action in mental health 2009–2014*,DoHA, CanberraAs accessed from www.health.gov.au on 28/10/10

or very high psychological distress compared to one in six (15.3%) with alcohol harmful use' (Slade et al 2009:32).[7]

Coghlan and colleagues, in a Western Australian (WA) study, found that the overall death rate of people with mental illness was 2.5 times higher than the general population of WA. The study found higher prevalence of heart disease, respiratory disorders, infectious diseases such as hepatitis C and HIV, injuries, deficiency anaemia and a much poorer prognosis once cancer was diagnosed.[8] They were also concerned that the data on 'hospitalisation rates' suggested that 'people with mental illness do not receive the same level of medical treatment in hospital, based on need.' In addition, suicide was a significant contributor to 'excess deaths' in people experiencing mental health issues with the greatest period of risk occurring in the first two weeks after discharge from inpatient care.[9]

Poorer living arrangements can be one of the impacts associated with mental illness whilst a lack of secure accommodation can contribute to poor mental health. People who reported as homeless in the 2007 National Survey of Mental Health and Wellbeing experienced mental health disorders at a rate two and a half times higher than for the general population.[10] The incidence of mental ill health in prison populations is much higher than the general population with around 40% of prisoners experiencing mental illness and 10–20% affected by severe disorders.[11]

The symptoms of mental illness often make it more difficult to manage the demands of day-to-day life, including work, study and relationships. Those with mental illness also experience problems such as isolation, discrimination and stigma.[12] The *Fourth National Mental Health Plan* (2009 -2014) highlights low educational attainment and participation in the workforce as key problems for those experiencing mental illness.[13]

Mental illness also has an economic impact with 7.3% of all government health spending (across Australia) devoted to responding to mental ill health.[14] In addition, the government bears further costs via disability welfare payments, unemployment benefits and the direct costs of imprisonment. The cost of mental illness due to lost productivity is also substantial: it is estimated that mental illness in young men aged 12-25 years costs the Australian economy $3.27 billion per annum.[15] These figures illustrate that the human and economic costs of mental illness are substantial and borne across a range of sectors and institutions beyond the health sector.

2.2 A recovery-focused response

Over recent years there has been growing recognition that recovery from serious mental ill health occurs. Recovery has been defined variously as indicated below.

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[7] Slade et al 2007.

[8] R Coghlan, D Lawrence, D Holman & A Jablensky, Duty to care: Physical illness in people with mental illness. University of Western Australia Department of Public Health and Department of Psychiatry, Perth, 2001.

[9] Coghlan et al 2001.

[10] Slade et al 2007.

[11] Slade et al 2007.

[12] AIHW, *Australia's Health 2012.*

[13] DoHA, *Fourth National Mental Health Plan,* 2009.

[14] AIHW, *Australia's Health 2012.*

[15] Ernst and Young, *Counting the cost: the impact of young men's mental health on the Australian economy,* Report for the Inspire Foundation. Inspire Foundation and Ernst and Young, 2012.

2. Background

> *Recovery is the journey toward a new and valued sense of identity, role and purpose outside the parameters of mental illness; and living well despite any limitations resulting from the illness, its treatment, and personal and environmental conditions*[16]

Burgess and colleagues provide the following definition:

> *...recovery is much more than the absence of symptoms and functional impairment, and is more akin to a change in outlook that is related to leading a meaningful, purposeful life, with or without ongoing episodes of illness. At most, the typically-sought-after reduction in symptoms and improvement in functioning might be thought of as clinical recovery, whereas the more nuanced attitudinal change can be considered as personal recovery.*[17]

Burgess goes on to describe the impact that government and non-government agencies can have on the quality of life experienced by people with a mental illness. Recognition of this has led to funding for programs such as Transition to Recovery.

In 2005, Queensland Health produced a recovery paper that detailed aspects and elements of care that are 'more likely to have an impact on the individual and their journey of recovery,[18]' these include:

- Peer support, self help
- Family education and support
- Mental health services
- Primary health care
- Disability support
- Community infrastructure
- Housing
- Vocational rehabilitation/employment
- Drug and alcohol services
- Trauma and abuse services.

This list emphasises the breadth of support that needs to be provided to support a recovery based framework, including drawing on and educating people's support networks as well as ensuring links to a wide range of services. Organisations that support recovery need to be well informed about their local service system and ideally have established partnerships and referral arrangements.

The concept of recovery and issues relating to the implementation of a recovery framework are discussed in more detail in the comprehensive literature review (Appendix A).

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[16] Queensland Health,*Sharing Responsibility for Recovery: creating and sustaining recovery oriented systems of care for mental health.* Intergovernmental Steering Committee, Queensland Government, Brisbane, 2005, p,9.

[17]Burgess, P, Pirkis, J, Coombs, T, Rosen, A. *Review of Recovery Measures*, Australian Mental Health Outcomes and Classification Network, February 2010 available at http://amhocn.org/static/files/assets/02e3f75a/Review_of_Recovery_Measures.pdf

[18] Queensland Health, 2005.

2.3 Queensland Plan for Mental Health

The *Queensland Plan for Mental Health 2007-2017*[19] (the Plan) outlines priorities for the reform and development of mental health care and improving mental health service delivery in Queensland, recognising that a whole-of-government, whole-of-community approach is needed to reduce the prevalence and impact of mental health problems and mental illness. The Plan aims to develop a coordinated approach that provides a full range of services that:

- Promote mental health and wellbeing
- Where possible prevent mental health problems and mental illness
- Reduce the impact of mental illness on individuals, their families and the community
- Promote recovery and build resilience
- Enable people who live with a mental illness to participate meaningfully in society.
- The delivery of recovery-oriented services (as described in Section 2.4) is central to the Plan. There is also a strong focus on a whole-of-government and whole-of-community approach, which includes not only diverse sectors of government, but also a strong role for the non-government sector in delivering comprehensive community-based care and support.

As part of the Plan, the Queensland Government in 2007-08 committed $98.09 million over four years for initiatives to increase access to support services and community-based accommodation for people with a mental illness. Within this allocation, $35.64 million was allocated to purchase a range of accommodation and personal support services from the non-government sector including the Transition from Correctional Facilities Program, Transitional Recovery Program and Resident Recovery Program.[20] Collectively these three Programs are called the Transition to Recovery Programs.

The key characteristics of each of the three programs are discussed in the following sections and a comparative summary is provided in Appendix B.

2.4 Transition to Recovery Programs

Each of the Transition to Recovery Programs operates within a recovery framework and 'provides targeted rehabilitative psychosocial interventions that are known to facilitate the recovery journey[21]' including:

- Improved access to social interactions and community inclusion
- Support to develop skills to self-manage mental and general health care
- Development of lifestyle skills that assist with maintaining a personally meaningful lifestyle and community tenure
- Links to vocational/employment support or meaningful occupation.

[19] Queensland Government, *Queensland Plan for Mental Health 2007-2017*, Queensland Health, Brisbane, 2008.

[20] Queensland Department of Communities, *ITO Final: Evaluation of the Community Mental Health Transition to Recovery Programs*. Queensland Government, Brisbane, 2009.

[21] Queensland Government, *Overview of Future Directions – Transitional Recovery Program*. Disability Services Queensland, Brisbane, 2008, p.3.

2.4.1 Transition from Correctional Facilities Program

This program is targeted towards adults with moderate to severe mental illness who are being released from correctional facilities. The need for this initiative is based on the prevalence of mental illness amongst individuals in correctional facilities, current gaps in continuity of clinical and non-clinical mental health service delivery between prison and the community, and the mortality rates of individuals discharged from correctional facilities.[22]

The key goals of the program are:

- To deliver a support service to people with moderate to severe mental illness about to be released from correctional facilities so they can:
  - Access appropriate accommodation/housing
  - Connect with the local mental health service and GP
  - Improve their quality of life
  - Be supported to enhance their mental health and their recovery
  - Link with employment agencies and work opportunities
  - Attend court hearings
  - Link to longer term formal and informal supports in the community.
- Strengthen working relationships between Queensland Correctional Services, Prison Mental Health Service, funded non-government service providers and community based mental health services.

There are two phases of work undertaken by the service provider organisation. The first phase ideally commences at least two weeks prior to release, with a further six month period of support provided by the service provider organisation, post-release. There is also a transition of clinical mental health care from the Prison Mental Health Service to the local District Community Mental Health Service. More complex needs are managed by the Community Forensic Service.

2.4.2 Transitional Recovery Program

To be eligible for support from the program, individuals are required to have:

- A mental illness with medium to high support needs
- Stable mental health status and mental health needs that can be met within a community-based environment
- Agreed to fully participate in a recovery-based support program and to work towards achieving independence in the community, including stable, long-term community housing solutions.

Again, this program provides for two phases of intervention. These are:

- Short to medium-term recovery-based support and accommodation provided for at least one month and up to twelve months with specific requirements around the type of environment

[22] Queensland Government.,. *Overview of Future Directions – Transition from Correctional Facilities Program*. Disability Services Queensland, Brisbane, 2008.

including living spaces that allow for privacy as well as appropriate areas for social interaction. It is expected that 24 hour per day psychosocial support will be provided. Clinical support is to be provided by the local integrated mental health service, or referring private mental health provider

- Time-limited transitional outreach support post departure to own accommodation (where required) up to six months.

A local inter-agency governance structure is recommended for supporting strategies that will meet the diverse needs of program participants.

2.4.3 Resident Recovery Program

This program is for adults due to be discharged from inpatient mental health care to boarding house or hostel accommodation or those who are being actively case managed by the local mental health service while living in boarding house or hostel accommodation. In addition, it needs to be apparent that:

- The client will be vulnerable and exposed to a range of risks in this accommodation
- Boarding house or hostel environmental conditions are not conducive to their recovery
- Individuals are willing to fully participate in a recovery-based support program and work towards achieving their goals.

The model of service delivery is to be supportive, flexible and tailored to each individual's needs. It is expected that service providers will work collaboratively with the referred client, private residential service provider and the person's local integrated mental health service provider.

The duration and level of support for each individual could vary, depending on the individual's need and recovery goals. Support is expected to progressively reduce as recovery-based goals are achieved. One of the aims of this type of support is to assist clients in breaking the cycle of moving through acute care, temporary accommodation, homelessness and back into acute care.[23]

2.5 Evaluation of the Transition to Recovery Programs

In December 2010, Australian Healthcare Associates (AHA) was appointed by the Queensland Government Department of Communities, Child Safety and Disability Services, to undertake an *Evaluation of the Community Mental Health Transition to Recovery Programs.* Each of the three different recovery programs funded under the Transition to Recovery Program were to be considered in the evaluation. The evaluation objectives were to:

- Profile the clients who receive support through each of the transition programs
- Determine the cost and client outcomes of these TTR community programs versus acute mental health services in terms of:
  - Establishment and ongoing costs for each program
  - Indicative program costs per person while in the program
  - Outcomes for clients while in the program

[23] Queensland Government. *Overview of Future Directions – Resident Recovery Program*. Disability Services Queensland, Brisbane, 2008.

  - Comparative cost-benefits of providing community based mental health programs in addition to public mental health services, compared to public mental health services alone

- To identify the outcomes for the target groups of each of the programs. Outcomes may include, but are not limited to:
  - Promotion of health and personal safety
  - Development of relationships and social connections (including participation in social/community activities)
  - Promotion of living skills including self care, domestic skills, community living skills
  - Obtaining stable employment, volunteering or undertaking vocational activities
  - Transition to sustainable housing
- To describe any unintended outcomes of the three transition programs
- To examine the perceptions of carers/significant others and service providers in relation to the outcomes achieved for clients with a mental illness who participate in the three transition programs
- To examine the effect of the three Transition Programs on usage of Public Mental Health Services by clients supported by these programs.

3 METHODOLOGY

This chapter outlines the methodology that was implemented in the evaluation of the three Transition to Recovery Programs.

3.1 Framework for the evaluation

Program Logic Models (see Section 3.1.1) were used to:

- Facilitate the development of a project plan, including a systematic evaluation framework
- Determine the key evaluation questions
- Identify appropriate process and impact indicators and relevant data sources.

A Program Logic is a diagrammatic representation of the premises and assumptions underpinning a model. It includes standards of performance and focuses on the specific processes involved in bringing about change in an intervention.[24]

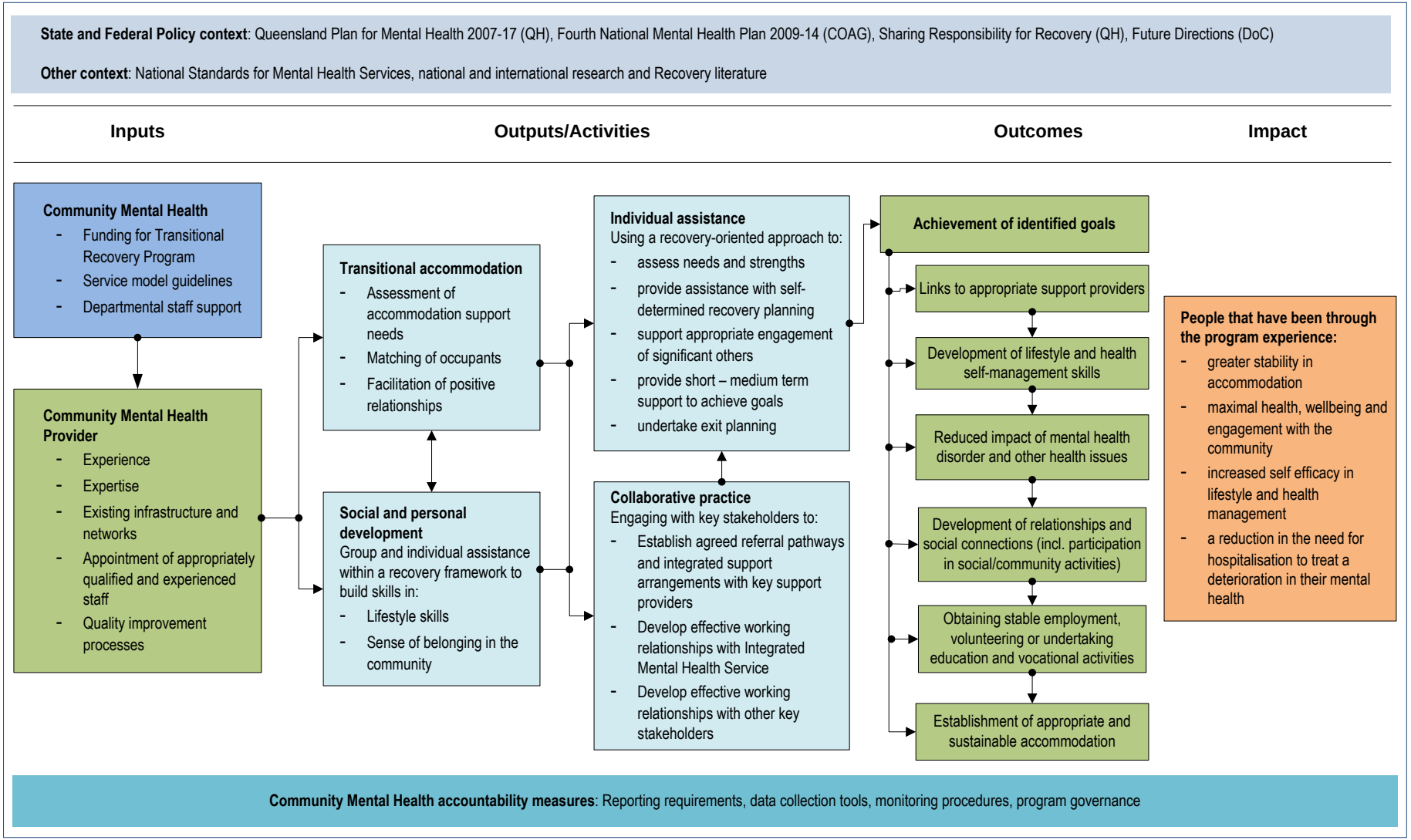
3.1.1 Program logic models

Separate program logic models were developed for each of the three TTR programs (Figure 3-1, Figure 3-2 and Figure 3-3).

[24] SC Funnel & PJ Rogers, *Purposeful Program Theory: Effective Use of Theories of Change and Logic Models*. Jossey-Bass, San Francisco, 2011.

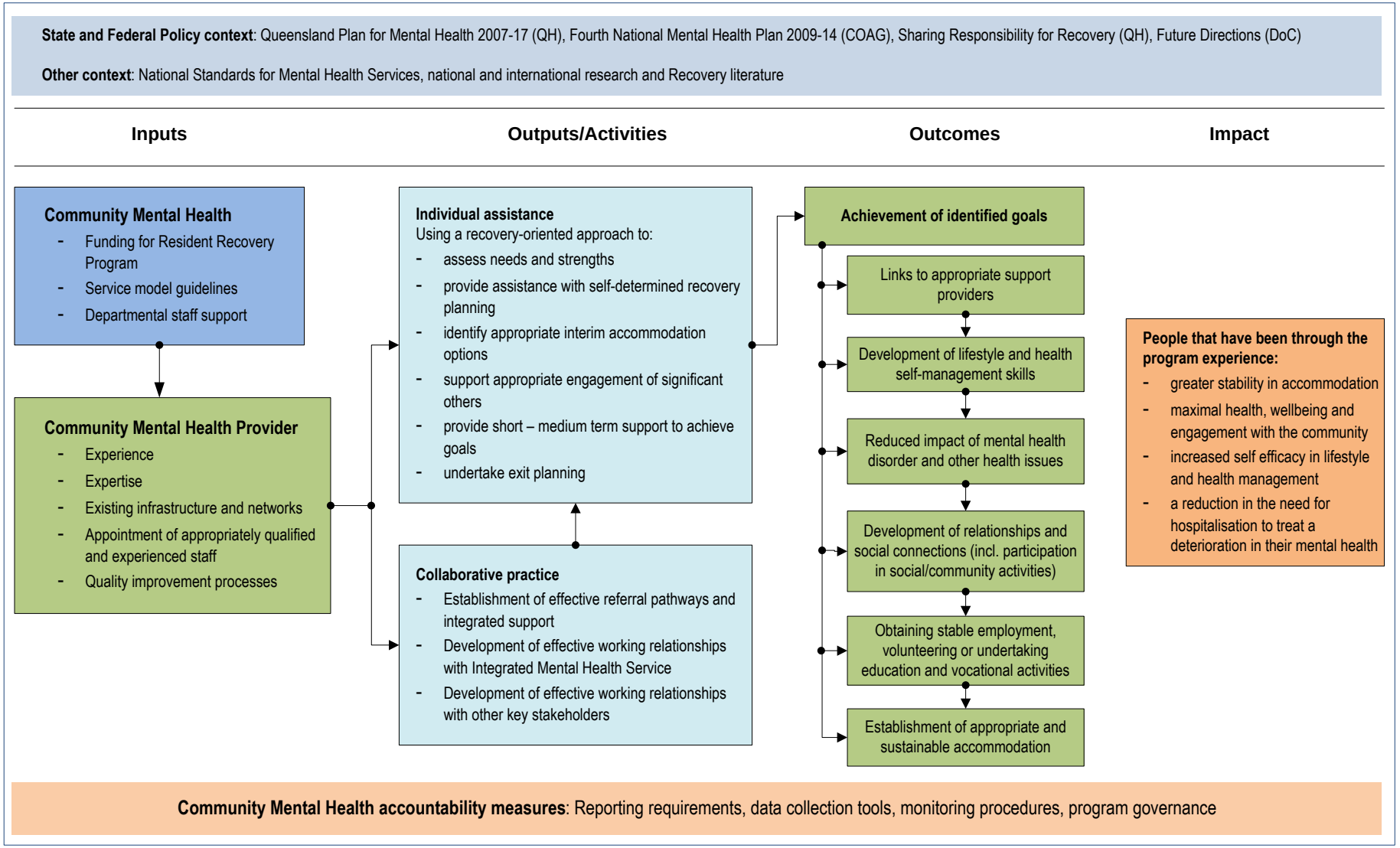
3. Methodology

Figure 3-1: Transitional Recovery Program – Program Logic



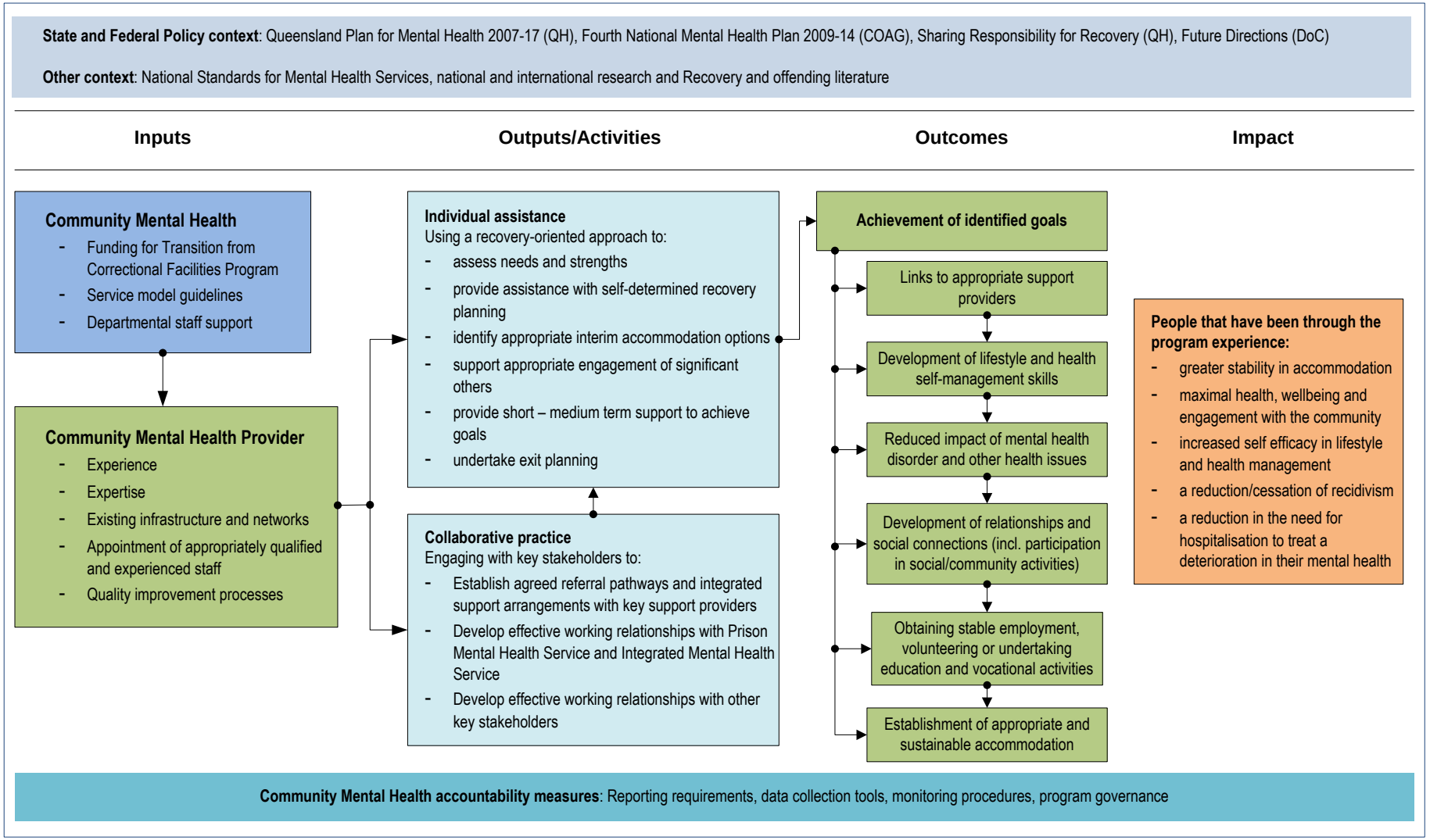
3. Methodology

Figure 3-2: Resident Recovery Program – Program Logic



3. Methodology

Figure 3-3: Transition from Correctional Facilities Program – Program Logic



3.1.2 Key Evaluation Questions

Drawing on the program logic models, the following key evaluation questions were developed:

- What is the cost of establishing each Transition to Recovery program?
- What is the cost of implementing each of the three transition programs?
- Is cycling through clinical mental health services and/or correctional services and/or periods of homelessness reduced by participation in the three transition programs?
- What is the cost of hospitalisation and/or other acute mental health interventions?
- What is the cost of incarceration and correctional services?
- What are the associated inputs required with providing the three transition programs (e.g. supported housing, employment assistance and so on)?
- What does the published literature indicate are the costs, cost-benefits and client outcomes of implementing community based transitional mental health programs in comparison to acute mental health services?
- Are there cost-benefits of providing community-based transitional mental health programs when compared to acute mental health services?
- Have the models been implemented as intended and are working at full capacity?
- Is the program reaching the intended target audience?
- What evidence is there that the target cohort has benefited from these particular models of service delivery?
- What changes to the broader service system have occurred as a result of the program?
- What impact do each of the three transition programs have on hospital admissions/return to prison and length of stay among clients that use these services?
- What are the intended and unintended outcomes of each of the transition programs?
- How do the costs and client outcomes of these community programs compare to acute mental health services?
- What are the opportunities for enhancing the programs?

To address these questions, a mixed methods approach was developed.

3.2 Phase 1: Development of the Evaluation Framework and Project Plan

The evaluation was designed to be conducted in two stages. However, delays in the ethics application process (see Section 3.2.2) meant that the Stage 1 and Stage 2 data collection activities could not follow the sequence that was originally envisaged. For this reason, the findings are reported in terms of client, service provider and systems level parameters rather than by Stage. Although the sequence of activities varied from what was originally planned, all planned data collection was carried out.

The key Phases of the revised Evaluation Plan are presented in *Table 3.1* below.

3. Methodology

Table 3.1: Phases of the evaluation plan

Phases	Component of the evaluation		Outputs
Phase 1	**Development of the Evaluation Framework and Project Plan**		▪ Project Plan ▪ Literature and document review ▪ Ethics application approved
Phase 2	**Data Collection and Analysis**	Developing Service Model and Client Profile	▪ Profile of service models ▪ Profile service users ▪ Interim report
		Determining Program and Client Outcomes	▪ Determination of program outcomes ▪ Outcome comparison between recovery programs and acute mental health services
		Cost Analysis	▪ Determination of establishment and ongoing costs ▪ Cost analysis ▪ Impact on hospitalisation and acute care
Phase 3	**Evaluation Reporting**		▪ Draft and Final Report

As described in Section 3.1, a program logic mapping exercise provided the basis for the development of the evaluation framework, thus ensuring a consistent and systematic approach to the evaluation of the three TTR programs. This stage also saw the completion of the literature review and Human Research Ethics Approval process.

As part of the evaluation framework, two TTR service providers from each program stream were selected for detailed study (Table X 3.2). The primary criteria used in the selection of these service providers was that they had been operating for a reasonable length of time and were thus aware of a range of potential and actual issues associated with program implementation. The assumption that the selected service providers and their experiences with the implementation of the model are representative of the other organisations involved in the program was not tested as part of the evaluation.
It is also important to note that the evaluation was based on the TTR program model overall, not the individual service providers who participated in the evaluation.

Table 3.2 lists the TTR service providers who participated in this evaluation.

Table 3.2: TTR service providers who participated in the evaluation

Program Stream	Service Provider Name and Acronym/Abbreviation		Program commencement date
TFCF	Richmond Fellowship Queensland	RFQ	5 March 2007
	Supported Options in Lifestyle and Access Services	SOLAS	3 September 2009
TRP	FSG Australia	FSG	4 March 2009
	Psychiatric Rehabilitation Australia*	PRA	19 June 2010
RRP	Nextt Health	Nextt	19 January 2009
	Footprints in Brisbane	Footprints	23 February 2009

* As a result of a merger between Richmond Fellowship New South Wales and Psychiatric Rehabilitation Australia, PRA is now known as Richmond PRA

3.2.1 Literature and Document Review

This included a review of current literature on recovery programs as well as existing documents, policies and reports relevant to the initiative.

Particular areas of interest included:

- The costs of implementing community based mental health programs and a comparison of these costs to the costs of acute mental health service delivery
- Client outcomes in community based mental health programs compared to client outcomes in acute mental health settings
- Strategies for the effective implementation of recovery programs.

3.2.2 Ethics Application Process

The ethics approval process in this project was multi-staged and resulted in substantial delays to the project timeline.

Following finalisation of the evaluation framework and data collection tools, an ethics application was made to the Gold Coast Health Service District Human Research Ethics Committee (Gold Coast HREC) on 7 March 2011. Concerns raised by Queensland Health regarding access to Queensland Health data resulted in the initial application being withdrawn after further consultation. Consequently, submission of the final version of the ethics application was delayed until 10 May 2011.

Gold Coast HREC subsequently requested further information and then withdrew this request a month later. These combined events resulted in data collection being delayed by four and a half months. AHA was a granted a variation to the project timeline in October 2011.

Public Health Act (PHA) approval was a pre-requisite to obtaining Queensland Health data and to conducting consultations with Queensland Health mental health staff. This approval was not issued until 22 December 2011. Submission of the request to obtain access to de-identified Unit Record data for a subsample of TTR clients therefore could not begin until January 2012. Likewise, the process of

obtaining Site Specific Assessment approvals (SSA) from six Health Service Districts to interview their mental health staff was delayed until January 2012.

SSAs were submitted to the following organisations/Health Service Districts (HSD) in January 2012:

- Redcliffe-Caboolture HSD
- Metro North Mental Health, Royal Brisbane Women's Hospital HSD
- Metro South Mental Health Service, Princess Alexandra Hospital, Metro South HSD
- Adult Community Mental Health Services, Robina Hospital, Gold Coast HSD
- Prison Mental Health Service
- Townsville HSD.

Delays in the approval process meant that SSA approvals were secured for only three organisations within the timeframe of the evaluation, namely Adult Community Mental Health Services, Robina Hospital (Gold Coast HSD), Metro North Mental Health (Royal Brisbane Women's Hospital HSD) and Prison Mental Health Services. Accordingly, interviews with Queensland Health mental health staff were restricted to these three organisations (see Section 5.5.2).

These delays necessitated a change to the sequence of activities.

3.3 Phase 2: Data Collection and Analysis

The evaluation methodology included the collection of a range of quantitative and qualitative data, obtained at several time points throughout the evaluation. Data was collected from six TTR organisations. Methods for data collection are discussed in the following sections under these headings:

- Quantitative Data Collection
- Qualitative Data Collection
- Service Model Profile Data Collection.

Table 3.3 summarises the tools, methods and data sources that were employed during all phases of the evaluation.

Table 3.3: Summary of data collection methods and data sources

Methods	Data sources/tools	Are as of enquiry
Review existing datasets	**Service provider datasets** The six participating TTR organisations (two from each program stream) were asked to provide data from their existing datasets	▪ Client profile ▪ Client outcomes ▪ Links to other services

3. Methodology

Methods	Data sources/tools	Are as of enquiry
	Queensland Health Mental Health data Mental Health data on inpatient admissions and days per admission. Also community mental health services data regarding contacts.	▪ Level of usage of Queensland Health Mental Health services after TTR participation compared to a control group
Collect additional quantitative data *(Only from the 6 participating TTR services)*	**RAS 24 Client Survey + other questions**	▪ Demographic + MH diagnoses information ▪ Client Profile ▪ Client Outcomes – Assess individual's recovery – Housing situation – Education, Training, Employment status – Physical health – Health supports (MH and physical) – Exercise
	RSA Consumer/Carer Survey (21 items of 36 items)	▪ Scope and value of service provider assistance ▪ Collected as part of client interview
	RSA Staff Survey	▪ Scope and value of service provider assistance
	RSA Service provider CEO Survey	▪ Scope and value of service provider assistance
	National Health Survey Questions (Module D – Q.2)	▪ Improvements in client health (included in RAS 24 Client Survey – extra questions)
	Program Financial Reports	▪ Cost analysis
Collect qualitative data (interviews, focus groups)	**Service providers**	▪ Implementation of the service model ▪ Understanding of Recovery ▪ Important local contextual information e.g. availability of housing, GPs, social programs ▪ Program outcomes and challenges ▪ Reflect on the RSA data ▪ Options for enhancements
	Queensland Health Community Mental Health services staff – Team leaders and community based Case Managers	▪ Reflections on the service model ▪ Program outcomes and challenges ▪ Options for enhancements
	Clients/carers/families	▪ Client journey prior to and since being part of program ▪ Impact of program on clients ▪ Acceptability of program to clients ▪ Support for Carers/families
	Departmental Stakeholders Central Dept of Communities senior program staff	▪ Strengths and challenges of implementing program ▪ Information about different services level of establishment

3. Methodology

Methods	Data sources/tools	Are as of enquiry
Other data	**Case Studies**	▪ Client outcomes ▪ Program Outcomes
	Staffing Profile	▪ Template developed by AHA to gather details regarding the qualifications and experience of program management and staff at the six target service providers
	Service Models	▪ AHA provided with information on the service models by each of the six target service providers

3.4 Quantitative data collection and analysis

Quantitative data collection related primarily to data on clients and client outcomes. Some data, such as the client profile and the Queensland Health data was drawn from existing datasets. To assess client outcomes, it was necessary to collect new data from the six participating TTR service providers. The following *Table 3.4* describes, for each data collection instrument and/or tool used, the area of enquiry to which it relates, the method for data collection and achieved sample size where applicable.

Table 3.4: Quantitative data collection

Data Collection Instrument/Tool	Appendix	Area of enquiry	Data collection method	Achieved Sample
Client Support and Outcomes (including client profile)	Appendix C	Identify the characteristics of people accessing the three TTR programs, supports provided to them and outcomes achieved.	Service providers completed the client profile template for all clients who had entered their program from commencement to 30 December 2011. The Client Support and Outcomes request was completed for a sample of clients who exited	Client Profile, n = 842
Financial information from service providers	-	Establishment and ongoing costs of each program	The six service providers submitted budgets and financial reports.	Not applicable
Queensland Health Data	-	Level of usage of Queensland Health Mental Health services after participation in the TTR Program compared to a control group	Service providers compiled a list of clients who had exited their program from 1 January 2010 to 30 June 2010; this was submitted directly to QH as it contained identifiable information and QH forwarded the information to DOC. Data was extracted for the sample of clients, and a matched comparison group, for the period 1 November 2008 – 30 June 2011.	81 TTR clients

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Data Collection Instrument/Tool	Appendix	Area of enquiry	Data collection method	Achieved Sample
Recovery Self Assessment (RSA)	Appendix D (staff version) Appendix E (CEO version)	Scope and value of service provider assistance	Clients – completed survey during interview Service Providers (Managers and staff) – completed survey prior to AHA's visit to conduct group interviews	21 Clients 27 Service providers
Recovery Assessment Scale 24 Item version (RAS 24) plus other questions	Appendix F	Assess individual's recovery (RAS 24). Additional questions regarding demographic and mental health diagnoses information; housing situation; education, training, employment status; physical health; health supports (mental health and physical); exercise.	Clients entering a TTR program during the period 6 September 2011 to 31 January 2012 were asked to consent to completing the entry survey. Exit surveys were administered prior to a client's exit from the program, or by 10 August 2012 if still in the program.	60 pre-intervention surveys 22 post-intervention surveys

Data collection tools

In February 2010, the Australian Mental Health Outcomes and Classification Network (AMHOCN) published a review of available recovery measures, which considered both instruments designed to measure individuals' recovery and instruments designed to assess the recovery orientation of services.[25] This review informed AHA's selection of tools for use in the evaluation, and the selected tools are discussed below.

Recovery Self Assessment (RSA)

The RSA is designed to measure the extent to which recovery-supporting practices are evident in mental health services. It contains 36 items which collectively assess five domains: life goals; involvement; diversity of treatment options; choice; and individually-tailored services. Each item is rated on a 5-point Likert scale. There are four versions, one for each of the following stakeholder groups: consumers (person in recovery version); family members or carers (family/significant others/advocates version); providers (provider version); and managers (CEO/Agency director version).[26] AHA utilised the manager version and modified this for use with consumers.

Recovery Assessment Scale (RAS)

The RAS was developed as an evaluation measure, and has been used to assess the impact of a range of programs. It is designed to assess various aspects of recovery from the perspective of the consumer, with a particular emphasis on hope and self-determination. The original instrument comprises 41 items, and a shorter version (used by AHA for this project) containing 24 items is also available (RAS 24). In both versions, each item is rated on a 5-point Likert scale. It covers five domains: personal confidence

[25] Burgess, P, Pirkis, J, Coombs, T, Rosen, A. *Review of Recovery Measures*, Australian Mental Health Outcomes and Classification Network, February 2010 available at http://amhocn.org/static/files/assets/02e3f75a/Review_of_Recovery_Measures.pdf

[26] Burgess et al, *Review of Recovery Measures*

and hope; willingness to ask for help; goal and success orientation; reliance on others; and no domination by symptoms.[27]

The review found the RAS to have good internal consistency, validity and reliability, sensitivity to change was untested. The RAS has been validated for use in the Australian context.[28] Importantly, as both the RAS and RSA were ranked[29] in the AMHOCN review as being among the four best suited instruments for measuring individuals' recovery and the recovery orientation of services respectively in the Australian public sector mental health services context, [30] these tools were considered a good fit for purpose in the current evaluation.

Stakeholder recruitment for quantitative data collection

RAS Surveys

All new clients who entered their program between 6 September 2011 and 31 January 2012 were informed by the service provider about the evaluation. A plain-English participant information and consent form (Appendix G) was used in this process. Clients who agreed to participate in the evaluation completed the consent form.

Recovery Self Assessment

All clients who participated in client interviews in August 2011 were asked to complete the RSA questionnaire.

Management and staff at the six service providers were provided with the RSA questionnaire by email and also a link to an online version of the questionnaire.

3.4.1 Qualitative data collection and analysis

Qualitative data collection was primarily through interviews with a range of stakeholders. This section describes the methods, consultation tools and recruitment strategy used.

Stakeholder consultation methods and tools for qualitative data collection

The following *Table 3.5* identifies the stakeholder group consulted, the method of consultation, the sample and timing of the consultation.

[27] Burgess et al, *Review of Recovery Measures*.

[28] M McNaught, P Caputi, LG Oades & & FPDeane,. Testing the validity of the Recovery Assessment Scale using an Australian sample. *Australian and New Zealand Journal of Psychiatry* vol. 41, no.5, 2007,450-57.

[29] A total of 33 instruments were included in this review.

[30] Burgess, P, Pirkis, J, Coombs, T, Rosen, A. *Review of Recovery Measures*, Australian Mental Health Outcomes and Classification Network, February 2010 available at http://amhocn.org/static/files/assets/02e3f75a/Review_of_Recovery_Measures.pdf

3. Methodology

Table 3.5: Stakeholder consultation by stakeholder group

Stakeholder Group	Consultation method and tool used	Achieved Sample	Date of Consultation
TTR service provider managers and staff	*Method:* Face to face interviews with management ▪ Focus groups with program manager/staff. ▪ Case studies of clients (compiled by program manager/staff) *Tool:* ▪ Service Provider Manager interview (Appendix H) ▪ Focus group with program manager/staff groups (Appendix H ▪ Case study proforma (Appendix I)	Footprints 6 FSG 7 Nextt 8 PRA 6 RFQ 7 SOLAS 10 TOTAL 44	29 – 31 August 2011
Clients	*Method:* ▪ Semi-structured face to face interviews ▪ Completion of RSA questionnaire during the interview. *Tool:* ▪ Client interview tool (Appendix J)	Footprints 5 FSG 2 Nextt 5 PRA 2 RFQ 6 SOLAS 1 TOTAL 21	29 – 31 August 2011
Other Stakeholders (Housing/accommodation providers, private psychologists, NGOs involved in providing counselling services, corrective/legal services, Alcohol and Other Drugs (AOD) services and employment services)	*Method:* ▪ Semi-structured phone interviews with managers or team leaders at organisations nominated by TTR providers who have a relationship with the TTR providers *Tool:* ▪ Other Stakeholders interview tool (Appendix K)	21 stakeholders	December 2011 – March 2012
Departmental stakeholders	*Method:* ▪ Semi-structured telephone interviews conducted with stakeholders identified by Department of Communities *Tool:* ▪ Department of Communities interview tool (Appendix L)	4 stakeholders	19 June 2012
Queensland Health Mental Health services /Team Leaders/Case Managers	*Method:* ▪ Semi-structured group interviews with team leaders, case managers and other relevant workers whose services relate to the six evaluation sites *Tool:* ▪ Queensland Health Community Mental Health services / Prison Mental Health Services - Interview/Focus Group schedule (Appendix M)	11 stakeholders	13 – 15 August 2012

3. Methodology

TTR Service Provider managers and staff

AHA liaised with the six TTR service providers to identify suitable senior management, management and staff to be involved in the manager and staff group interviews. Group interviews were held at the premises of each of the providers.

Clients/Participants

TTR service providers were asked to identify a specified number of suitable clients who had been involved in their program for a reasonable period of time and explain the evaluation and interview process using the Participant Information and Consent form. The number of clients in each case was proportionate to the size of the service in question. Clients who were willing to be involved provided written informed consent. All service providers recruited the required quota of clients.

A total of 23 clients/participants consented to be involved in an interview. Twenty-one interviews were completed as two clients were not well enough on the day of the interview to attend.

In line with the Australian Market and Social Research Society (AMSRS) code of conduct, those who participated in the interviews received a $30 Coles Myer voucher to thank them for their time.

Other Stakeholders

Each of the six TTR service providers were asked to identified four or five stakeholders with whom they work to support their clients and provided contact details for these stakeholders. They also informed the stakeholders of AHA's potential contact. Telephone interviews were conducted with a selection of stakeholders who were able to be contacted and agreed to participate.

Departmental stakeholders

While AHA liaised with a number of Departmental representatives throughout the evaluation, formal stakeholder interviews were arranged with senior program staff in June 2012. The principal program officer (Evaluation) in DCCSD identified the four senior representatives from the Department of Communities to be involved in individual telephone interviews.

Queensland Health Mental Health Services – Community Mental Health Services

Group interviews were held with nominated staff at each of the three Queensland Health Mental Health Services sites for which SSA approval was received.

Case Studies

Case studies were added to the range of data collection tools used in the evaluation. This addition occurred in response to TTR service providers' concerns that the complexity of client achievements might not be fully reflected from the quantitative data collected. Case studies were considered a useful means of illustrating the recovery journey and outcomes for people who participated in the TTR programs. Service providers were asked to select clients whose experiences in the Recovery program were illustrative of the recovery journey for clients, consent was then gained from clients. A proforma was provided to write the case studies.

3.4.2 Service Model Profile data collection

In addition to the quantitative and qualitative data collection methods discussed above, AHA collected further information from service providers, in relation to the service model and staffing profile. Service providers submitted this additional information using a profile template provided by AHA.

Service Model and Staffing Profile

Service providers were asked to complete a staffing profile including numbers of staff in the TTR program, qualifications and training completed and previous experience working in the sector for each staff member. The profiles were then submitted electronically. This information was added to the information obtained through interviews with service providers to develop Service Model profiles (Appendix O). The Service model profiles provide a snapshot of each of the organisations involved in this evaluation and how the TTR model is being implemented.

3.4.3 Data analysis

Characteristics of study participants were described using means and proportions. Examination of the distributions of RAS total and subscale scores identified substantial negative skewness for several domains, with scores generally clustering towards the higher end of possible range of score (i.e., towards the higher level of characteristic being measured). The distribution of difference scores from entry to exit also showed substantial negative skewness. Given that the data did not meet the normality assumption, statistical significance of changes in RAS total and domain scores were compared using the Wilcoxon signed-rank test.

The Wilcoxon signed-rank test tests the null hypothesis that the median difference between pairs of observations is zero. Statistically significant result ($p<0.05$) indicates that the observed changes in the scores obtained on two separate occasions are unlikely to have occurred by chance and therefore, represent 'real' change.

Thematic analysis was used to identify key themes and issues and to better understand the experiences of service users, and participating service providers. Case studies have also been included to provide examples of people who derived varying degrees of benefit from the Transition to Recovery Programs and highlight particular areas of good practice and areas of improvement.

The thematic analysis was conducted using Grounded Theory, a technique that uses a constant comparative method of coding and recoding.[31,32] Additionally, data from the clients interviews was analysed using a Miles and Hubermann matrix.[33]

[31] J Saldana, *The coding manual for qualitative researchers*, Sage, USA, 2009.

[32] E DePoy& LGitlin, *Introduction to research: understanding and applying multiple strategies.* (2nd *Edition*), Mosby, St Louis, 1988.

[33] M Miles and M Huberman, *Qualitative data analysis: an expanded sourcebook (2nd Edition),* Sage, USA, 1994.

4 FINDINGS: LITERATURE REVIEW

4.1 Introduction

A literature review was conducted to support the evaluation of the Community Mental Health Transition to Recovery programs, by presenting and discussing evidence relating to:

- The conceptual underpinnings of the recovery model
- Challenges in implementing recovery models, with specific attention to issues in the forensic mental health setting
- The Australian and international experience of implementing recovery programs
- The benefits and costs of recovery-oriented service models.

The key findings from the literature review are presented below. The full review is provided in *Appendix A.*

4.2 Search strategy

Key search words:	Recovery, mental illness, mental health, psychiatry, symptoms, prisoner, forensic, rehabilitation
Data sources:	Medline, Google Scholar, government reports and publications, with additional hand searching for additional relevant references.

The initial search was conducted in November 2011 and updated in July/August 2012. The literature review was reviewed by two content experts prior to finalisation.

4.3 Overview of key learnings

The body of literature supporting recovery-oriented approaches to mental health service delivery is growing rapidly. Despite strong enthusiasm for the concept, precise definitions of recovery vary. Nevertheless, most interpretations emphasise a shift away from a 'care model' of service delivery to a collaborative model that supports and enables mental health clients to improve their quality of life and fulfil their potential.

4.3.1 Implementation

Challenges exist with the implementation of recovery oriented services. These include barriers at the level of clients, service providers, the community and the broader health and social context. Challenges also exist in the evaluation and measurement of recovery-oriented approaches. Specific challenges have been identified for the implementation of recovery oriented programs within the correctional services system; these stem from the complex health and social needs of this population group, often compounded by societal attitudes towards ex-prisoners.

The literature review has highlighted the following considerations for effective implementation of recovery-oriented policy and practice:

- Ensure that there is a shared definition and understanding of recovery, at all levels of the system
- For recovery-oriented services to operate optimally, it is important that clients have access to appropriate housing, employment (where feasible) and that social inclusion is promoted. Responsibility for these requirements is outside the scope of the mental health system itself, and requires whole-of-government commitment
- The Consumer Operated Service model is an example of an effective recovery-oriented approach that has been shown to achieve the goal of consumer empowerment without creating unrealistic expectations or false hope.
- People with 'lived experience' of mental illness can act as powerful advocates to promote the benefits of a recovery orientation at all levels of the mental health system.

Within the forensic context, the key elements of effective recovery-oriented programs include:

- Access to competent care
- Assistance to obtain suitable housing
- Access vocational programs, and
- Ensuring appropriate community linkages upon release.

4.3.2 Benefits, costs and cost-effectiveness of recovery-oriented programs

Despite the implementation challenges outlined above, there is evidence of a range of benefits stemming from recovery-focused interventions. These include reductions in hospital admissions, decreased length of hospital stay, improved mental health, improved housing stability, improved occupational health and social functioning and decreased rates of imprisonment.

Table 4.1 provides an overview of the client outcomes and cost savings that have been demonstrated through recovery-oriented programs in Australia and internationally. One of the striking features of this table is the multiplier effect of individual interventions. Provision of stable housing for example, was found to be instrumental in reducing costs to the hospital and judicial systems, as did securing stable employment.

An assessment of the cost and cost effectiveness of recovery-based approaches not only involves reviewing the costs of providing particular interventions but also considering the broader ramifications of these interventions. Recovery-based approaches must be integrated into a diverse range of services in order to meet their clients' needs. Consequently, this is likely to trigger a transfer of costs from one system to another. For example, as outlined earlier, providing secure housing can result in reduced costs to the hospital and judicial systems. However, these savings come at a monetary cost to the housing sector itself. Likewise, providing community-based mental health may reduce the need for and therefore the costs of acute hospital care. However, in addition to increasing costs to the community mental health sector, this change may also involve a transfer of costs from the acute hospital setting to outpatient services.

Paradoxically, despite their community-based orientation, recovery programs may actually generate an increase in the use of acute services. This appropriate increase generally occurs in the case of clients who, prior to being involved in a recovery program, had been inadequately accessing services they needed.

Determining whether these cost transfers ultimately yield cost savings, cost increases or represents the most cost effective solution to delivering mental health services is therefore a complex issue. Delivering services at community level is generally less expensive than providing acute hospital services. So too is providing services in an outpatient rather than an acute setting. Failure to provide appropriate services also comes with its own costs, particularly when the outcomes for this potential client group are increased homelessness, recidivism, unemployment, social exclusion and mental illness.

4. Findings: Literature Review

Table 4.1: Client outcomes and cost savings demonstrated through recovery-oriented programs in Australia and internationally

Study	Year published	Country	Intervention	Outcomes	Savings
Dual diagnosis patients in community or hospital care: One-year outcomes and health care utilisation and costs[34]	2006	USA	Community-based versus hospital-based acute residential treatment for dual diagnosis patients (substance use and psychiatric disorders)	▪ Better substance use and psychiatric outcomes for patients assigned to care in community residential facilities (CRF) rather than hospital acute care ▪ Shorter, but more costly, stays for patients in hospital acute care ▪ Patients in hospital acute care had more expensive mental health follow-up stays over the next 12 months.	▪ For those patients considered to be in remission at 1 year follow-up, the average cost for hospitalised patients was US$25 462, and the cost for CRF patients was US$12 174 (these findings should be treated with caution due to small numbers of patients involved).
Mental health peer support for hospital avoidance and early discharge: An Australian example of consumer driven and operated service[35]	2008	Australia (SA)	Mental health peer support service (Hospital avoidance and early discharge support).	▪ Overwhelmingly positive feedback from all stakeholders ▪ Only 17% of referrals relapsed to hospital either during or directly after the support period (n=8); the expected relapse rate prior to the project was 30%.	In first 3 months of operation 49 support packages were provided : ▪ 300 bed days saved ▪ Saving of AU$93 150 after project set up, delivery and administration costs of approximately AU$19850.
The cost-effectiveness of homelessness programs: a first assessment : Volume 1 Main report for the Australian Housing and Urban Research Institute Western Australia Research Centre[36]	2008	Australia (WA)	Homeless programs (43% of sample had mental health condition).	▪ Reduced use and associated cost of all justice services ▪ Appropriate increase in use of services	▪ Annual cost reduction of AU$1739 per client. because of reduced use and associated cost of all justice services ▪ Potential annual whole-of-government savings of at least twice the annual cost of delivering effective homelessness programs; e.g. single male homelessness assistance costs only AU$4625 per client compared to average health and justice costs of AU$10 212 above the normal population rate while homeless.

[34] C Timko, S Chen, J Sempel, P Barnett, 'Dual diagnosis patients in community or hospital care: One-year outcomes and health care utilization and costs'. *Journal of Mental Health*, 2006, vol. 15, no.2, pp.163-177.

[35] S Lawn, A Smith, & K Hunter, 'Mental health peer support for hospital avoidance and early discharge: An Australian example of consumer driven and operated service', *Journal of Mental Health*, vol. 17, no. 5, pp.498-508.

[36] P Flatau, K Zaretzky, M Brady, Y Haigh & R Martin, *The cost-effectiveness of homelessness programs: a first assessment Volume 1* – main report for the Australian Housing and Urban Research Institute Western Australia Research Centre (AHURI Final Report No.119), Australian Housing and Urban Research Institute, WA, 2008.

4. Findings: Literature Review

Study	Year published	Country	Intervention	Outcomes	Savings
The long-term impact of employment on mental health service use and costs for persons with severe mental illness[37]	2009	USA	Stable employment (observational study)	▪ Significantly greater decline in use of outpatient services for the steady-work group than minimum-work group ▪ Institutional (hospital, jail, or prison) stays declined for both groups .	▪ Average cost per participant for outpatient services and institutional stays for those in the steady-work group was US $166 350 less than the minimum-work group over ten years.
Housing and Support Program (HASP) Final Evaluation Report [38]	2010	Australia (QLD)	Housing and support (including clinical support)	▪ 82.2% of clients helped or were currently being helped to achieve their goals through HASP. ▪ The majority of HASP tenancies remained stable; 82.5% living in the initial accommodation provided through HASP. ▪ Number of support hours provided each week decreased by 7.13 hours from an average of 27.6 hours on entry into HASP to an average of 20.4 hours at the follow up time point. ▪ Average inpatient care time per individual decreased from an average of 227 days in the 12 months prior to HASP to an average of 18.9 days in the 12 months post-HASP. ▪ Decrease in average number of admissions from 1.22 admissions in the 12 months prior to HASP to an average of 0.66 admissions per individual in the following 12 months.	▪ Overall, the recurrent cost of keeping the 'average' client in HASP for 12 months appears to be: – AU$74 000 less expensive than keeping the same client in a community care unit (CCU) and – AU$178 000 less expensive than keeping the same client in an acute inpatient unit. The findings suggest that ▪ two clients could be maintained in HASP for the cost of keeping one client in a CCU ▪ almost 3 clients could be maintained in HASP for the cost of keeping one client in an acute inpatient unit. *

[37] P Bush, R Drake, H Xie, G McHugo & W Haslett, 'The long-term impact of employment on mental health service use and costs for persons with severe mental illness', *Psychiatric Services*, vol. 60, no. 8, pp.1024-31.

[38] T Meehan, K Madson, N Shepherd & D Siskind. *Housing and Support Program (HASP) Final Evaluation Report*, University of Queensland and The Park Centre for Mental Health, Brisbane, 2010.

4. Findings: Literature Review

Study	Year published	Country	Intervention	Outcomes	Savings
Effect of Full-Service Partnerships on Homelessness, Use and Costs of Mental Health Services, and Quality of Life Among Adults With Serious Mental Illness[39]	2010	USA	Housing to reduce homelessness Also engaging and retaining clients using team-based services.	▪ Mean number of days spent homeless per year declined 129 days from 191 to 62 days ▪ the probability of receiving inpatient services declined by 14% ▪ the probability of emergency services declined by 32% ▪ the probability of receiving inpatient services declined by 17% ▪ outpatient mental health visits increased by 78 visits ▪ Quality of life was greater among participants than among homeless clients per person receiving services in outpatient programs.	▪ Inpatient costs declined by US$6882 per person ▪ Emergency service costs declined by US$1721 per person ▪ Jail mental health services costs declined by US$1641 per person. ▪ Reductions in costs of inpatient/emergency and justice system services offset 82% of the cost of the intervention. – Housing costs increased by US$3180 per person – Outpatient costs increased by US$9180
Evaluation of the Whole of Mental Health, Housing and Accommodation Support Initiative (HASI), Second Report'[40]	2011	Australia (NSW)	Access to secure housing and support to maintain their tenancy. Facilitate improved mental and physical health through access to appropriate services.	▪ average number of hospital admissions each year decreased by 24% ▪ mean number of days spent in hospital per person per year decreased by 60% ▪ average number of days hospitalised per admission decreased by 68 % ▪ 54% of consumers independently participating in social and recreational activities	The total program budget over four years was: ▪ $118 million accommodation support costs ▪ $1 million project management costs Previous housing capital investment 2002-07 was AU$26 million. This is equivalent to an annual unit cost per consumer ranging from AU$11,000 to AU$58,000, plus project management costs of between $200 to $500 per person, depending on the level of accommodation support and the method of calculating the annual unit costs. *Note: The final report will assess the cost of HASI against the outcomes experienced by HASI consumers*

[39] T Gilmer, A Stefancic, S Ettner, W Manning, S Tsemberis, 'Effect of Full-Service Partnerships on Homelessness, Use and Costs of Mental Health Services, and Quality of Life Among Adults With Serious Mental Illness', *Archives of General Psychiatry*, vol. 67, no. 6, 2010, pp. 645-52.

[40] S McDermott, J Bruce, I Oprea, K Fisher & and K Muir, *Evaluation of the Whole of Mental Health, Housing and Accommodation Support Initiative (HASI), Second Report*, prepared for NSW Health and Housing , Sydney, 2010.

4. Findings: Literature Review

Study	Year published	Country	Intervention	Outcomes	Savings
Does supported accommodation improve the clinical and social outcomes for people with severe psychiatric disability? The Project 300 experience[41]	2011	Australia (QLD)	Providing long-stay hospitalised patients with their own home in the community and an average 20 hours/week non-clinical support.	▪ Improved freedom and autonomy (most were still living in the community at 7 years follow-up) ▪ 40% had not had acute hospital admission after 7 years. ▪ Little impact on social inclusion, clinical functioning and overall disability	▪ Average cost per Project 300 client per annum: AU$61 580 (includes allocated 20 hours personal care, GP/case management services and allocation for 10 day admission to acute care). ▪ This compares favourably with cost of keeping the same client in an acute inpatient unit (AU$246700) or a community care unit ($133 225)

**Costs based on recurrent costs only. Initial costs involved in selecting clients for the program, securing housing options and establishing infrastructure in the community to support each individual have not been considered in estimates*

[41] T Meehan, T Stedman, S Robertson, S Drake & R King, 'Does supported accommodation improve the clinical and social outcomes for people with severe psychiatric disability? The Project 300 experience', *Australian and New Zealand Journal of Psychiatry* vol.45, pp.586-92.

5 FINDINGS: SERVICE MODEL IMPLEMENTATION

This chapter focuses on how the TTR service model has been implemented by the six service providers involved in this evaluation. This chapter reports on how the model conceptualised in the policy documents (refer Section 2.4) has been operationalised within the TTR program streams, so that findings in relation to service delivery and client outcomes (presented in later chapters) can be contextualised.

Implementation is viewed from multiple perspectives, including that of management, staff and clients in the TTR programs, as well as the views of other key stakeholders the projects engage with.

Four main data sources were used:

- Interviews with program management at two time points in the evaluation (August/September 2011 and July/August 2012)
- Interviews with program staff at the August/September 2011 time point
- Comparison of Recovery Self Assessment (RSA) scores from management, staff and client
- Interviews with Queensland Department of Health.

These data are presented for each of the program streams, to:

- Ascertain the extent to which the three TTR program service models have been implemented as intended
- Identify the key barriers and enablers to program implementation
- Identify current and future improvements and challenges
- Assess the extent to which management, staff and clients share a common perception of the recovery-oriented characteristics of the program.

Findings in relation to the above key issues are reported in the following six sections:

Further information about how the service model was implemented by each of the six organisations studied as part of the evaluation, is provided in Appendix O.

5. Findings: Service Model Implementation

5.1 Transition from Correctional Facilities Program

The key elements of the Transition from Correctional Facilities Program are outlined in *Table 5.1*. A full description of the service model can be found in Section 2.4.1.

Four organisations are involved in the Transition from Correctional Facilities Program in Queensland. This evaluation was based on detailed information on the Richmond Fellowship Queensland (RFQ) and Supported Options in Lifestyle Access Services Inc (SOLAS) only.

Table 5.1: Transition from Correctional Facilities Program elements

Service model: key elements	
Eligibility criteria; source of referral	▪ 18+; Australian residency/citizenship criteria met ▪ referred by Queensland Health's Prison Mental Health Service (PMHS) ▪ diagnosed (primary) moderate to severe mental illness by PMHS ▪ willing to participate In the context of the potential client: ▪ leaving a Queensland Correctional Facility ▪ accessing clinical case management from an appropriate agency post-release.
Mode of delivery	A regular forum between service provider and referring PMHS to ensure referral and intake prioritisation processes managed and other stakeholder needs addressed
Proposed service	Provision of individualised, flexible and responsive transitional support to assist the person to plan and achieve their agreed personal recovery goals on leaving corrections, including long-term community housing solutions.
Duration of support	Pre-release support: ▪ ideally two weeks before release: service provider and client work together ▪ up to three months before release: PMHS, service provider and client work together
	Post-release support: ▪ up to six months.

5.1.1 Developments in Transition from Correctional Facilities service model by 2011

Extent of shift from service model original intent

The Transition from Correctional Facilities service model had been largely implemented as planned. The only shift found from the original intent of the service model is pre-release support from the service provider sometimes failed to commence at the ideal minimum of least two weeks prior to the individual's release date. This occurred despite positive relations between clinical PMHS and non-clinical service providers.

Barriers and Enablers to service model implementation

Meeting the multiple needs of the client group was reported as the major challenge to implementation of the service model. Mental health issues were commonly compounded by illiteracy, substance abuse, cognitive impairment, physical ill health and a history of repeated incarceration amongst this client

group. Challenges were particularly evident in the post release phase of the service model, when a range of community supports needed to be accessed, including mental health, AOD and housing. Service providers reported that the double stigma of mental illness and a prison background affected access to housing in particular, when long term housing was already scarce. Prior to engaging with their service, clients often had the expectation that things would fail, were transient in lifestyle or did not have previous positive experiences of support services, and entered the service with expectations of failing again. Staff needed to be very flexible in order to provide support where a particular client most needed it, or was most ready to change.

To support the staff who encountered these difficulties on a daily basis, management at both service providers had embedded their organisations' recovery/practice model in induction and staff performance management processes. One organisation provided a three month induction process which involved mentoring, including mentoring by Indigenous mentors, while the other provided ongoing training in the organisation's practice model. Awareness of the relative nature of client 'success' or the need for a long term view of 'success' amongst this client group was also cited as enablers. Staff interviews confirmed the training and supervision support provided by both service providers; AOD training was particularly valued.

The service providers' management and monitoring of relationships with pre-release and post-release stakeholders was seen as crucial to the integrity of the service model. Pre-release relationships were important in influencing both appropriateness of referrals and the timelines in which pre-planning for transition could occur with clients, by both PMHS and service providers.

The difficulty of maintaining post-release stakeholder networks was exacerbated by the size of the geographical areas which the Transition from Correctional Facilities programs covered, and the transient nature of their client group.

5.1.2 Current and future challenges: Transition from Correctional Facilities service model

Each organisation was consulted again approximately one year after the original consultation. At this time, current and future challenges were discussed and management were asked about any significant differences to their implementation of the model in the intervening year.

Mode of delivery pre and post-release

The majority of implementation effort within this service model continued to be spent on maintaining cooperative relationships amongst pre-release/referring stakeholders. Whilst work outputs between clinical and non-clinical stakeholders remained productive, service provider staff continued to express concern that this aspect of the service model relies on personal relationships rather than system level policies and procedures or consistent respect from clinical staff for the role of non-clinical mental health service provider staff.

Effort spent to engage, access and sustain appropriate community support services for clients in the post release phase, also continued. Access to AOD services for clients remained a particular challenge, mainly due to scarcity of detoxification and rehabilitation services. Staff continued to report encountering discrimination against ex-prisoners by some mental health staff, and gate-keeping between mental health and AOD services when the client had dual diagnosis issues resulting in lack of any service. Integration at a policy level had occurred with mental health and AOD services now part of the one Directorate, but this had not flowed through into integrated services on the ground.

Staff of one organisation had been successful in accessing AOD motivational interviewing training as a means of addressing AOD client needs directly.

Access to immediate and long term housing was a challenge in different areas of the state, and overall, staff reported limited capacity in most housing services.

Duration of support

The length of the program continued to be sufficient for many people, but some still need additional support at the end of six months. Both services reported increasing challenges with referring exiting clients onto other, post discharge services. The Growing Stronger Initiative[42] had particularly affected one program as services were no longer able to refer directly to each other and clients needed to "cycle through the referral and assessment process" every time their needs changed. This had also undermined organisations' ability to use other programs within their own service to support exited clients. Nevertheless, access to Disaster Relief funding had provided additional capacity in some cases for client support. Personal Helpers and Mentors Scheme (PHaMS) in rural and remote areas were still accepting referrals for exiting Transition from Corrections clients. Rotation of clients through the program more than once was another means by which support beyond six months was obtained.

5.2 Transitional Recovery Program

The key elements of the Transitional Recovery Program are summarised in *Table 5.2.* Three organisations are involved in the program in Queensland. The evaluation considered detailed information on FSG Australia (FSG) and Psychiatric Rehabilitation Australia (PRA) only. A full description of the Transitional Recovery Program service model can be found in Appendix O.

Table 5.2: Transitional Recovery Program elements

Service model: key elements	
Eligibility criteria; source of referral	▪ 18+; Australian residency/citizenship criteria ▪ diagnosed (primary) moderate to severe mental illness; status of which is stable enough to live in community accommodation, but with medium to high support needs ▪ need for short to medium term psychosocial support to live in the community ▪ willing to participate, including work towards achieving stable, long-term community housing solutions ▪ clinical case management support from an appropriate agency
Mode of delivery recommendations	▪ Service provider and relevant local mental health service develop agreed entry pathways and a process for assessing eligibility, priority of access and referrals. ▪ A local inter-agency governance structure to support collaborative

[42] The Queensland Government's reform *Growing Stronger: Investing in a better disability service system*, came into effect in July 2011. Its three main improvements encompassed: a new way for prioritising requests for support; a process of review to ensure that the services and support people receive continue to provide the support they need; changes to service provider funding. Source: The Queensland Government Department Communities, Child Safety and Disability Services Accessed 27th August 2012 http://www.communities.qld.gov.au/disability/key-projects/growing-stronger-investing-in-a-better-disability-service-system

Service model: key elements	
	practice amongst government, service providers, mental health service providers and relevant stakeholders, including management of referral and prioritisation processes.
Proposed service and duration of support	▪ Up to twelve months: Community accommodation and 24 hours per day psychosocial recovery support ▪ Up to six months: Outreach recovery support in client's own accommodation

5.2.1 Developments in Transitional Recovery service model by 2011

Extent of shift from service model original intent

The Transitional Recovery service model had been implemented as planned. The allocation of housing to FSG by Government Housing to accommodate clients in stage two of the model was a notable enhancement of the original service model.

Barriers and enablers to service model implementation

By accessing recovery-specific training, FSG enabled a recovery focus to be instilled in the program from the beginning.[43] The input of Helen Glover in forging this service model's key partnership, with Queensland Health, ensured recovery remained central. The benefit of the FSG program's commitment to a recovery focus was passed onto PRA, when PRA learnt from FSG's experience to set-up the second program. PRA has maintained its recovery focus through training in recovery mentoring undertaken by the coordinator and staff supervision.

The Reference Group mechanism was a major enabler in ensuring that the Transitional Recovery service model entry and assessment process was implemented as originally intended in both programs. Department support of the Reference Groups and related processes was a key, positive influence.

By 2011, both service providers were successful in maintaining these referral and assessment systems with Queensland Health, although FSG had flagged the Growing Stronger Initiative [44]as a threat and PRA reported that maintenance of the referral and assessment systems required considerable energy.

Availability of housing or accommodation options for clients to transition into, at both stage two of the program and on exiting the program, remained a service model tension. In 2011 this issue was being managed by both implementing service providers, and all clients had exited the program within the expected timelines. The additional block of accommodation provided to FSG as transitional housing stock ensured that clients could move on from stage one when they were ready to do so.

[43] Recovery-specific training was initially funded by the Department of Communities as part of the 2007-2008 Queensland Government budget allocation to the TTR Initiative. Training was provided by Helen Glover of *enLightened Consultants. Source: AHA consultation with Department of Communities.*

[44] Ibid

5.2.2 Current and future improvements and challenges: Transitional Recovery service model

Each organisation was consulted again approximately one year after the original consultation. At this time, current and future challenges and improvements were discussed and management were asked about any significant differences to their implementation of the model in the intervening year.

There have been two significant improvements made to the Transitional Recovery service models.

Recovery focus

Continuous quality improvement activity had focused on maintenance and development of the service model's recovery philosophy.

At FSG client involvement in personal planning and initiatives which foster greater client financial independence had been implemented. Peer support workers had been employed, who provide ongoing support to clients after exit from the program.

At PRA staff structures had been modified in response to feedback from clients and staff. These changes linked staff to portfolio roles within the program and aimed to provide clearer communication with and better support for clients. The changes had been implemented with additional training around recovery. Future directions for the service included the use of a peer support worker.

Mode of delivery

Relationships and systems with Queensland Health continued to evolve.

FSG no longer accepted a referral until all referral information was provided, and their ongoing interactions with local clinical mental health services had resulted in increased respect within the sector. Doctors responded quickly when deterioration in a client's mental health was reported, psychiatrists had begun referring to FSG, and FSG service plans were sometimes included in clinical settings.

PRA had modified entry criteria to include some self-referrals for people who had their own housing and who received clinical support through their GP. This is in alignment with service model guidelines. High client and clinician turnover in acute clinical mental health impacts on PRA client management and is managed via regular meetings between each service's team leaders. Appropriateness of referrals was slowly improving. Modification to the assessment process had ensured that clients are reasonably well on entry to the program, as well as committed to a recovery program.

Current and future challenge: duration of support

The issue of client throughput through the programs and housing availability continues to be managed and innovations made.

Housing quality and availability in FSG's region had improved greatly and communications between FSG and Government Housing was enhanced through a revised MOU. Some FSG clients were going straight into the outreach stage of the program as they did not need the first stage; this was partly because FSG's referral sources had broadened and not all clients had a long term psychiatric rehabilitation history.

Housing availability in PRA's region remained an issue which PRA continued to proactively manage. For example, while clients could still remain on the program for 12 months, there is now a three month review which focused on preparation for independent housing.

5.3 Resident Recovery Program

The key elements of the Resident Recovery Program are summarised in *Table 5.3*. Five organisations are involved in the program in Queensland. The evaluation considered detailed information on Nextt Health Pty Ltd (Nextt Health) and Footprints in Brisbane Incorporated (Footprints) only. A full description of the Resident Recovery Program service model can be found in Appendix O.

Table 5.3: Resident Recovery Program elements

Service model: key elements	
Eligibility criteria; source of referral	▪ 18 years +; Australian residency/citizenship criteria ▪ referred by the local mental health service ▪ receiving clinical case management by local mental health service ▪ diagnosed (primary) moderate to severe mental illness ▪ willing to participate In the context of the potential client's: ▪ imminent discharge from inpatient care to boarding house/ hostel ▪ or residing in boarding house/hostel accommodation
Mode of delivery	A Reference Group to be established on commencement of operations
Proposed service	Provision of individualised, flexible and responsive support to assist the client to plan and achieve their agreed personal recovery goals
Duration of support	Variable, but all clients to receive short to medium term support

5.3.1 Developments in Resident Recovery service model by 2011

Extent of shift from service model original intent

Target group, eligibility and source of referral were the areas where shift from the original intent for the Resident Recovery service model had occurred at August/September 2011. In summary the shifts were:

- The acceptance of referrals from a wide variety of sources, including and beyond the planned sole source of Queensland Health, was the biggest instance of change.
- The original expectation that clinical management would be provided by mental health case managers from the local mental health service had relaxed. The service model worked with clinical managers or any private or public mental health provider, and GPs.

The original service model defined the duration of support provision as short to medium term. Nextt Health endeavoured to work within a 12 month timeframe and found exiting clients a constant program challenge. Footprints reported that the duration of support provided to clients sometimes extended beyond 12 months; poor access to suitable housing stock for sole client-tenants was a common reason for this extended duration. While the Resident Recovery program Service Model Guidelines[45] do not quantify duration of support, the Department advised AHA in June 2012 that 12 months was intended as a guideline.[46]

[45] Resident Recovery Service Model Guidelines, ibid.

[46] AHA interviews with Department of Communities personnel, ibid

Barriers and enablers to service model implementation

Both service providers had accessed the Helen Glover recovery training together, with different results:

- One service provider participated in the training, then "*brought it back to our organisation; we now use that language*" (i.e. the Helen Glover training and other recovery specific training has been made available to staff through the organisation's performance management system. The recovery philosophy was also embedded in the organisation's individual supervision process and team meetings).
- The other service provider found the initial Helen Glover training unsuitable to their client group because it:
    - relied on the individual having "existing circles of support" to access
    - was found to be difficult to apply as practical tools were not provided.

  This organisation also found the cost of training and its generic nature (not customised to Resident Recovery) to be a barrier; they asserted that ongoing funding should be provided for recovery training, "especially given service provider staff turnover". Staff have nevertheless accessed some further Helen Glover training in recovery and through other means (accredited training qualifications). This organisation has also developed their own recovery training and embedded the recovery philosophy into individual supervision and team meetings.

Both service providers cited the usefulness of their respective Reference Groups as a mechanism through which to address resistance to or lack of understanding about the program, and enabling its acceptance and use. The two key examples were: boarding house resistance; clinical mental health service provider understanding and cooperation. Both service providers acknowledged the key support of the Department of Communities in or for the Reference Groups.

The way in which both service providers dedicated regular time to educate clinical mental health referrers about the nature, purpose and requirements of the Resident Recovery programs was the other key way in which referrals were kept appropriate and the clinical component of support for clients was ensured.

The Reference Groups were integral to the service providers' pro-active development of community, AOD, housing, vocational, social and other community support organisation networks, as well as clinical referral processes. In addition to the Reference Groups, Nextt Health highly valued their community development position in fostering these networks, while Footprints' noted their use of the internal clubhouse program resource.

5.3.2 Current and future challenges: Resident Recovery service model

There have been several challenges both current and future effecting the Resident Recovery service model since late 2011.

Eligibility criteria

In one program location, a significant reduction in available hostel places had occurred, hostels were more crowded, and those people living in hostels had far more complex needs. On the other hand more public housing options had become available for those clients leaving hospital, although not all those clients had yet developed independent living skills. The service provider had, once again, become more flexible in their eligibility criteria in order to accommodate these changes, and they now provided more outreach services to people in their own accommodation.

The changes in hostel places also affected client participation in the social program. Following an internal evaluation, the social needs of clients are now addressed differently.

The other service provider continued to provide regular in-service education to clinical mental health case managers about the program purpose and what it was an appropriate referral. This remained an ongoing need due to the high rate of staff turnover in clinical mental health services. The issue of case managers withdrawing from the client without informing the service provider remains.

Mode of delivery

Commonwealth and Queensland Government changes had affected maintenance of the community and clinical support networks which sustained successful implementation of the Resident Recovery service model. The Queensland Government no longer attends one service provider's Reference Group, and as the region's Division of General Practice transitions to the new structure of Medicare Locals[47], there has been no representation from GPs.

One service provider had not been able to identify their contact person in the Department since the beginning of 2012 and was concerned that Departmental commitment to the program's recovery philosophy may change.

Duration of support

Both implementing organisations continued to find meeting the original service model requirement of short to medium term support for clients, or the guideline of 12 months, a challenge. Aspects of the challenge included:

- The service providers noted that Government's introduction of the Growing Stronger Initiative[48] across all Queensland disability service providers means that all potential clients of any disability service must be assessed through a central point. Resident Recovery service providers reported that this requirement had caused either delays in accessing service for most resident recovery clients, or ineligibility for potential clients, as mental health clients did not fit well with the Growing Stronger assessment process which is geared toward people with intellectual disabilities.
- The service providers also reported finding less funding available for disability services in general, and for Resident Recovery program participants, less support options after or in preparation for exit from the program. For example, in the past, on occasion clients were able to access respite services as an alternative to readmission if their mental health state was deteriorating. This was no longer an option.
- Both organisations reported that the slow Growing Stronger assessment process had the unwanted effect of reducing the ability of services to work together in a timely way.
- Some Resident Recovery clients required longer term support because of reduced capacity in other services such as Personal Helpers and Mentors (PHaMs) Programs.

[47] As part of the Commonwealth Government's national primary healthcare reform, the Australian Government is funding Medicare Locals and will cease to fund Divisions of General Practice. Nineteen Medicare Locals began operations in July 2011. A further 18 commenced operations in January 2012 and the remaining commenced from July 2012. Source: http://www.yourhealth.gov.au/internet/yourhealth Accessed 28th August 2012

[48] Ibid http://www.communities.qld.gov.au/disability/key-projects/growing-stronger-investing-in-a-better-disability-service-system

- One service provider reported increasing difficulty marrying the need to be flexible in response to clients' needs with the "inflexible structure of an output funded model", particularly when the service is transitioning clients to long term supports, as clients were deemed to be "double dipping".

Both organisations had continued to pro-actively foster a wide range of community support organisation networks, in their model:

- Nextt Health had strongly affirmed their staffing model of direct care team members being supported by a dedicated community development worker position. This was despite the service model output based reporting structure which focused on client output measures, which made it difficult to reflect the time spent on community development activity.
- Footprints reported innovations designed to counter the issue of clients staying or needing to stay in the Resident Recovery program longer than 12 months. For example, their inclusion of peer support workers in the team had developed into a cross-organisational strategy of supporting peer workers, which had resulted in increased community links for all clients, reduction in specific program participant mental stress levels and a decrease in readmissions for clients who use the after-hours support program. Overall, the organisation was using more group work and peer support to promote independence and recovery and this will continue in the future.

5.4 Perceptions of the recovery-oriented characteristics of the program: Recovery Self Assessment (RSA) data

Managers, staff and interviewed clients at each of the six TTR service providers completed the Recovery Self-Assessment (RSA). This self-report survey contains 36 items that reflect the conceptual domains of recovery-oriented practice.

Respondents are asked to rate the degree to which their service/service provider engaged in the recovery-oriented practices using a 5 point Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree). Respondents could also indicate if the item was not applicable. Higher scores reflect greater agreement with the item being examined.

The RSA has been developed with five subscales:

- Diversity of treatment options

  The items in this subscale reflect the extent to which the service/service providers provide linkages to peer mentors and support and a variety of treatment options. It also includes views on how well the service/service provider assists people to become involved in activities outside mental health/addiction activities.
- Client involvement and recovery education

  These items provide a view on the extent to which clients are involved in the development and provision of services, community activities, staff training and governance of the service.
- Life goals vs symptom management

  These items assess the extent to which staff assist clients to pursue individually defined goals.
- Rights and respect

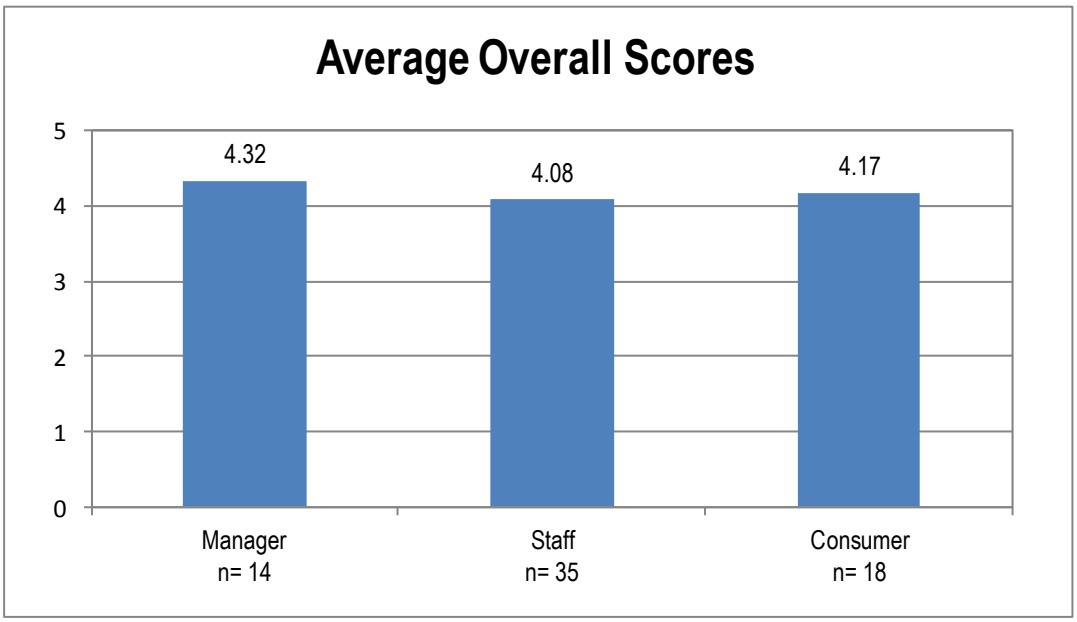
  These items assess the extent to which staff refrain from coercion and provide clients with access to records and facilitate referrals.

- Individually-tailored services

  These items assess the extent to which services are individually tailored. This takes into account cultural needs, interests. Service provision should be in a natural environment and the focus should be on building community connections.

Management and staff answered the complete survey but clients answered a modified set of questions that excluded some questions related to the philosophies and structural issues of the service provider. As the overall numbers of respondents was small, only summary results are presented. Nonetheless, from the available data a pattern emerges whereby the high mean scores overall, and within subscales, for the 21 questions common to all groups indicate good agreement across each group of respondents regarding recovery oriented practices in the organisations taking part in the evaluation (Figure 5-1).

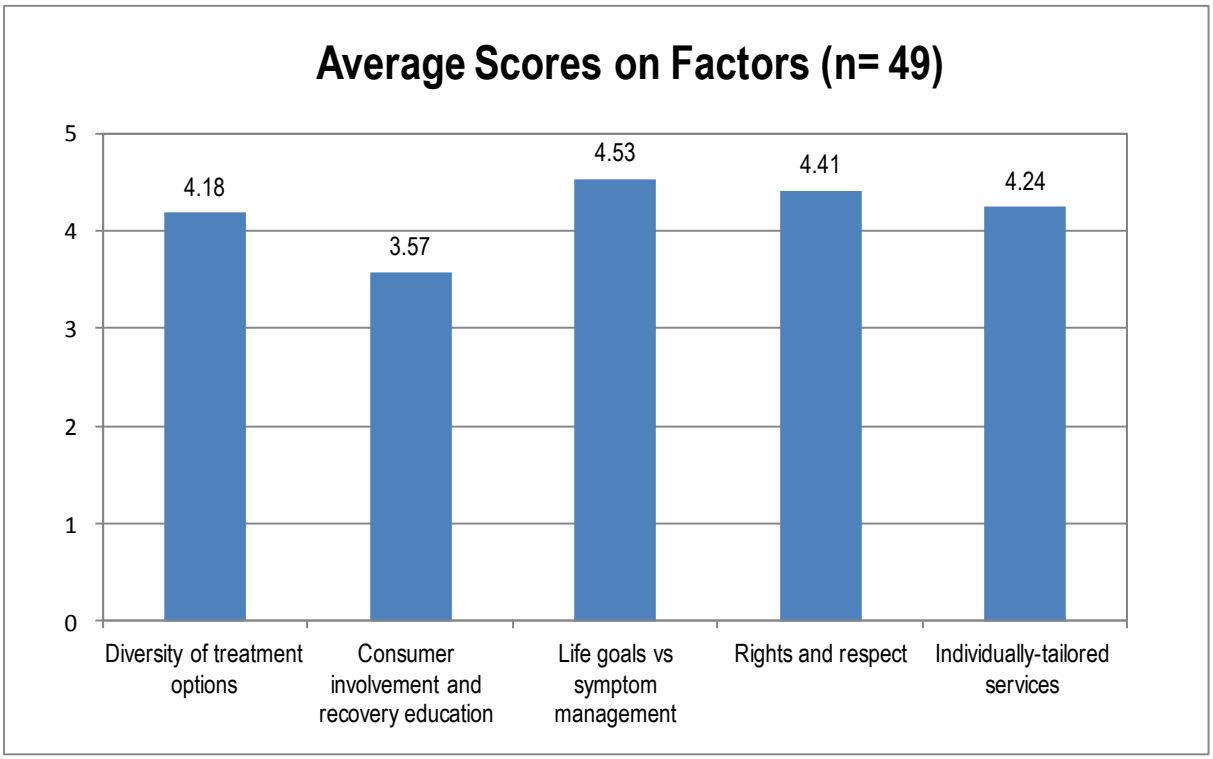
Figure 5-1: RSA average scores for 21 questions common to all groups



The following Figure 5-2 relates to staff and management only as there were insufficient client responses in the different factor areas to allow meaningful analysis. For staff and management however, their adherence to a recovery-oriented model is reflected in high scores in most of the factor domains.

The lower score in the *'Consumer involvement and recovery education'* domain needs to be interpreted with caution. It may indicate a real or artificial deficit in this area (although the average is still at close to the 'agree' mark (4). Alternatively, given that 20/49 respondents did not answer all questions related to this factor, the reliability of this data may be limited.

Figure** 5-2**: Average factor scores, Management and Staff



5.5 Other stakeholder interviews

To ascertain the broader systems level impacts of the TTR program, consultations were undertaken with a number of key stakeholders who work with the six TTR service providers in supporting TTR clients. These included:

- Stakeholders involved in providing community-based support services
- Queensland Health Mental Health staff.

The findings from these consultations are presented in the sections that follow.

5.5.1 Stakeholders involved in providing community-based mental health support services

Each of the six TTR service providers were requested to identify four or five stakeholders with whom they work to support their clients and provide contact details for these stakeholders. Telephone interviews were conducted with a total 21 stakeholders between December 2011 and March 2012.

These stakeholders included housing/accommodation providers, private psychologists, service providers involved in providing counselling services, corrective/legal services, Alcohol and Other Drugs (AOD) services and employment services.

Several key themes were identified in these stakeholder consultations. These included:

- Inter-agency relationships and communication
- Referral pathways
- Systemic factors such as housing stock availability and timeliness of referrals as well as the duration of client support

- Challenges working with the client group.

Inter-agency relationships and communication

Overall, stakeholders felt that relationships and communication between themselves and the TTR Programs were functioning well not only at worker level but also at management level. In several instances, stakeholders remarked that this communication helped them to keep track of their client's whereabouts and any changes in circumstances or wellbeing. However, some enhancements were suggested to improve and/or increase communication between the TTR provider and stakeholders such as more regular case conferences and being provided with updates when clients are hospitalised: "*If someone is admitted to hospital, we hope they'll contact us, it helps us to know if something major happens – we don't always get a call.*"

Referral pathways

Referral and service arrangements between TTR Programs and the stakeholders tended not to be formalised. At the time of interview, only one Memorandum of Understanding was in the process being finalised and one partnership agreement was in place. Overall, stakeholders considered that the TTR providers were referring clients that were appropriate to the stakeholders' services.

While stakeholders generally had a good overall understanding of the TTR model and its intended aims, in some instances, they were unaware that the specific clients they were dealing with were part of a Transition to Recovery Program.

Systemic factors

From the stakeholders' perspective, systemic factors represented the main areas where challenges to achieving outcomes for clients existed. Housing stock availability and the timeliness of referrals were core systemic issues. The time-limited nature of interventions available to clients and the fact that a clear pathway to alternative accommodation did not always exist were also listed.

Challenges working with the client group

The complexity of many of the clients' needs, particularly those with substance use issues, was seen to present considerable challenges. Addressing transport needs was also raised as an issue for TTR clients. Several stakeholders recognised the key role that TTR programs played in "*assisting clients to get to appointments*". This support not only took the form of providing transport support to get clients to appointments (e.g. doctor, psychologist, parole/probation) but also in terms of providing a support person at appointments.

Key findings

Overall, the impressions of stakeholders were positive and they felt that the TTR programs are providing good client outcomes and are effective and worthwhile although they were generally unable to describe client outcomes in detail. Stakeholders also observed that the TTR programs provide some 'normality' and 'stability' in clients' lives.

5.5.2 Interviews with Queensland Health Mental Health Staff

Interviews were held with the following Queensland Health Mental Health teams, who refer clients to the Transition to Recovery programs at the three sites for which SSA approval was obtained:

- Adult Community Mental Health Services, Robina Hospital (Gold Coast HSD)
- Metro North Mental Health (Royal Brisbane Women's Hospital HSD)
- Prison Mental Health Services.

One mental health team was interviewed for each of the three service models (TFCF, RRP and TRP). .

Key findings

The mental health teams valued the role of the TTR service providers and felt that positive outcomes were being achieved for clients through their involvement with recovery programs. One team said that the TTR program felt like '*the only thing keeping clients afloat'* and that the same program "*filled a niche for a particular group of clients*."

Although it was a commonly held view that TTR programs were achieving good outcomes for the clients they were involved with, there was also a sense that the TTR programs may not be able to meet the needs of the most complex clients. This limitation was thought to be more of a systemic issue than a reflection on the TTR providers' ability to achieve good outcomes for clients. One mental health team stated that "*there is still a gap in services for the most complex clients*" and another one stated "*there is a lot unmet need out there in the community, people who need support – the chronic, long term patients stuck in hospital for 4-5 years; they're the ones who need more support*."

The main suggestion made for improving how the TTR service providers work with their clients is to provide better linkages to longer-term supports in the community while the client is still in the TTR program so that on exit, some supports are in place.

5.6 Synthesis of findings

The findings from each of the preceding sections of this chapter are synthesised below under the following headings:

1. Program implementation
2. Barriers and enablers to program implementation
3. Current and future improvements and challenges
4. Perception of the recovery-oriented characteristics of the program.

5.6.1 Program implementation

Overall, the Transition to Recovery Program has been implemented largely as planned. Exceptions were found in the Resident Recovery Program, where:

- Referrals have been accepted from a wider variety of sources than originally envisaged
- Clinical management has been provided not only by mental health case managers from the local mental health service but also from GPs and public and private mental health providers.

Duration of support at one of the organisations was also extending beyond the guideline of 12 months. Difficulties with obtaining suitable housing were cited as a key reason for this situation.

5.6.2 Barriers and enablers to program implementation

A range of barriers and enablers were identified across the three programs.

In the Transition from Correctional Facilities program, the primary barrier to program implementation was meeting the multiple needs of the client group and gaining access to community, housing, mental health and AOD support services. Large geographical areas covered by these programs increased implementation difficulties. Several enablers supported the implementation of the program. Having internal training and mentoring programs to assist staff working in this area was seen as being very helpful. Managing and monitoring pre and post stakeholder relationships was also seen as a key enabler, particularly in influencing appropriate referrals.

The presence of an embedded recovery focus within the Transitional Recovery Program organisations was seen as being very important. Establishment and support of reference groups has assisted greatly in the implementation of the program, especially intake and referral processes. Availability of appropriate housing stock and ensuring continuing availability was important to the program meeting the needs of the clients.

In the Resident Recovery Program, working towards the embedding of a recovery focus was seen as being very important. Although both organisations had been involved in formal recovery training, this was seen as of varying utility. One organisation had embraced the training and incorporated it into their work whilst the other organisation had felt the training was not quite right for their client population but has embedded aspects of it and implemented their own version of in-house recovery focused training. Establishment and support of reference groups has assisted organisations to address resistance and or lack of understanding about the program. Continually educating clinical referrers was seen as a necessary part of ensuring appropriate referrals to the program.

5.6.3 Current and future improvements and challenges

All programs reported a continuing move towards improved processes and procedures around referrals. Effort continues in this area as relationships are often based on personnel rather than embedded policy and procedure so stakeholder management was seen as a critically important aspect of all three programs.

Changes in government policy and post-election changes posed challenges for the TTR programs. All three TTR program streams reported that the QLD Government's *Growing Stronger Initiative* negatively impacted assessment processes for TTR clients and complicated discharge and referral processes. Following the election of the new Government in Queensland, Department of Communities representatives no longer attended Resident Recovery program reference groups and one service provider was unable to identify their QH contact person. Since the introduction of the Commonwealth Government's Medicare Locals GP representatives have not attended Resident Recovery program reference groups.

5.6.1 Perceptions of the recovery-oriented characteristics of the program

There was good agreement about recovery-oriented practices by management, staff and clients, in the organisations taking part in the evaluation. This was demonstrated by high mean scores overall, and within subscales of the RAS, for the 21 questions common to management, staff and client groups. Likewise, adherence to a recovery-oriented model by management and staff was reflected in high scores in most of the factor domains.

6 FINDINGS: STAFFING PROFILE

In this chapter, the staffing profile of the six TTR programs is examined using two main data sources:

- Data provided by TTR program management between August and October 2011.
- Consultations with TTR program management at two time points:
  - August/September 2011 (first interview)
  - July/August 2012 (second interview.

6.1 Workforce size and roles

The six TTR service provider organisations were asked to provide data about the profile of their program staff. *Table 6.1* below provides detail about the roles within each service delivery team in October 2011 and includes leaders who carried a case/ client load.

As Psychiatric Rehabilitation Australia (PRA) has two service delivery teams, to cover their clients residing in Caboolture and Redcliffe, both of these teams and their respective team leaders, are listed in the table. .Nextt Health had two leadership positions for the one service delivery team, with each position responsible for different leadership functions as well as client care.

Table 6.1: Composition of six TTR service provider service delivery teams

Program	NGO	Team Leader or Coordinator		Support Worker	Peer Support Worker	Community Development Worker
Transition from Correctional Facilities	RFQ	1		5		
	SOLAS	1		5		
Transitional Recovery	FSG	1		6		
	PRA (site 1)	1	1	4		1
	PRA (site 2)		1	4		
Resident Recovery	Nextt Health	2		4		1
	Footprints	1		6	2	

Workforce size and roles were discussed in further detail during interviews with the service providers, and the key points are described below. Senior management were reported to have provided the TTR teams with valued support during the establishment phase of the programs, particularly in relation to providing guidance around client recruitment.

PRA and Nextt Health included community development workers in their teams. During the first interview they explained that they felt this was crucial to the identification and establishment of the community networks which underpin TTR service delivery. Inclusion of staff with these skills in the service delivery team is consistent with the findings of the *Queensland NGO Mental Health Sector*

Training Analysis Report, which listed "collaboration and networking" as the third essential skill for the sector."[49]

By the time of the second interview, PRA had implemented a major staff restructure, aimed at improving support for clients. Two staff members now work exclusively with clients around tenancy support, such as cooking, cleaning and budgeting. One staff member provides all the outreach support for clients entering and leaving the program. Two other staff members are responsible for working with clients around social connections, study and work, while they are living in the supported accommodation. Two senior workers were replaced with one team leader, resulting in clearer lines of accountability and consistent messages within the organisation. While the designated single community development worker position had been restructured, those staff members working on tenancy support, outreach and social connections would still need to utilise collaboration and networking skills.

In the second interview, Footprints reported that a trial of using peer support staff working alongside staff in a women's empowerment group as part of the Resident Recovery Program had been very successful. They had subsequently expanded the use of peer support workers across all program areas. Similarly, FSG reported that management recognised the value of intentional peer support and had employed two peer support workers whose role is to provide ongoing support to clients upon completion of the program. For PRA, future directions may include the use of a peer support worker.

Both RFQ and SOLAS reported referring clients onto Personal Helpers and Mentor schemes (PHaMs) across their respective regions at both interview time points in the evaluation.

6.2 Qualification profile of the TTR program workforce

A qualification in health and community services with mental health content, or a mental health specific qualification, is generally considered to equip staff to enter the workforce of the NGO community mental health sector. As *Figure 6-1* shows, at November 2011, 71% of the TTR program workforce held such a qualification and 13.2% were working towards these qualifications.

The *'Consumer Carer Representative'* category includes staff employed in consumer carer roles without these qualifications. The category entitled 'No qualifications' encompasses staff without these qualifications. Staff without health and community services or mental health qualifications may have held other qualifications, including qualifications in visual arts, which at least one organisation indicated were qualifications useful to implementation of recovery programs.

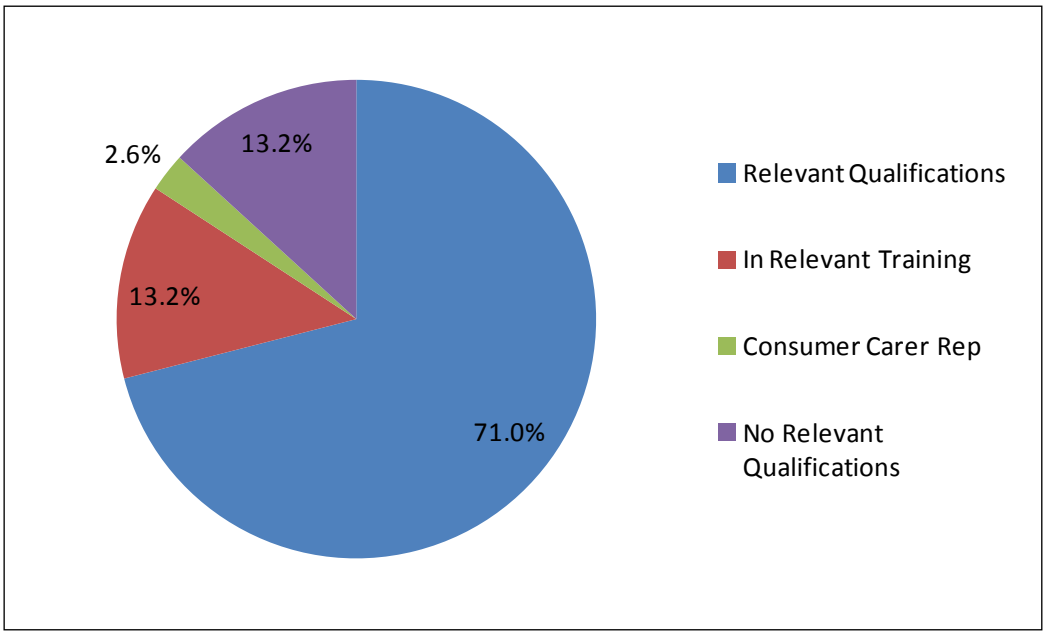
In comparison, the *Queensland NGO Mental Health Sector Training Analysis Report*, found that only 35% of the NGO mental health sector have undertaken formal studies in mental health.[50] This suggests that a larger proportion of the TTR workforce holds relevant qualifications, compared to the broader Queensland NGO mental health sector.

[49] ConNetica Consulting, *Queensland NGO Mental Health Sector Training Analysis Report:* Knowledge and skill requirements for competent practice: Brisbane, 2009, p.72.

[50] ConNetica Consulting, 2009.

6. Findings: Staffing Profile

Figure 6-1: Qualification profile of TTR program workforce (n=49)



6.3 Disciplinary profile of the TTR program workforce

Managers

The managers of TTR Program services were degree-qualified in the relevant disciplines of psychology, social work and occupational therapy. One manager was completing a course in business administration. The most common discipline was psychology.

Middle managers

At middle management level degree qualifications in psychology, social work, social science, nursing, criminal justice and theology were found. The most common higher education discipline was psychology. Four middle managers' qualifications were from the vocational education and training (VET) system, in mental health, disability, community services and nursing respectively. Some middle managers were also completing management/leadership training and or had completed additional VET qualifications. The most common VET discipline overall at middle management level was in mental health.

Support workers

At support worker level the dominant higher education qualification was Bachelor of Arts (BA). Wide variety in the BA majors was found, including: Psychology, Human Services, Social Welfare, Social Sciences (e.g. Diversional Therapy), Psychology and Sociology. Bachelor of Nursing degrees were also found. The most common relevant VET qualifications were: Certificate IV in Mental Health and Certificate IV or Diploma level qualifications in Mental Health or Alcohol and Other Drugs.

The practice of employing staff qualified in clinical mental health in manager and leadership positions in the TTR Program services mirrored practice in the broader NGO mental health sector. A related finding by AHA was that only three out of the six TTR Program service providers employed staff who had spent time working in clinical mental health. Of the three organisations where staff had worked in clinical mental health, the majority were staff in management roles. Two of these organisations reported that the clinical mental health industry experience of these staff was very useful in establishing productive relationships and communications with clinical mental health referring networks and partners.

6. Findings: Staffing Profile

Four organisations employed staff who had spent time working in Alcohol and Other Drugs (AOD) organisations; these staff encompassed both management and workers. AHA interviews found that AOD qualifications and experience, including advanced courses such as motivational interviewing, were of particular relevance to the work conducted in the Transition from Correctional Facilities Program.

6.4 Dual diagnosis professional development profile of TTR program workforce

The TTR program staffing profile assessed the extent to which the workforce had undertaken dual diagnosis professional development or up-skilling. Dual diagnosis professional development may be accredited or non-accredited. For those with mental health qualifications, dual diagnosis professional development routinely includes AOD content. For those with AOD qualifications, dual diagnosis professional development routinely involves completion of mental health content.

There was little evidence that middle management staff had engaged with professional development in dual diagnosis. Instead, most respondents indicated that the accredited training undertaken to earn their qualifications had included dual diagnosis content. As such it is likely that lack of engagement with dual diagnosis training among this group was due to absence of learning need.

In contrast, dual diagnosis professional development activity amongst support workers was varied. Non-accredited, short form mental health specific and AOD specific training courses were attended by staff of all programs. The content areas of these courses were diverse. Interviews with service providers found that this diversity was due to individual staff accessing professional development through their respective organisations' performance management systems according to individual learning need.

6.5 Recovery orientation profile of TTR program workforce

The *Queensland NGO Mental Health Sector Training Analysis Report* concluded that "the level of knowledge and understanding of recovery, and recovery-oriented service models is not highly developed across the Queensland NGO Mental Health Sector".[51] However, the profile of TTR staff, in relation to recovery training, does not support this conclusion.

The 2007-2008 Queensland budget allocation to the TTR program Initiative included funding for recovery-specific training.[52] This initial training was provided by Helen Glover *enLightened Consultants* and was targeted to managers as mentor/leadership training in recovery.[53] This mentor/leadership training aims to embed a recovery approach within the practice of organisations, by 'seeding' the recovery philosophy among the leadership team.[54] The NGOs implementing the Transitional Recovery Program and the Resident Recovery Program reported accessing this mentor/leadership training during the establishment phase of their programs. The Transition from Correctional Facilities service providers

[51] ConNetica Consulting, *Queensland NGO Mental Health Sector Training Analysis Report:* Knowledge and skill requirements for competent practice : Brisbane, 2009, p.72, p.72.

[52] AHA consultation with the Department of Communities

[53] The website of *enLightened Consultants* reported that the Recovery-Oriented Mentoring Project (ROMP) was funded by Disability Services Queensland to provide recovery oriented training and mentorship to leaders working in mental health services in both government and non-government services. Source: Accessed November 2011 http://www.enlightened.com.au/index.php?option=com_content&view=article&id=72&Itemid=78.

[54] Ibid.

(RFQ and SOLAS) did not report utilising the mentor/leadership training. However RFQ explained that all the services across their organisation, including the Transition from Correctional Facilities program, had adopted a recovery orientation. SOLAS reported that they have worked with, and fostered among staff, a recovery philosophy since 1995.

As already noted, all the service providers reported using their performance management system to support and supervise staff. They also emphasised that recovery-oriented practice was embedded into their performance management systems.

Table 6.2 provides an overview of recovery training providers which had been accessed as part of professional development by TTR program staff at the time of the first interview. All the training providers in the table provide short form, recovery-specific, non-accredited training, except in two instances where the recovery training formed part of an accredited training course.

Table 6.2: Recovery training accessed by TTR program staff and management

Workforce Level	*Course Details*	*Training Provider*
Management	Recovery Oriented Mentoring Project (ROMP) - builds leaders' capacity to mentor staff on recovery approaches (minimum 5 days)	Helen Glover enLightened Consultants
	Collaborative Recovery Model	Wollongong University
Middle management	ROMP, (minimum 5 days)	Helen Glover enLightened Consultants
	Unpacking Recovery Workshop (2 days)	Helen Glover enLightened Consultants
	VicServ Key Worker Series (8 days)	Health and Community Services Workforce Council
	Mental Health Recovery	part of Post-Graduate Diploma Nursing*
Support workers	Helen Glover training- Unpacking Recovery (3 to 9 days)	Helen Glover enLightened Consultants
	Consumer and Carer Rep training	Department of Families, Housing, Community Support and Indigenous Affairs (FaHCSIA) Peer Support Workers forum
	VicServ Key Worker Series (8 days)	Health and Community Services Workforce Council
	Strengths based training	part of Cert IV Community Services (Mental Health)*

*Training is part of an accredited training course

6.6 Key findings

The key findings of this chapter are:

- The structure of teams delivering TTR programs varies among service providers. Community Development Workers and Peer Support Workers are used in some programs.
- Relative to the broader Queensland NGO mental health sector, TTR staff is well qualified.
- Most TTR staff have competencies in dual diagnosis.
- A recovery orientation is demonstrated through the uptake of a range of recovery training programs.

7 FINDINGS: CLIENT PROFILE

In this chapter, a profile is provided of all clients who were assisted by the six TTR service providers, from the program commencement until 31 December 2011. This chapter is set out under the following main headings:

7.1 Data collection

7.2 Client service usage data

7.3 Characteristics of TTR program participants

7.4 Key findings.

7.1 Data collection

Each of the six service providers gathered the following information about all clients assisted by their program, from commencement until 31 December 2011:

- Client entry and exit dates
- Gender
- Aboriginal and/or Torres Strait Islander cultural background
- Country of birth
- Mental health diagnoses
- Other disabilities.

Data collection periods for each service provider varied because the TTR programs commenced at different points in time, as shown below.

Program Stream	Service Provider	Program Commencement Date
Transition from Correctional Facilities (TFCF)	RFQ	5 March 2007
	SOLAS	3 September 2009
Transitional Recovery Program (TRP)	FSG Australia	4 March 2009
	PRA	19 June 2010
Resident Recovery Program (RRP)	Nextt Health	19 January 2009
	Footprints	23 February 2009

7.2 Client service usage data

The following analysis identifies the number of clients and the duration of support provided, for each of the six service providers. The results are presented by program stream and identify:

- Number of clients per month
- Duration of support per client.

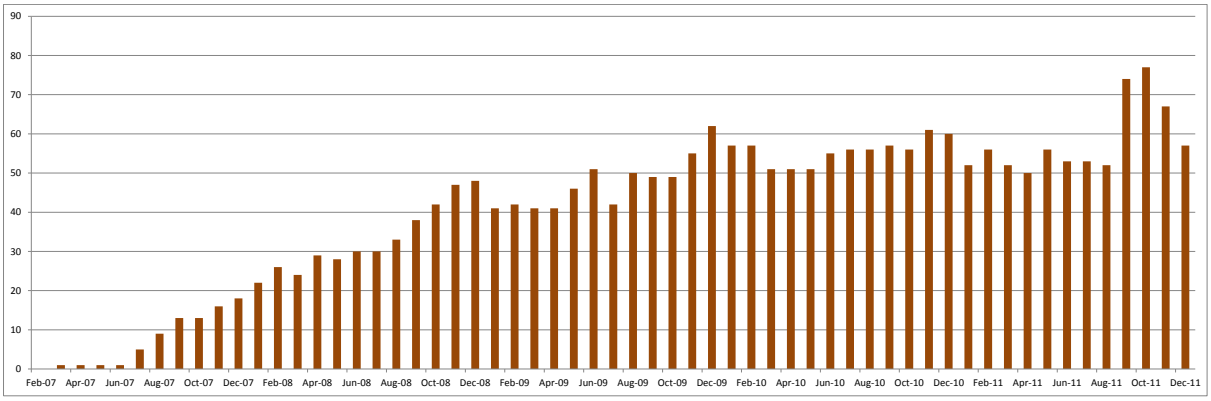
7. Findings: Client Profile

7.2.1 Transition from Correctional Facilities Program Stream

Number of clients supported per month

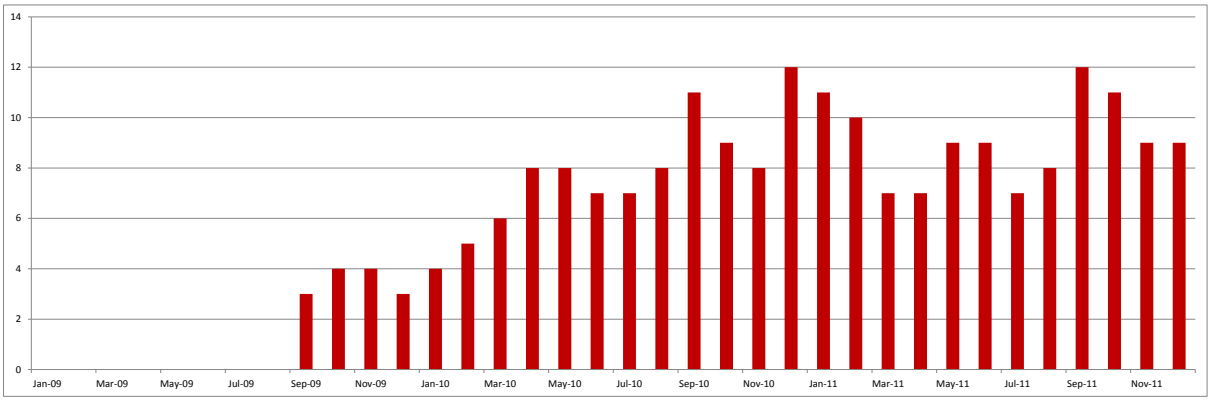
RFQ commenced providing TFCF support in March 2007. By October 2008 (after 19 months), it supported 40 clients per month, and thereafter supported between 40 and 60 clients per month, rising to over 70 clients in the later months of 2011 (Figure 7-1).

Figure 7-1: RFQ - TFCF clients per month, to December 2011



SOLAS commenced providing TFCF support in September 2009. By March 2010 (after 6 months) it supported eight clients per month, and thereafter supported between seven and 12 clients per month (Figure 7-2).

Figure 7-2: SOLAS - TFCF clients per month, to December 2011



Duration of support per client

The duration of support provision for clients who exited from the TFCF program up to December 2011 was broadly similar for RFQ and SOLAS, with most clients receiving between one and eight months of support. On average clients received 4.8 months of support, however as Figure 7-3 and Figure 7-4 illustrate, there is considerable variability, reflecting the individualised support model adopted.

7. Findings: Client Profile

Figure 7-3: RFQ - Months of support provided to clients up to TTR exit, to December 2011

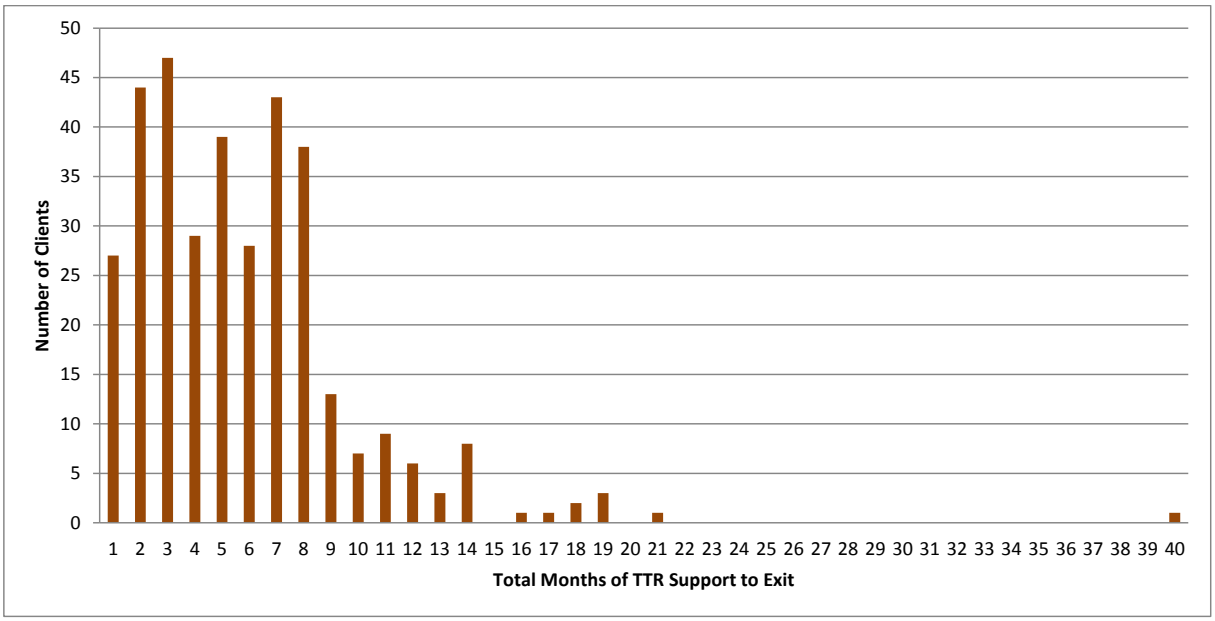
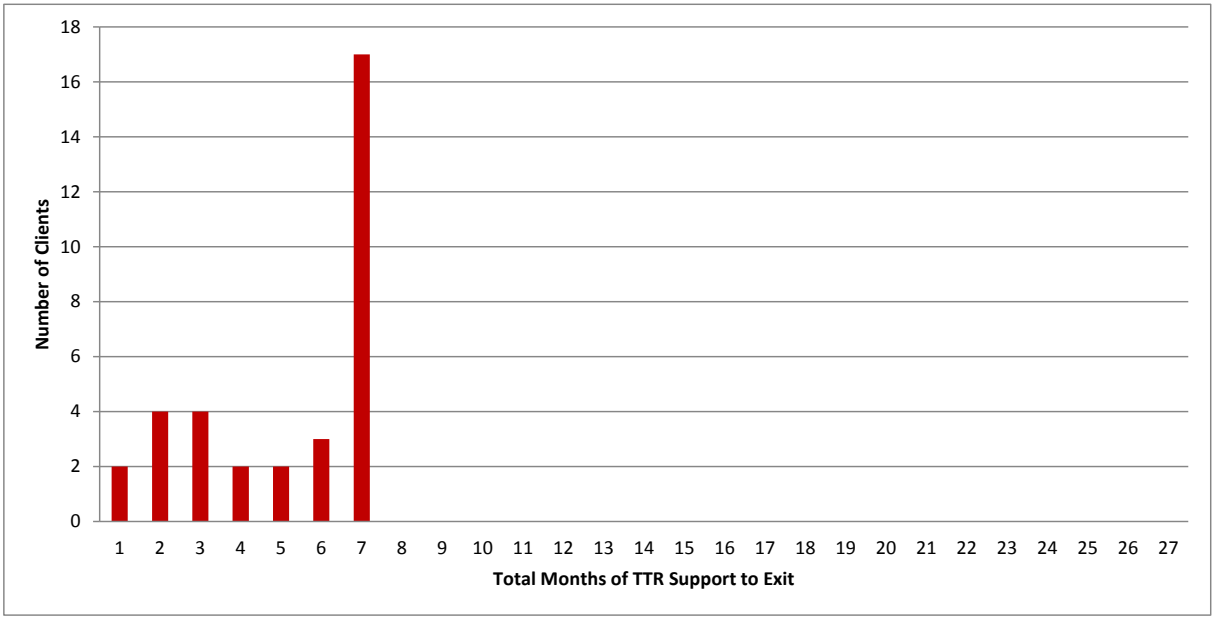


Figure 7-4: SOLAS - Months of support provided to clients up to TTR exit, to December 2011



Summary of findings for TFCF program stream

Up to December 2011:

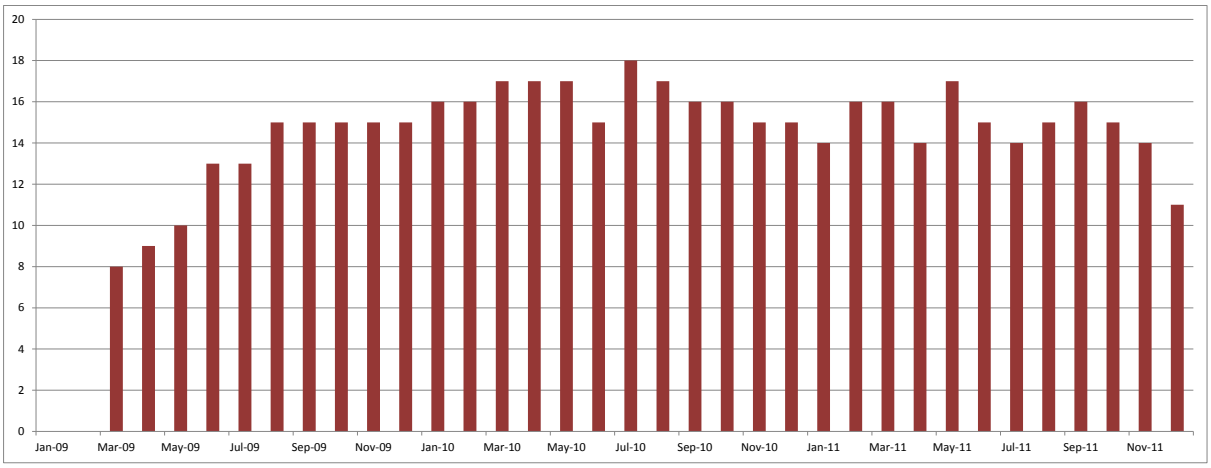
- 446 clients received support in the TFCF program (RFQ 404; SOLAS 42)
- 384 of these 446 clients had exited the program
- Average duration of support to exit was 4.8 months (RFQ 4.9; Solas 4.2), however there was considerably variability.

7.2.2 Transitional Recovery Program Stream

Number of clients supported per month

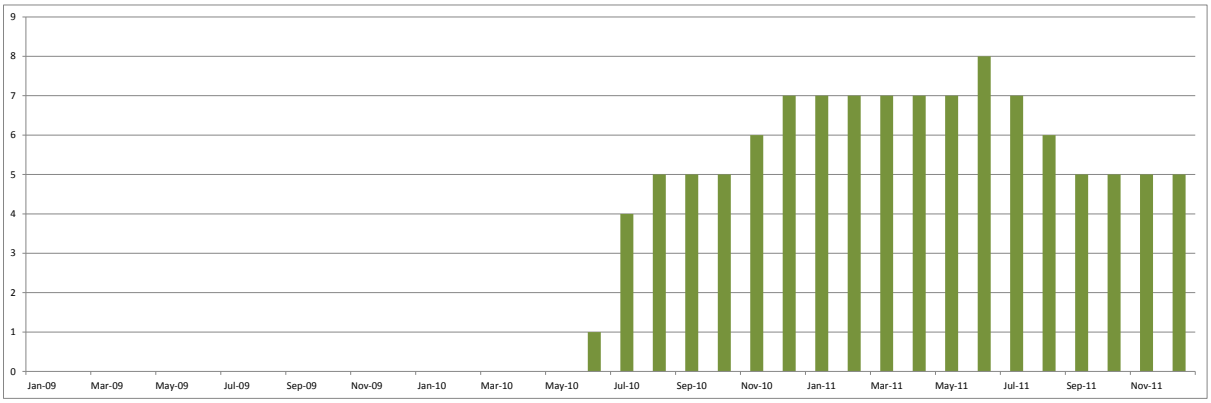
FSG commenced providing TRP services in March 2009. By August 2009, it supported 15 clients per month, and thereafter supported between 14 and 18 clients per month, except for December 2011 (11 clients) (Figure 7-5).

Figure 7-5: FSG - TRP clients per month, to December 2011



PRA was the last of the six service providers to commence TRP service provision, doing so from June 2010. By August 2010, it supported five clients per month, and thereafter supported between five and eight clients per month (Figure 7-6)[55].

Figure 7-6: PRA - TRP clients per month, to December 2011



Duration of support per client

The duration of support provision for clients who exited from the TRP program up to December 2011 is shown in Figure 7-8 and Figure 7-7.

[55] Collectively the PRA sites have a total potential capacity of eight residents.

7. Findings: Client Profile

Overall, clients received an average of 15.4 months of support, however there is considerable variability between the two organisations.

Only four PRA clients exited TTR, having received between eight and 14 months of support. These figures are consistent with the intensive nature of PRA's residential support service and their restricted residential capacity, both of which combine to result in a high staff to client ratio. In the case of FSG clients, support ranged from one month up to 27 months. Such variability is consistent with the intended TTR model of individualised support provision.

Figure 7-7: FSG - Months of support provided to clients up to TTR exit, to December 2011

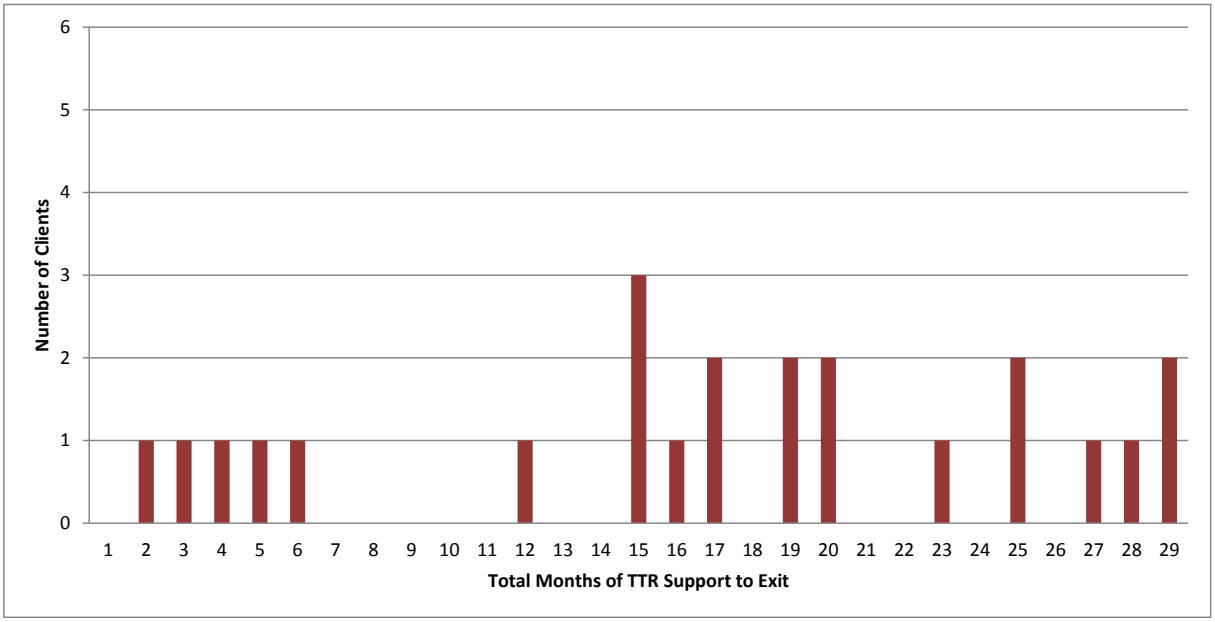
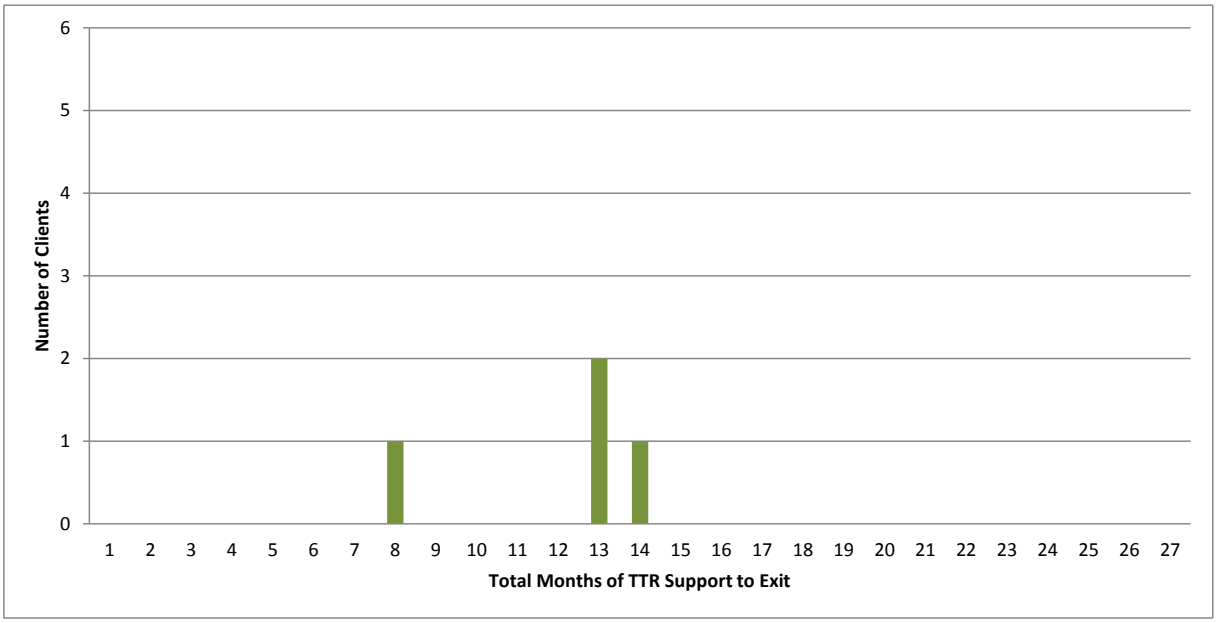


Figure 7-8: PRA - Months of support provided to clients up to TTR exit, to December 2011



Summary of findings for TRP stream

Up to December 2011:

- 42 clients received support in the TRP stream (PRA 9; FSG 33)

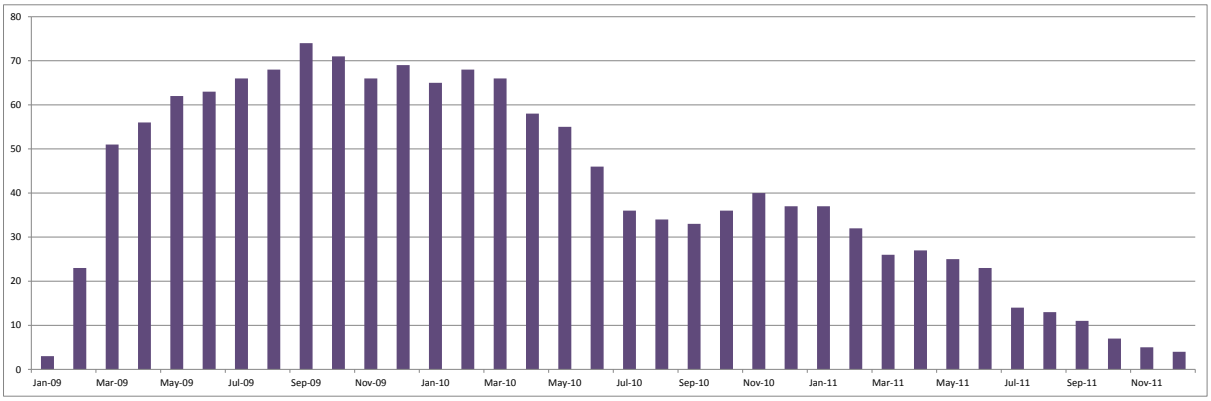
- 27 of the 42 clients had exited
- Average duration of service to exit was 15.4 months (PRA 11.2; FSG 16.1), however there was considerably variability between clients.

7.2.3 Resident Recovery Program Stream

Number of clients supported per month

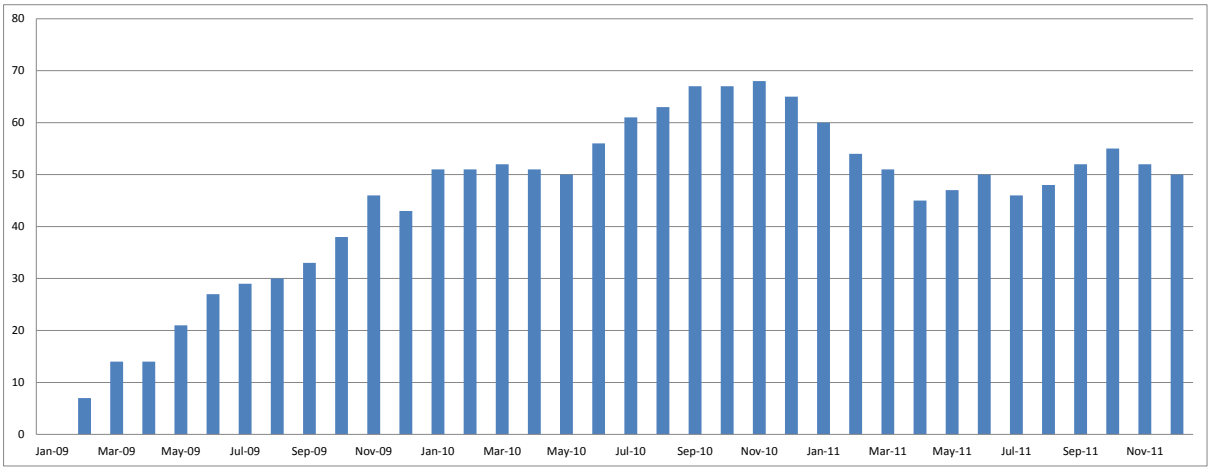
Nextt commenced providing RRP support in January 2009, and from March 2009 to April 2010 had over 50 clients per month (Figure 7-9). Thereafter the number of clients progressively declined, reaching only four clients for December 2011. Subsequent consultations with Nextt found that this decline had occurred as a result of staffing issues. The Department of Communities was made aware of this decline and undertook to raise it with contract managers.

Figure 7-9: Nextt - RRP clients per month, to December 2011



Footprints commenced providing RRP support in February 2009. By January 2010, it supported 51 clients per month, and thereafter supported between 45 and 68 clients per month (Figure 7-10).

Figure 7-10: Footprints - RRP clients per month, to December 2011



Duration of support per client

The duration of support provision for clients who exited from the RRP program stream up to December 2011 is shown in Figure 7-11 and Figure 7-12.

7. Findings: Client Profile

There was marked variation in the duration of support provided by Nextt and Footprints. Many of Nextt's clients received a longer duration of support than those in the Footprints program. Average duration of support was 8.9 months for Nextt and 7.2 months for Footprints clients. Most Footprints clients received six months or less months of support. The overall average duration of support per client was 8.1 months across the two providers, however marked variability was evident in the Nextt cohort (range one month to 27 months of support). Such variability is consistent with the intended RRP model of individualised support.

Figure 7-11: Nextt - Months of support provided to clients up to TTR exit, to December 2011

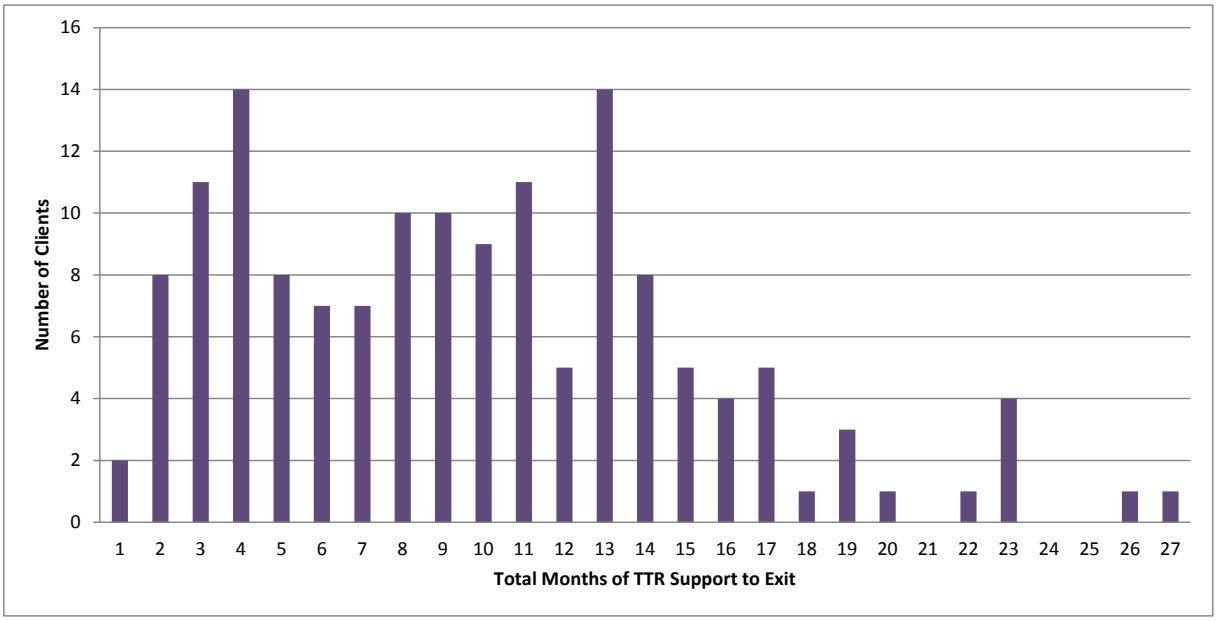
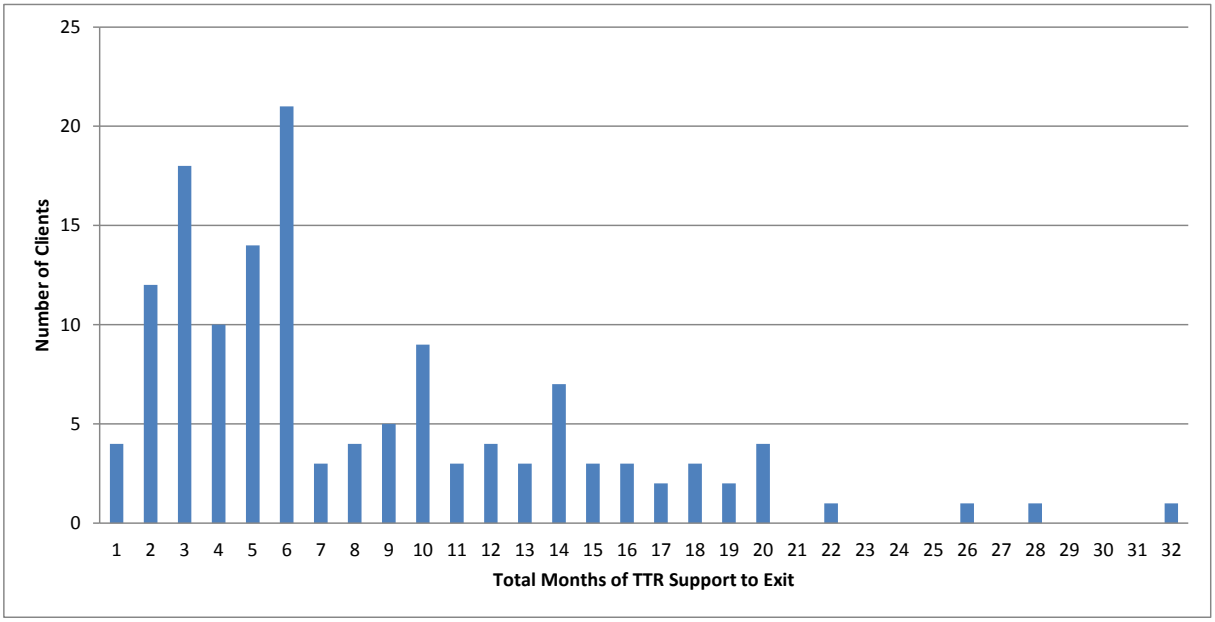


Figure 7-12: Footprints - Months of support provided to clients up to TTR exit, to December 2011



Summary of findings for RRP stream

Up to December 2011:

- 341 clients received support in the RRP stream (Nextt 153; Footprints 188)
- 288 of these 341 clients had exited

- Average duration of support was 8.1 months (Nextt 8.9; Footprints 7.2), however there was considerably variability between clients
- Staff issues in one organisation had a significant impact on client numbers.

7.2.4 Program support relative to service model expectations

Table 7.1 shows for each service model, the anticipated maximum duration of support according to the service guidelines and the actual duration of support provided by the service providers.

Table 7.1: Duration of support

Service Model	Anticipated maximum duration of support	Actual duration of support up to exit (average)
Transition from Correctional Facilities (TFCF) Program	9 months (3 months pre-release, 6 months post-release)	4.8 months
Transitional Recovery Program (TRP)	18 months (comprising up to 12 months recovery-based support and accommodation and up to 6 months outreach support)	15.4 months
Resident Recovery Program (RRP)	Varies depending on individuals' needs. Intended to be short to medium term support	8.1 months

For the TFCF and TRP programs, the average duration of support provided was less than the anticipated duration of support. The average duration of support for the RRP program (8.1 months) is consistent with the service model objective of providing short to medium term support to clients.

7.3 Characteristics of TTR program participants

A total of 842 clients entered recovery programs in the period up to 31 December 2011. The characteristics of this cohort are provided in the following *Table 7.2*.

Table 7.2: Characteristics of TTR program participants

Characteristic	TFCF participants N= 446	TRP participants N= 42	RRP participants N = 341	All participants N = 829
Gender (% Male)	83%	62%	63%	74%
Age (Mean, range)	33 (17.5-70.3)	33 (20-55)	42 (18-72)	37 (17.5-72)
Standard deviation	9.8	9.1	11.5	11.3
Aboriginal/Torres Strait Islander background (%)	100 (22%)	1 (2%)	26 (8%)	127 (15%)
Country of Birth (n, %)				
Australia	433 (97%)	38 (90%)	285 (84%)	756 (91%)
UK	-	1 (2%)	10 (3%)	11 (1%)
NZ	4 (<1%)	1 (2%)	7 (22%)	12 (1%)
All other	9 (2%)	1 (2%)	34 (10.0%)	44 (5%)
Unknown	-	1 (2%)	5 (2%)	6 (<1%)

7. Findings: Client Profile

Characteristic	TFCF participants N= 446	TRP participants N= 42	RRP participants N = 341	All participants N = 829
Duration of intervention *	N = 384	N = 27	N = 288	N = 699
Average number of months	4.8	15.4	8.1	6.6
Minimum number of months	0	1.2	0.2	0
Maximum number of months	40	27.9	30.1	40
Standard deviation	4	8.1	5.8	5.6
Primary Diagnosis n (%)**				
Organic mental disorders	9 (2%)	-	4 (1%)	13 (1%)
Mental and behavioural disorders due to psychoactive substance use	27 (6%)	-	2 (1%)	39 (4%)
Schizophrenia, schizotypal and delusional disorders	271 (61%)	33 (79%)	238 (70%)	542 (65%)
Mood disorders	70 (16%)	3 (7%)	56 (16%)	129 (16%)
Neurotic, stress-related and somatoform disorders	43 (10%)	2 (5%)	24 (7%)	79 (8%)
Disorders of adult personality and behaviour	20 (5%)	3 (7%)	12 (4%)	35 (4%)
Mental retardation	4 (<1%)	1 (2%)	-	5 (<1%)
Disorders of psychological development	-	-	2 (1%)	2 (<1%)
Behavioural and emotional disorders with onset usually occurring in childhood and adolescence	1(<1%)	-	-	1 (<1%)
Not stated	1 (<1%)	-	3 (1%)	4 (<1%)

* Excludes clients who were still in the program after 31 December 2011 (data cut off), i.e. is exited clients only
** Categories consistent with the ICD-10, Chapter V.

Classification of mental health diagnoses

For the purposes of analysis, the diagnoses provided by service providers were grouped according to the International Classification of Diseases (ICD-10), Chapter V: Mental and behavioural disorders[56], as shown in Table 7.3.

Table 7.3: Classification of mental health diagnoses provided in client profile

ICD-10 Chapter V: Mental and behavioural disorders		Examples of diagnoses provided by service providers
F00–F09	Organic, including symptomatic, mental disorders	Alzheimer's, dementia, panic disorder, organic personality disorder
F10–F19	Mental and behavioural disorders due to psychoactive substance use	Alcohol dementia, alcohol dependency drug induced psychosis, substance abuse disorder

[56] International Statistical Classification of Diseases and Related Health Problems 10th Revision (ICD-10) Version for 2010, http://apps.who.int/classifications/icd10/browse/2010/en#/V accessed 29 August 2012.

ICD-10 Chapter V: Mental and behavioural disorders		Examples of diagnoses provided by service providers
F20–F29	Schizophrenia, schizotypal and delusional disorder	Paranoid schizophrenia, psychotic disorder, schizoaffective disorder, delusional disorder
F30–F39	Mood [affective] disorders	Bipolar affective disorder, depression, dsysthymic disorder
F40–F48	Neurotic, stress-related and somatoform disorders	Anxiety, anxiety/depression, dissociative disorder, post traumatic stress disorder, generalised anxiety
F50–F59	Behavioural syndromes associated with physiological disturbances and physical factors	Nil reported
F60–F69	Disorders of adult personality and behaviour	Borderline personality disorder, gender dysphoria, personality disorder
F70–F79	Mental retardation	Intellectual impairment
F80–F89	Disorders of psychological development	Aspergers syndrome, autism spectrum disorder
F90–F98	Behavioural and emotional disorders with onset usually occurring in childhood and adolescence	ADHD
F99	Unspecified mental disorder	Nil reported

7.3.1 Demographic information

Age
The average age for participants was 36.8 years. Minor variations were evident by program stream, with clients in the RRP program being slightly older than the average for the total cohort.

The youngest person to participate in a Recovery program was aged 17.5 years at the date of their commencement with a TFCF program.

Gender
The overall ratio of women to men in the TTR program was one female to every three males (26.5% and 73.5% respectively). The gender balance is skewed by the fact that over half of the total TTR cohort (55%) were from the TFCF program, of which 83% of clients were male.

Cultural background
While the majority of clients were Australian born (91.2%), a considerable proportion of program clients were of Aboriginal and Torres Strait Islander cultural background (15.3% of the total cohort). This was particularly true for the TFCF program, where people from Aboriginal and Torres Strait Islander cultural backgrounds represented almost a quarter of the cohort (22.4%).

These figures signify that people from Aboriginal and Torres Strait Islander cultural backgrounds were over-represented in the study cohort when compared to Queensland population, where they constitute only 3.6% of the population.[57] However, the proportion of people from Aboriginal and Torres Strait Islander cultural backgrounds in the TFCF cohort is representative of the overall Queensland population, where people from Aboriginal and Torres Strait Islander cultural backgrounds represent 29.9 per cent of the prison population (as at 30 June 2010).[58]

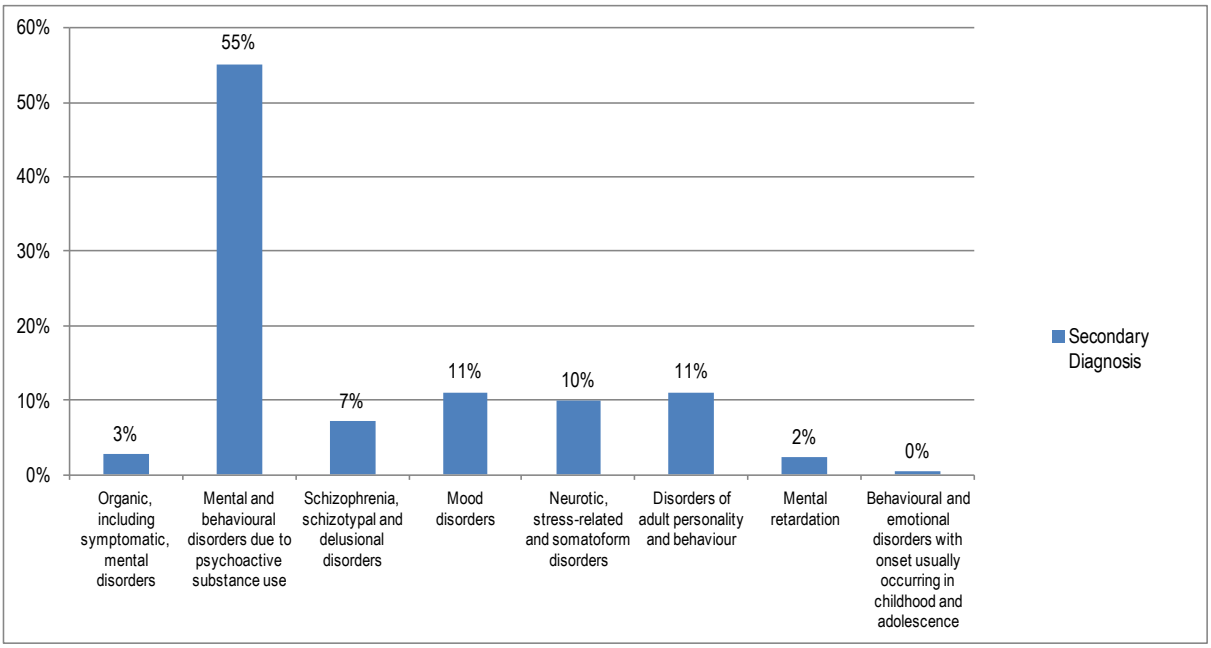
The RRP program cohort had the greatest proportion of overseas-born clients (15%).

7.3.2 Severity of mental health disorders

Two-thirds of all TTR clients (65.4%) had a primary diagnosis of schizophrenia, schizotypal or delusional disorders. The next most common primary diagnosis was mood disorders (15.6%).

Of the 542 clients with a primary diagnosis of schizophrenia, schizotypal or delusional disorders, 252 (46%) had a secondary diagnosis recorded. The following *Figure 7-13* shows the secondary diagnoses for these 252 clients. Mental and behavioural disorders due to psychoactive substance use accounted for 55% (144) of secondary diagnoses for clients with a primary diagnosis of schizophrenia, schizotypal or delusional disorders.

Figure 7-13: Secondary diagnoses for clients with a primary diagnosis of schizophrenia, schizotypal or delusional disorders, n= 542



Twenty nine people had mental and behavioural disorders due to psychoactive substance use recorded as their primary diagnosis and of this group 17 people had a co-occurring mental health disorder. Of the 422 clients who had a secondary diagnosis recorded, almost half (47.4%) had mental and

[57] 2011 Census Counts — Aboriginal And Torres Strait Islander Peoples, http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/2075.0main+features32011 accessed on 30 August 2012.

[58] *Just Futures 2012–2015. Growing community, family, opportunity and justice for Aboriginal and Torres Strait Islander Queenslanders*, p6. http://www.communities.qld.gov.au/resources/atsis/government/programs-initiatives/just-futures-strategy.pdf accessed on 30 August 2012.

behavioural disorders due to psychoactive substance. In total, 229 (27%) clients have co-morbid mental health and substance use disorders.

Only 14 people were reported as having a third diagnosis, including substance use disorders. Fifty-two people were reported as having an 'other disability' (excluding substance use disorders).

7.3.3 Service utilisation differences between the TTR program stream cohorts

This section provides insight to the different client populations in each of the three TTR programs, from the perspective of their varying usage of Queensland Health funded specialist mental health services. This analysis is based on data provided by Queensland Health for a sample of 81 TTR clients across each of the three TTR programs, which identify clients' use of:

- Inpatient mental health services (inpatient)
- Community-based mental health services (community).

Data in this section is shown to illustrate the difference in service utilisation by the client populations in each of the three TTR programs.

Inpatient data

The following table identifies the use of Queensland Health inpatient mental health services, by clients in each of the three TTR programs for a 23 month period following exit from the TTR program.

Table 7.4: Queensland Health inpatient data, TTR clients, by program stream, 23 months

Inpatient Data	RRP	TFCF	TRP
Clients	24	53	4
Inpatient Admissions	26	18	6
Inpatient Bed Days	319	216	140
Average per Client			
Inpatient Admissions per Client	1.1	0.3	1.5
Average Length of Stay (Days)	12.3	12.0	23.3
Inpatient Bed Days per Client	13.3	4.1	35.0

Note: Figures in the table are rounded.

The above table suggests that the average length of stay for RRP clients (12.3 days) and TFCF clients (12.0) are roughly similar. The data indicates however, that RRP clients have over three times more inpatient admissions (1.1) as compared to TFCF clients (0.3), resulting in a significantly higher number of days in hospital (13.3 vs 4.1) during the period. The data included in the table for TRP clients is based on only 4 clients and therefore cannot be considered to be reliable for this cohort.

The above information suggests that clients have relatively high inpatient service needs, across all three streams.

7. Findings: Client Profile

Community data

The following table identifies the use of Queensland community-based mental health services, by clients in each of the three TTR program streams.

Table 7.5: Queensland Health community data, TTR clients, by program, 23 months

Community Data	RRP	TFCF	TRP
Clients	24	53	4
Contacts	3,470	5,040	704
Contact Minutes	162,557	209,204	22,380
Average per Client			
Contacts per Client	145	95	176
Contact Minutes per Contact	47	42	32
Contact Minutes per Client	6,773	3,947	5,595

Note: Figures in the table are rounded.

As identified in the above table, usage of community support appears significantly higher for RRP clients than TFCF clients, based upon the number of contacts (145 contacts vs 95 contacts) and the minutes of contact (6,773 minutes vs 3,947 minutes). Once again, it is not possible to provide meaningful comparison for clients in TRP as the sample included only 4 TRP clients.

7.4 Key findings

The key findings of this analysis are:

- The mental health diagnostic profile of TTR clients, indicates that the TTR programs were reaching the intended client group (i.e. those with moderate to severe mental illness).
- The age profile of TTR clients, indicates that the TTR programs were reaching the intended age group of clients (i.e. adults aged 18 years and older). Only one age discrepancy was evident where a person aged 17.5 years entered a TFCF program.
- Duration of service provision, was either less than or consistent with the anticipated duration of support specified in the Service Models.
- Staff issues in one organisation had a significant impact on client numbers.

8 FINDINGS: CLIENT OUTCOMES

Client outcomes were assessed using five main mechanisms:

1. Interviews with TTR clients
2. Case studies of TTR clients
3. Interviews with service providers
4. Comparison of client Recovery Assessment Scale (RAS) survey responses at entry and exit
5. Analysis of clients' usage of specialist mental health services after exit from the TTR.

Outcomes reported through each of these mechanisms are described in the following five sections. The overall findings from this chapter are synthesised in Section 8.6.

8.1 Interviews with TTR clients

Face-to-face interviews were conducted with a purposive sample of 21 TTR clients. Two additional clients who were scheduled for interviews were not well enough on the day to meet with AHA's evaluation team. Interviewees were existing clients of the service providers and drawn proportionally over the six service providers. Recruitment of clients was undertaken by the service providers and all clients who agreed to participate provided written consent.

These interviews were designed to attain a greater depth of understanding of client outcomes to that available through quantitative data sources alone.

Interviewee Profile

Of the 21 clients interviewed, seven were from the Transition From Correctional Facilities (TFCF) Program, 10 from the Transitional Recovery Program (TRP) and four from the Resident Recovery Program (RRP). The majority (n=16) were males. Two thirds were Australian-born. Two interviewees reported being of Aboriginal descent and two were born overseas. Interviewees ranged in age from 23 to 56 years. All interviewees reported having multiple mental health issues, with schizophrenia, depression, anxiety disorders, and bipolar disorders being the most common diagnoses listed. One had drug and alcohol problems but no stated mental health disorder. Duration in the program was varied, ranging from a number of weeks to up to one year.

Table 8.1: Interviewee Profile

Characteristic	TFCF participants N = 7	TRP participants N = 4	RRP participants N = 10	All participants N = 21
Gender (% Male)	86%	75%	70%	76%
Age (Mean, range)	40 (26-56)	33 (28-41)	43 (23-55)	40
Aboriginal/Torres Strait Islander background (%)	1 (14%)	-	1(10%)	2 (10%)
Country of Birth (n, %)				
Australia	4 (57%)	3 (75%)	7 (70%)	14 (67%)
UK	-	-	1 (10%)	1 (5%)
NZ	-	-	-	-
All other	1 (14%)	-	-	1 (5%)

Characteristic	TFCF participants N = 7	TRP participants N = 4	RRP participants N = 10	All participants N = 21
Unknown/Not stated	2 (29%)	1 (25%)	2 (20%)	5 (24%)

Key: TFCF: Transition from Correctional Facilities Program; TRP: Transitional Recovery Program; RRP: Resident Recovery Program

Range of interventions/services provided

While the programs differed in terms of the specific range of interventions/services provided, a number of commonalties were evident in the client interviews. These included:

- Appointment of a designated support worker per client
- Focus on developing independence including activities of daily living. This included providing interviewees with assistance in using public transport, finding health care providers, shopping and getting about generally as well as teaching them basic skills in cooking and cleaning which also contributed to interviewees developing greater independence
- Administrative support. This included assisting clients to fill out forms for bank accounts and Centrelink, and completing tax returns
- Promotion of health and personal safety. Activities in this domain fell into four main groups:
  - Accompanying interviewees on visits to the Community Mental Health team, doctors and other health care providers/services
  - Making appointments for interviewees
  - Connecting interviewees to programs and services such as drug/alcohol/gambling rehabilitation, general practitioners, psychiatrists, psychologists and other support workers. This included assisting clients to find practitioners with whom the client was comfortable to work
  - Proactively assisting interviewees to obtain glasses and attend dental appointments. In the case of clients who either had no car or licence, or who were unable to use public transport, support workers were involved in taking clients to appointments.
- Providing occasions of social engagement. This included internal BBQs, picnics and social clubs. In some cases, clients were taken to external group activities such as numeracy and literacy classes, and arts/craft groups
- Assistance in getting employment
- Assistance in finding accommodation.

Key achievements of interviewees since joining the program

Overall, interviewees reported positive experiences of the TTR program. While interviewees' outcomes varied at an individual level, the main key achievements were evident for many since joining the program:

- Reconnection or improved relationships with family and children
- Increased sense of direction
- Fewer/no hospital episodes
- Increased attendance at health appointments

- Greater medication compliance
- Cessation of addictive behaviour/s (i.e. off drugs/alcohol/cigarettes/gambling)
- Engaging in exercise
- Securing part-time work
- Voluntary disassociation from former acquaintances connected to prior prison life or from those engaged in addictive behaviours
- Improved self-confidence –reflected in increased social engagement and use of public transport
- Improved skills in self care.

The following quotations from client interviews provide an example of these achievements:

"Before [Transitional Recovery Program] life was a rollercoaster... I was very suicidal; in and out of intensive care after suicide attempts. [Client had an estimated 40 admissions before coming to the program. He has not been back to hospital since.]. *They have been a great help, teaching me different stuff, and getting me into the community... Everything was done for me in hostel and I didn't feel like I learnt anything about coping with life….I can go to shopping centres now that I am comfortable around a lot of people. I can even go to concerts"* (TRP interviewee #2, male, age 28).

"I would be back in jail by now if they hadn't helped me. I'm doing OK now. Things don't bother me as much" (TFCF interviewee #2, age 26).

"To say I've gone 180 degrees in 9 months is an understatement" (RRP interviewee #1, male, age 35).

"I've got a new life" (RRP interviewee #4, male, age 54).

*"I don't think they [parents] get the mental illness thing. They didn't like me when I was drinking and drugging. I used to steal money from them...They're now supportive and will have me back in the family" (*TRP interviewee #2, male, age 33).

"Even [ex-wife] has said I've changed" (TFCF interviewee #6, male, age 38).

The importance of the recovery-oriented approach

One of the key tenets of the recovery-oriented approach is that recovery is about developing individual ways to lead a fulfilling life whilst managing the effects of mental illness.[59]

The range of services listed earlier in this section illustrates the holistic approach that is being used to assist clients on their recovery journey. Likewise, the list of key achievements presented above provides evidence of how involvement in the TTR program has resulted in clients being empowered in their lives.

[59] Mental Health Coordinating Council, *Social Inclusion: Its Importance to Mental Health*, Mental Health Coordinating Council, Sydney, 2007.

8. Findings: Client Outcomes

The following quotations provide examples of the impact of the recovery-oriented nature of the programs from the client's perspective:

> *"They helped me with different ways of coping with things"* (TFCF interviewee #6, male, age 38).
>
> *"[Resident Recovery Program] staff always talk to me in a respectful way. I always feel like I'm on a one to one level"* (RRP interviewee #9, male, age 39).
>
> *"[The staff] are trying to grow my confidence"* (RRP interviewee #8, female, aged 48).
>
> *"The program has allowed me to plan for my future...[Previously] I didn't have a sense of what my future was, my life was dominated by being sick"* (RRP interviewee #4, male age 54).
>
> *"Now I can function the same as everyone else. I don't have a disability now. I still have depression but I make sure I take my medication"* (TRP interviewee #2, male, age 28).

Enablers and barriers to successful outcomes

Enablers
From the analysis of interview narratives, three key enablers were evident:

1. Interviewees' reported that their **relationship with their TTR support worker played a critical role in achieving successful outcomes.** The one-to-one nature of this relationship meant that:

   - Support could be customised to the specific needs of the client

> *"I would not have thought about stopping drinking and drugging without [Resident Recovery Program]. No one offered to help me before. They found a program to meet my needs"* (RRP interviewee #4, male, age 54).

   - The development of the client–case worker relationship could be paced according to the client's capacity to engage

> *"They got to know me very, very slowly and carefully"* (RRP interviewee #1, male, age 35).

   - Support could be delivered when and where needed.

> *"When I get a bit down. I can ring them up and they will come around to see if I'm alright*" (TFCF interviewee #4, male, age 39).

2. **Development of trust** was a key outcome of this investment in relationship building between client and those delivering services:

> *"[Transition from Correctional Facilities Program staff] have kept their word and delivered what they said they would"* (TFCF interviewee #5, male, age 40).

3. This trust, in turn, made clients **more open and responsive to encouragement** from their support worker:

> *"While I was in jail, I wanted to change but after I came out I was tempted to go back to my old behaviour but [support worker] kept pinning me down, telling me I am a better person and that I could do it"* (TFCF interviewee #2, male, age 26).
>
> *"Staff are encouraging and if they think you're sitting back then they will give you a bit of a nudge"* (RRP interviewee #4, male, age 54).
>
> *"[Transitional Recovery Program] workers are positive people, always trying to help and make us succeed"* (TRP interviewee #3, male, age 30)

Key finding

The TTR Programs seem to be providing valuable assistance to their clients. The program methods of assisting clients appear to be providing a supportive, recovery oriented focus that is helpful and well received by program clients.

Barrier

A clear barrier to successful outcomes was some clients' **continued exposure to old acquaintances or old ways** (e.g. alcohol, former inmates, etc.) particularly those in the boarding house context:

> *"I spend a lot of time in my room because I find it's hard with other men drinking out the front"* (TFCF interviewee #6, male, age 38).

This example illustrates the externalities that can impinge on program success and which service providers may need to address with the individual clients that these factors specifically apply to.

Unintended consequences

One of the possible negative unintended consequences of the program is the risk of dependency developing between the interviewee and their support worker. As the following quotations illustrate, the boundaries between client and support worker have become blurred in some instances and this has obvious risks not only for clients but for support workers and organisations.

> *"[Support worker]'s wonderful. She makes things as easy as she can. She is available on the weekends and checks in every day"* (TRP interviewee #4, male, age 33).
>
> *"She does all the leg work"* (RRP interviewee #4, male, age 54).
>
> *"I love [support worker]. I've got no family. He's my family. It's good to know there is something out there"* (TRP interviewee #7, male, age 32).

8. Findings: Client Outcomes

"I would be lost without [support worker]...She's a big help to me. She's my security blanket "(TCF interviewee #6, male, age 38).

"It's just about having a friend there [at social activity]. *It reduces my anxiety… I don't know if I'd keep going* [if support worker did not continue to attend with him]" (RRP interviewee #9, male, age 39).

Characteristics of the support worker relationship that were valued by the client, such as their ready availability and the critical role they play in connecting clients to services, have the potential to blur relational boundaries. This can result in the support worker being elevated to the role of surrogate family or friend by the client in their life. This, in turn, can mean that activities implemented in conjunction with the support worker, which are ultimately designed to engender independence, may result in prolonged dependency because of unresolved boundary issues.

Negative cases

While overall, interviewees reported positive experiences of the TTR program some, albeit small amounts, of negative feedback were also received. One interviewee reported dissatisfaction with the conditions imposed by the residential program that restricted his freedom to have a partner cohabitate.

Despite having achieved employment through the program, another interviewee reported enduring concerns about what will happen to him if he's taken off the pension. Although this concern raised by the interviewee is not a direct result of the TTR program, it suggests a need to ensure that program clients understand the implications of taking up employment as a result of the program.

8.2 Case studies of TTR Clients

In addition to the interviews, 11 case studies of TTR clients were compiled. The majority (10) of these case studies were by written up by TTR staff and one by a client. In each case, the proforma provided (Appendix I) was used to structure the case study content. De-identified copies of these case studies are provided in Appendix P. The demographic profile of case study clients is shown in Table 8.2.

Table 8.2: Profile of case study clients

Characteristic	TFCF N = 4	TRP N = 3	RRP N = 4	Total Case Studies N = 11
Gender (% Male)	100%	100%	25%	76.19%
Age (Mean, range)	35 (28-42)	34 (24-48)	40 (28-49)	36 (24-49)
Aboriginal/Torres Strait Islander background (%)	-	-	-	-
Country of Birth (n, %)				
Australia	2 (50%)	3 (100%)	1 (25%)	6 (55%)
UK	-	-	1 (25%)	1 (9%)
NZ	-	-	-	-
All other	2 (50%)	-	-	2 (18%)
Unknown/Not stated	-	-	2 (50%)	2 (18%)

8. Findings: Client Outcomes

Range of interventions/services provided

The range of services and interventions listed in the case studies was similar to those self-reported by clients in the interviews (Section 8.1) and included:

- Training, education and assistance with activities of daily living (including grocery shopping, cooking or personal care, negotiating public transport, literacy skills)
- Assistance with administrative tasks (obtaining car registration, applying for identification documents, Centrelink applications)
- Assistance with financial matters, including opening bank accounts, consolidating debts, completing tax returns, learning how to budget, and referral to financial counsellors in some cases
- Assistance with applications for housing, bond applications, and in one case, assistance to secure a grant for the purchase of furniture and appliances.
- Providing transportation to appointments (and, for Transition from Correctional Facilities clients, providing transport to their accommodation upon release from prison)
- Promotion of health and safety, including:
    - Assistance to find a supportive GP or psychologist
    - Assistance to book and attend dental and optometry appointments
    - Assistance with managing alcohol use and problem gambling. The support provided ranged from motivational interviewing/counselling to practical assistance (e.g. helping the client set limits on bank card so that ATM withdrawals could only be made during business hours).
    - Referral to support groups.
- Assistance to develop community connections (e.g. writing groups, painting classes). This was often undertaken with a view to addressing the goal of improving assertiveness, confidence and self-esteem.
- Provision of emotional support, feedback and encouragement.

Key achievements of clients since joining the program

The range of achievements resulting from the TTR program evident from the case studies was consistent with those self-reported by clients in the interviews (Section 8.1) and included:

- Improved management of mental health issues. This was demonstrated by reports of:
    - Decreased suicidal ideation
    - Fewer hospital admissions
    - More effective management of anxiety issues,
    - Improved management of substance misuse issues
    - Development of wellness action plans
    - Improved confidence, self-esteem and empowerment.
- Improved management of concurrent health problems. This included:
    - Finding a supportive GP

  - Attending appointments
  - Improved management of chronic pain
  - Improved physical fitness (e.g. being able to walk to shops)
  - Obtaining new glasses or dentures.
- Gaining control of financial issues and debts
- Obtaining stable housing
- Finding a job
- Re-establishing or improving relationships with family and friends.

The importance of the recovery-oriented approach

Although not always explicit, a recovery orientation was evident throughout the accounts of the services provided through the programs. The importance of empowering the client, respecting their values, and working together closely towards addressing agreed priorities was clear. Regular review and modification of goals in light of shifting circumstances was also apparent, and the focus was on improving quality of life in spite of challenging health issues and in many cases, adverse social circumstances.

The following extracts from the case studies illustrate the recovery-orientation of the programs:

> *"We have been a stable and trusted personal support in his life and have reflected to him the fact that he has a good future and is making progress towards it. We regard him as a valuable human being and expressed admiration at his attempted to move on in his life."* (TFCF Case study #1, male, age 34).
>
> *"Finding strengths in [the client], and always focusing on a positive future and emphasis on his self-worth"* [were listed as key factors for successfully achieving goals] (RRP Case study #2, male, age 28).

Enablers and barriers to successful outcomes

Enablers

Consistent with findings from the interviews, the relationship between the client and their support worker was considered critical to achieving successful outcomes. Building respect and rapport were listed as being vital to the process of developing clear expectations, negotiating goals and assisting clients to develop a long term vision. Good humour, flexibility and acceptance were also considered important.

> *"Nothing was rushed but I was pushed to do things I didn't think I could do but [Transitional Recovery Program] staff had the faith that I could."* (TRP Case Study #1, male, age 24).
>
> *"Understanding his past traumatic experience that impacted on his attitudes and beliefs" [was important].* (RRP case study #2, male, age 29).

8. Findings: Client Outcomes

While a strong and trusting relationship with a main support worker was considered essential, in some cases exposure to a range of staff from the program team was considered useful as it enabled access to a different approaches and perspectives. Careful matching of key workers with the 'personality and needs' of clients was also considered to be important.

> *"Exposure to different workers, people with different experiences in life"* (TRP case study #3, male, age 48).
>
> *"[The client] has also benefited from working with different members of the Transition Support team. Each team member's individual style of practice has benefitted [the client] in working through his pain management and depressive feelings"* (TFCF case Study #2, male, age 42).

Strong advocacy by support workers, and effective communications with other agencies was also highlighted.

Achievement of key goals seemed to provide a stable foundation from which clients could make other positive changes in their lives. For example, achieving the goal of safe and secure housing enabled other issues to be addressed:

> *"A safe and stable environment is necessary for the recovery journey, and provides 'somewhere that she feels safe enough to deal with other issues"* (RRP case study #3, female, age 33).

Similarly, for those with the goal of improving relationships with family and friends, achieving this goal provided a strong base from which they could to achieve other aims:

> *"Re-establishing a supportive relationship with his brother and family has been the most important."* (TFCF case study #4, male, age 34).

Barriers

A number of barriers to the achievement of successful outcomes were identified. These included:

- Difficulties in obtaining housing:

> *"We attempted to arrange suitable accommodation, but accommodation facilities declined to take him and parole was declined"* (TFCF Case Study #3, male, age 28).
>
> *"[The client] also found it hard securing a safe living environment.'"* (RRP Case Study #2, male, age 28).

- External factors that impacted on clients' recovery:

> *The boarding house lacked privacy and constantly exposed [the client] to other individuals suffering mental health crises'"* (RRP Case Study #2, male, age 28).

This issue was also raised by clients during the interviews.

- Delays in provision of services from government bodies, due to waiting lists and procedures, were reported.

- Securing ongoing support and funding beyond the duration of the program was difficult in some cases. For example, one client needed ongoing part time support to manage independently in the community but was assessed as outside the criteria for some services.

"The more challenges and barriers that were overcome, and the better this man became – although he still had major areas that required support - the harder it became to obtain the services that were needed." (TRP case study #3, male, age 48).

- Difficulties on discharge because of client's dependency on the support worker:

"Despite clear boundaries, [the client] did develop dependency on the case manager and found discharge difficult." (RRP case study #1, female, age 48).

This issue was also raised by clients during the interviews.

- The ongoing challenges posed by mental illness, physical ill-health and adverse social situations were also reported as crucial barriers. These included a reluctance to seek psychological help for mental health issues, persistent substance misuse or gambling problems, mental health crises, or breaches of parole resulting in return to prison.

"Depression was a factor. In 2010 I was admitted back into hospital after a suicide attempt""(TRP Case Study #1, male, age 24).

- Language, literacy and cultural barriers
- Reluctance of case managers to embrace the shared decision making that characterises a recovery-oriented approach was reported in one case.

Unintended consequences

In the case studies, both positive and negative unintended consequences of the TTR program were evident. Consistent with the interview findings dependency on support workers emerged as a negative unintended consequence. While the development of strong, supportive and trusting relationships with support workers were again clearly an important ingredient for the success of the TTR program, the short term nature of the program means that it cannot fulfil the need for ongoing personal support that many clients appeared to require. This, along with the challenges of securing appropriate ongoing practical support (for example, assistance to live independently), made exit from the program difficult.

Among the positive unintended consequences of the program was the discovery of new talents and interests as a result of establishing new community connections. For example, one client joined an art group and began working towards entering a painting in an art exhibition; another rediscovered an interest in playing the guitar.

Negative cases

Most accounts of the TTR program were positive, with little negative feedback provided. In one case, a support worker felt bound by duty of care to request a Justice Examination Order (JEO) for the client to

receive a Mental Health Assessment which the client was not willing to voluntarily seek. The JEO led to imposition of an Involuntary Treatment Order (IT0). This subsequently resulted in a breakdown of the relationship between the worker and the client because of the latter's perceived breach of trust. While this example demonstrates the importance of trust, mutual understanding and shared decision making within the recovery framework, it also suggests that the TTR program may not be appropriate for some clients, particularly those with limited insight into or denial of their mental health problems.

8.3 Client outcomes: Service providers' perspectives

During the face to face interviews conducted with the six TTR services in August/September 2011 and July/August 2012, the service providers' perspectives on client outcomes and the barriers to achieving positive results were also discussed.

Consistent with a recovery approach, service providers emphasised that they worked in collaboration with clients to determine their goals. This meant that in some cases the workers would identify needs (for example, treatment of alcohol and other drug problems) but if clients did not agree that these were priorities, they were not considered goals for the program.

A discussion of the key outcomes identified by service providers follows below.

Promotion of personal health and safety

Several service providers reported a number of positive mental health outcomes. These included reductions in the number of readmissions for their clients or, in the case of those re-admitted, much shorter durations of stay. Reduced levels of emotional distress were also reported by one centre for clients participating in their 'Women's Empowerment' training

Perhaps not surprisingly, mental health relapses sometimes occurred during the programs. However, for some clients, re-engagement with the mental health system (which had previously been viewed by clients with fear and mistrust) was seen as a positive outcome. Others clients developed coping skills which meant they were better able to deal with mental health crises without presenting to hospital. Clients also became more involved in developing their own goals and plans, such as developing their own 'Wellness toolkit' and their own action plans.

Other positive outcomes included developing practical living skills (such as cooking), and positively addressing gambling issues.

Development of relationships and social connectedness

Several programs reported improved community connections as a result of services provided. A number of clients were able to re-establish relationships with family as a result of participation in TTR programs. For example, a mother, who had been homeless for several years and had been separated from her child due to her mental health problems, was able to reconnect with her after four years. Additionally, as a result of the program, she was also able to establish a home, buy a car, save money, and reconnect with family in New Zealand. Another client developed a positive partner relationship and moved in with that partner.

8. Findings: Client Outcomes

Employment, volunteering and vocational outcomes

Client outcomes in employment terms were mixed:

> *"Success is relative. One participant studied at night, got qualifications and went to work. He got right outside of his comfort zone – beyond manual labour, cold calling sales and into new work. Because of the recovery program support, he re-engaged with mental health, although he did relapse in mental health terms".*

Others moved into volunteering roles or took up education and training. For some, the assessment processes required by mainstream employment services put them off seeking paid employment.

Sustainable housing

Securing appropriate housing was frequently a key goal of clients within TTR programs. However, service providers reported that a lack of appropriate housing stock made this goal difficult to achieve.

Staff would like to work more intensively with participants at the beginning of the 12 months in order to meet the meet the program outcome of securing appropriate housing, but the 'black and white message of recovery' is to work with clients on their immediate goals. Despite this, several programs assisted clients to find accommodation. One program was particularly proud that it had helped mothers (many with histories of trauma) to re-establish tenancies.

For many clients who were living in boarding house or hostel accommodation, hygiene, safety and privacy issues associated with this living environment were not conducive to recovery. Concerns included shared rooms with no locks, exposure to other residents who were 'shooting up', unsatisfactory toilet facilities, and an excessive power imbalance between hostel owners and residents.

Unintended outcomes

As described above, securing appropriate housing was an ongoing challenge. In some cases, the regulations around access to social housing made it difficult for clients to achieve their recovery goals and as the following example illustrates, resulted in less than optimum accommodation arrangements

> *"[The client] has ended up in a caravan park and because this is deemed to be suitable housing, he is taken off the social housing list. In recovery terms, it is a backward step and not conducive to ongoing recovery.'"*

While this example is illustrative, the extent to which this is representative of the experiences of clients in general is unclear. Likewise, it might not reflect the experience/approach of the Department of Communities

Barriers

Service providers reported that the extent to which positive outcomes were achieved often depended on clients' level of need upon entering the program. Clients who are older (e.g. in their fifties) tended to be more insightful, but were also more likely to be 'stuck in the system' or 'institutionalised'. For some clients, a lack of acceptance of their mental health diagnosis was viewed as a limitation to achieving positive outcomes.

Other barriers to achieving agreed outcomes, as reported by service providers included:

- Fluctuating support needs of clients, depending on changes in mental health status over time, as well as changes in social circumstances.
- The relatively short duration of the programs and difficulty transitioning clients to longer term support beyond the program. One service provider noted that "*it takes a long time to unlearn the skills you have learned to survive*". Linked to this were barriers related to 'people getting comfortable' (in the program) and a lack of preparation for 'the move.' The short duration can also be viewed as a positive in that it 'creates a sense of urgency'.
- Limited availability of appropriate housing
- Clients' criminal history, which was a barrier to finding secure tenancies
- Discrimination. This was seen as an issue for many clients; one that was compounded for those with a history of incarceration.
- Concurrent alcohol and other drug problems
- Return to prison for those with a history of incarceration: *"Minor things can result in a return to prison"*
- Mental health relapses.

8.4 Comparison of Client Survey responses at entry and exit

All new clients who entered the TTR program between September 2011 and January 2012 were asked to complete a Recovery Assessment Scale (RAS) survey at two time points: on entry and on exit. In the case of those, who had yet to exit the program, 10 August 2012 was nominated as the date for post-intervention data collection. In addition to the RAS, further questions were asked at each time point regarding clients' perceptions of mental health support, safety in accommodation, confidence in activities of daily living, health, exercise, and staff assistance.

8.4.1 RAS survey results

Of the 60 clients who completed an entry survey, only 22 subsequently completed an exit survey. Of the latter, three could not be included in the analysis because of the number of missing survey responses. The characteristics of each group are shown in Table 8.3.

Table 8.3: Characteristics of RAS survey participants

Characteristic	On entry (n=60)	Included in analysis (n=19)
Gender (% male)	57%	53%
Age, Mean, range	39 (20-63)	42 (26-63)
Country of birth, n (%)		
Australia	53 (88%)	18 (95%)
New Zealand	4 (7%)	-
UK	2 (3%)	1 (5%)
Not stated	1 (2%)	-
Aboriginal and Torres Strait Islander Status, n (%)	7 (12%)	1 (5%)

8. Findings: Client Outcomes

Characteristic	On entry (n=60)	Included in analysis (n=19)
Main diagnoses (self-reported), n(%)		
Affective disorder	1 (2%)	
Anxiety	2 (3%)	1 (5%)
Bipolar	3 (5%)	
Depression	15 (25%)	3 (16%)
Panic Disorder	1 (2%)	
Paranoia	1 (2%)	
PTSD	3 (5%)	2 (11%)
Psychosis	3 (5%)	
Schizophrenia	24 (40%)	10 (53%)
Do not have illness	1 (2%)	
Not stated	6 (10%)	2 (11%)
TTR Program, n(%)		
Transition from Correctional Facilities Program	15 (25%)	-
Transitional Recovery Program	13 (22%)	5 (26%)
Resident Recovery Program	32 (53%)	14 (74%)

The Wilcoxon Signed Rank Test was used to examine changes in total scores and scores by domain (Table 8.4). Overall, mean and median values were similar at entry and exit. Small increases were evident in the mean total exit scores (from 92.8 to 94.3) and in three of the five domain scores. A small decrease was evident in the *Goal and Success Orientation* domain (from 21.0 to 20.9) while the *Reliance on Others* domain remained unchanged. However, these changes were not statistically significant.

These findings suggest that the program had very little effect on clients' score. However, given the small sample size, these results need to be interpreted with caution.

Table 8.4: Summary of RAS total and domain scores at entry and exit

Domain	Time	Mean	(SD)	Median	(IQR)	Minimum	Maximum	p-value*
Total RAS scores	Entry	92.8	(17.3)	92	(79-104)	63	120	0.888
	Exit	94.3	(14.9)	96	(81-107)	64	116	
Goal and success orientation	Entry	21.0	(3.1)	21	(18-24)	15	25	0.823
	Exit	20.9	(3.3)	21	(20-24)	14	25	
Personal confidence and hope	Entry	33.3	(6.8)	33	(28-38)	23	45	0.812
	Exit	33.8	(6.2)	36	(30-39)	22	43	
Reliance on others	Entry	16.4	(3.1)	16	(15-20)	10	20	0.979
	Exit	16.4	(2.9)	16	(15-19)	10	20	

Domain	Time	Mean	(SD)	Median	(IQR)	Minimum	Maximum	p-value*
Willingness to ask for help	Entry	11.5	(3.0)	12	(10-13)	4	15	0.899
	Exit	11.9	(2.0)	12	(10-13)	8	15	
Not dominated by symptoms	Entry	10.6	(3.0)	10	(8-13)	6	15	0.438
	Exit	11.2	(2.5)	12	(9-13)	7	15	

*From Wilcoxon Signed Rank Test
Abbreviations: SD: Standard Deviation; IQR: Interquartile Range

8.4.2 Analysis of client perception questions

Analysis of clients' responses to the additional Client Survey questions asked showed marked changes over a number of areas.

At the end of the program, there was a considerable increase in the proportion of clients who agreed that they had ongoing support for their mental health, from 37% at entry to 74% at exit (Table 8.5). While the proportion who either strongly disagreed or strongly agreed decreased at exit the program (from 16% to 5%, and from 42% to 16% respectively), the overall pattern was one of greater perceived ongoing support for mental health by clients.

Table 8.5: Ongoing support for mental health

I have ongoing support for my mental health		
	Entry n (%)	**Exit n (%)**
Strongly disagree	3 (16%)	1 (5%)
Disagree	1 (5%)	1 (5%)
Agree	7 (37%)	14 (74%)
Strongly agree	8 (42%)	3 (16%)
Total	19 (100%)	19 (100%)

Clients were more ambivalent regarding whether they felt safe in their accommodation at both times points (Table 8.6). While overall, the proportion of clients who agreed/strongly agreed remained relatively stable with more than three quarter of all responses falling in these categories, nonetheless 23% of clients did not agree that they felt safe in their accommodation upon exit.

Table 8.6: Safety in accommodation

I feel safe in my accommodation		
	Entry n (%)	**Exit n (%)**
Strongly disagree	1 (5%)	1 (6%)
Disagree	2 (11%)	1 (6%)
Not sure	1 (5%)	2 (11%)
Agree	7 (37%)	9 (50%)

I feel safe in my accommodation		
Strongly agree	8 (42%)	5 (28%)
Total	19 (100%)	18 (100%)

Despite the client concerns evident in the previous table, the majority of clients (88%) agreed/strongly agreed that staff had assisted them with obtaining appropriate housing/accommodation (Table 8.7). Only 12% disagreed/strongly disagreed that they had been provided assistance.

Table 8.7: Assistance to obtain housing/accommodation

Staff have been assisting me with obtaining appropriate housing/accommodation	
	n (%)
Strongly disagree	1 (6%)
Disagree	1 (6%)
Not sure	0 (0%)
Agree	8 (44%)
Strongly agree	8 (44%)
Total	18 (100%)

The overall proportion who felt confident with shopping, cooking and maintaining their home situation remained relatively stable at both time points with more than three-quarters of all responses falling into these categories (Table 8.8). However, the proportion who disagreed increased at exit, (from 5% to 11%) indicating that some clients had enduring difficulties in performing activities of daily living at exit.

Table 8.8: Confidence with shopping, cooking and maintaining home situation

I feel confident with shopping, cooking and maintaining my home situation		
	Entry n (%)	**Exit n (%)**
Disagree	1 (5%)	2 (11%)
Not sure	5 (26%)	4 (22%)
Agree	8 (42%)	7 (39%)
Strongly agree	5 (26%)	5 (28%)
Total	19 (100%)	18 (100%)

Considerable improvements were evident in clients' self-rated health status between entry and exit (Table 8.9). Overall, the proportion who reported having excellent/very good health increased from 27% to 42%. The proportion of clients who reported their health as either fair/poor remained unchanged at both time points.

Table 8.9: General Health

In general would you say that your health is:		
	Entry n (%)	**Exit n (%)**
Excellent	3 (16%)	3 (16%)
Very good	2 (11%)	5 (26%)
Good	8 (42%)	5 (26%)
Fair	3 (16%)	3 (16%)
Poor	3 (16%)	3 (16%)
Total	19 (100%)	19 (100%)

Overall improvements in health status were not accompanied by an overall increase in the proportion of clients who had exercised more than twice in the week before interview at both time points (

Table 8.10)

Table 8.10: Physical Exercise

How many times did you exercise for fitness, recreation or sport in the last week?		
Number of times	**Entry n (%)**	**Exit n (%)**
1	5 (31%)	5 (31%)
2	4 (25%)	2 (13%)
3	2 (13%)	4 (25%)
4	0 (0%)	3 (19%)
5	3 (19%)	1 (6%)
6	1 (6%)	0 (0%)
7	1 (6%)	1 (6%)
Total	16 (100%)	16 (100%)

Considerable changes were evident in the training/employment status of clients between entry and exit (Table 8.11). The proportion unemployed decreased from 80% to 56%. More were in part-time employment (17% at exit compared with 13% at entry) and the proportion in education/training had quadrupled (7% to 28%).

Table 8.11: Employment, Education, Training and/or Volunteering

Do you have any involvement in Employment, Education, Training and/or Volunteering? (can circle more than one)		
	Entry n (%)	**Exit n (%)**

Do you have any involvement in Employment, Education, Training and/or Volunteering? (can circle more than one)		
	Entry n (%)	**Exit n (%)**
Part-time employment	2 (13%)	3 (17%)
Not employed	12 (80%)	10 (56%)
In education or training	1 (7%)	5 (28%)
Total	15 (100%)	18 (100%)

The majority of clients (68%) agreed/strongly agreed that staff had assisted or linked them to an organisation that had been assisting them to find appropriate education, training, employment and/or volunteering opportunities (Table 8.12). Despite the overall improvements reported in Table 8.11, more than a quarter (27%) either disagreed/strongly disagreed that that they had been provided adequate assistance in this regard.

Table 8.12: Assistance with Education, Training, Employment or Volunteering

Staff have been assisting me or have linked me to an organisation that has been assisting me with finding appropriate education, training, employment and/or volunteering opportunities	
	n (%)
Strongly disagree	3 (16%)
Disagree	2 (11%)
Not sure	1 (5%)
Agree	8 (42%)
Strongly agree	5 (26%)
Total	19 (100%)

8.5 Client outcomes: Usage of specialist mental health services

This section estimates the impact of the TTR program on clients' usage of the following specialist mental health services, after exit from the TTR program:

- Inpatient mental health services
- Community-based mental health services.

In developing estimates, two different methods of analysis were considered as follows:

- Comparison of service usage of clients prior to entering the TTR program, with service usage data for the same clients following exit from the program
- Comparison of service usage for TTR clients following exit from the program, with a control group who have not participated in the TTR Program.

The first approach was found not to be feasible due to client privacy constraints. The de-identified service usage data (inpatient and community) provided by Queensland Health, excluded client specific

data such as TTR service entry and exit dates, to ensure individual clients could not be identified. Consequently, it was not possible to reasonably determine pre and post TTR service usage.

The analysis therefore focussed on comparison of the TTR group with a control group. The estimates set out in this section are based upon a comparison of TTR clients' usage of services after exiting the TTR program, with a control groups' usage of services over the same period. The TTR group is a subset of clients who exited the TTR program between January and July 2010. The control group was selected by Queensland Health and has similar client characteristics as the TTR Sample, in terms of age and diagnoses.

Queensland Health data

De-identified patient record data was provided by Queensland Health (QH) from their Client Integrated Mental Health Application (CIMHA) system, for:

- Sample of 81 TTR clients (TTR Sample), being all clients who left the TTR Program between 1 January and 30 June 2010
- Control group of 79 people (Control Group) who accessed QH-funded mental health services (inpatient and/or community) and have similar characteristics as the TTR Sample, in terms of age and diagnoses.

This data included:

- Inpatient episodes (i.e. services provided in an inpatient setting, including forensic services). Data fields included admission dates, discharge dates, length of stay and ICD-10 diagnoses codes.
- Community episodes (i.e. services provided in the community, including ambulatory services the Continuing Care Rehabilitation Units and the Community Mental Health Team). Data fields included episode commencement and end dates, episode duration, number of contacts, number of contact minutes and ICD-10 diagnoses codes.

De-identified records of clients' service usage were provided for the period up to May 2012. Records for each client extend back to the point of first service contact, the majority of which extend back to 2008.

The Control Group was selected by identifying QH service users with the same age and diagnoses as those in the TTR Sample. Due to privacy considerations, data was not available to us in respect of other characteristics of clients which potentially may impact upon service usage, such as sex, socio-economic background or whether clients have been incarcerated. As it is not known whether the Control Group is representative of the TTR Sample in terms of these other characteristics or whether these impact upon service usage, the comparisons of the two cohorts provided in this report should be used with caution.

8.5.1 Inpatient mental health services

The following *Table 8.13* identifies inpatient mental health service usage by the TTR Sample and by the control group, as follows:

- Number of clients
- Inpatient admissions

- Inpatient bed days
- Admissions per client
- Inpatient bed days per client.

The data covers the period after the clients in the TTR Sample exited the TTR Program, i.e. from July 2010 until May 2012. All inpatient episodes which commenced and were completed during this period are included. Bed days data relating to incomplete inpatient episodes (not available from QH) and data relating to episodes which commenced prior to July 2010, are not included.

Table 8.13: QH Inpatient Data, TTR Sample and Control Group, July 2010 to May 2012

Inpatient Data	TTR Sample	Control Group	
Clients	81	79	
Inpatient Admissions	50	141	
Inpatient Bed Days	675	1,877	
Average per Client			***Difference (%)***
Inpatient Admissions per Client	0.6	1.8	-65%
Length of Stay (Days)	13.5	13.3	+1%
Inpatient Bed Days per Client	8.3	23.8	-65%

Notes: 1. Figures in the table are rounded.

2. Percentages are based upon exact figures rather than the rounded figures identified in the table.

The numbers of clients in both groups were similar (TTR 81; control 79), however the TTR sample had significantly less inpatient admissions (50) and inpatient bed days (675), compared to the control group (141 admissions; 1,877 bed days).

On a per client basis, those that participated in the TTR program had a 65% lower admission rate than the control group (0.6 inpatient admissions compared to 1.8). Average length of stay was similar for both groups (13.5 days for TTR sample; 13.3 days for control group).

The lower admission rate for TTR program clients meant that the TTR group accrued markedly fewer inpatient days (65% fewer) during the period, with an average of 8.3 days per client, compared to 23.8 days per client for the control group.

The above data suggests that the TTR program significantly reduced the rate of inpatient admission and the number of days spent in inpatient care for people with a mental illness. This finding is based upon data for the 23-month period following client exit from the TTR Program. Additional monitoring and analysis would be required to determine whether this trend is sustained over a longer period.

8.5.2 Community-based mental health services

The following *Table 8.14* identifies community-based mental health service usage by the TTR Sample and by the control group, as follows:

- Number of clients

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- Contacts
- Contact minutes
- Contacts per client
- Average service length (minutes)
- Contact minutes per client.

This time period represents the post-TTR service utilisation for the TTR sample, and includes:

- Each community episode which commenced during or after July 2010
- Pro-rated data for community episodes which commenced prior to July 2010 and were completed by May 2012. Analysis is based on the assumption that contacts and contact minutes were spread evenly throughout the episode.

Table 8.14: QH Community Data, TTR Sample and Control Group, July 2010 to May 2012

Community Data	TTR Sample	Control Group	
Clients	81	79	
Contacts	9,214	4,465	
Contact Minutes	394,142	178,403	
Average per Client			***Difference (%)***
Contacts per Client	114	57	+101%
Contact Minutes per Contact	43	40	+7%
Contact Minutes per Client	4,866	2,258	+116%

Notes: 1. Figures in the table are rounded.

2. Percentages are based upon exact figures rather than the rounded figures identified in the table.

There were a similar number of clients in each group (TTR 81; control 79), however the TTR sample had more than double the number of contacts (TTR 9,214; control 4,465) and number of contact minutes (TTR 394,142; control 178,403).

Each client in the TTR Sample had an average of 114 community contacts over the period after exiting the TTR Program, which is double the number for those in the control group (57). Similarly, the average number of contact minutes for each of those in the TTR Sample (4,866) was approximately double (116% higher) than the control group (2,258). The average number of contact minutes associated with each contact was similar for both the TTR sample and the control group (TTR 43; control 40 minutes).

The above analysis suggests that people who participated in the TTR program, access community-based specialist mental health care services at approximately double the rate of those who do not participate. This finding is based upon data for the 23-month period following client exit from the TTR program. Additional monitoring and analysis would be required to determine whether this trend is sustained over a longer period.

8.5.3 Key findings

A comparison of QH-funded inpatient and community service usage, between the TTR sample and the control group, over a 23 month period after the TTR sample exited the program, found that:

- TTR sample had 65% fewer inpatient admissions and days spent in inpatient care than the control group. The average number of bed days was 8.3 for the TTR sample compared with 23.8 bed days for the control group.
- TTR sample accessed community-based specialist mental health care services at approximately double the rate of the control group (TTR 114 contacts; control 57 contacts).

This decrease in inpatients admissions and increase in community-based care, over the 23-month period, is consistent with findings from the international literature.

8.6 Synthesis of findings

This section synthesises information provided in the preceding sections about the outcomes for clients involved in the TTR programs.

Client outcomes are discussed from two main perspectives. First, a summary of the key characteristics and achievements of the TTR program is presented.

Second, the extent to which the expected program outcomes (described in the Program Logics, Figure 3-1, Figure 3-2, Figure 3-3) have been achieved, as follows:

- Greater stability in accommodation
- Improved management of mental health
- Maximal health, wellbeing and engagement in the community (including employment)
- Increased self-efficacy in lifestyle and health management
- Reduction in the need for hospitalisation to treat a deterioration in their mental health
- Decrease or cessation of recidivism (for Transition from Correctional Facilities clients).

Within each key outcome areas, barriers, enablers and unintended outcomes are discussed where relevant.

8.6.1 Key characteristics and achievements of the TTR program

Provision of individualised services

Across all programs, a key feature was the allocation of a support worker for each client. Based on the clients' needs and goals for the program, the support worker provided assistance across a range of areas. This included:

- Improving independence of daily living
- Administrative support (including assistance to get financial affairs in order)
- Promotion of health and safety
- Assistance with obtaining appropriate accommodation
- Assistance with finding paid or voluntary employment.

- Practical, hands-on assistance (e.g. training to use public transport)
- Referral to other organisations/agencies and advocacy, where necessary, for provision of services
- Counselling/motivational interviewing
- Transport to appointments
- Emotional support and encouragement.

The holistic range of services provided, along with the collaborative approach between support worker and client to the identification of goals and priorities, demonstrates the recovery oriented approach that underpinned these programs.

Key achievements of clients

A broad range of achievements have been identified by clients and service providers as a result of the programs. Positive outcomes were demonstrated in the following domains:

- Promotion of personal health and safety
- Improved management of mental health issues
- Improved management of concurrent health issues (including improved attendance at health appointments)
- Securing part-time work
- Gaining control of financial issues and debts
- Improved relationships with significant others
- Improved social connectedness
- For some Transition from Correctional Facilities program participants, a reduction in recidivism.

8.6.2 Expected outcomes in relation to Program Logic Models

Greater stability in accommodation

Some good news stories were evident in relation to housing stability in interviews with clients and service providers and the case studies; however, limitations in the availability of suitable housing for program participants remained a key barrier to the achievement of sustainable accommodation outcomes.

Finding secure and appropriate accommodation was a key goal for many program participants and it has been demonstrated in the Australian and international literature to be pivotal in achieving recovery outcomes. While the Client Survey indicated that the majority of clients agreed/strongly agreed that staff had assisted them with obtaining appropriate housing/accommodation, one in five (21%) did not agree that they felt safe in their accommodation at exit. Furthermore, a number of clients remained in accommodation situations that were not conducive to their recovery (such as caravan parks or sub-standard hostel/boarding house accommodation). Limitations in housing availability hampered the ability of the TTR programs to realise their full potential in assisting clients to attain greater stability in accommodation.

8. Findings: Client Outcomes

Improved management of mental health

Clients and service providers highlighted a number of positive mental health outcomes. These included decreased suicidal ideation, fewer hospital admissions, better management of anxiety or substance misuse issues, development of wellness action plans and improvements in confidence, self-esteem and empowerment. The Client Survey results suggested that clients felt that they had greater support for their mental health as a result of their participation in the program.

A comparison of the acute mental health service usage by a subset of TTR clients and a control group showed a reduction in the number of admissions and length of hospital stay for TTR clients, accompanied by an increase in usage of community based specialist mental health services. These findings are consistent with the international recovery literature and suggest that TTR clients are able to better manage their mental health in the community, with reduced need for emergency hospital admissions. The complexities of the mental health diagnoses and co-morbidities evident among the TTR client group means that high levels of support are likely to be needed by this group.

Maximal health, wellbeing and engagement in the community (including employment)

Improvements in management of concurrent health conditions were reported frequently throughout the interviews and case studies. Examples included making and keeping appointments with health service providers including GPs, psychologists, optometrists and dentists. The important role of support workers in facilitating these appointments was highlighted. The Client Survey found that the proportion of respondents who described their health as excellent/very good increased from 27% on entry to 42% on exit from the program. This was not matched by an increase in the proportion of clients taking part in regular physical activity.

Employment is one marker of engagement with the community. The Client Survey showed a marked decrease in the proportion unemployed (from 80% to 56%) and a quadrupling of the proportion involved in education/training (from 7% to 28%). Moreover, the majority of clients agreed or strongly agreed that TTR staff had assisted them to find appropriate education, training, employment or volunteering opportunities.

Positive outcomes in terms of improved social connectedness and encouraging stories of restored relationships with family members were evident. Several stories of clients discovering hidden talents in music and art as a result of engagement in community activities were also reported.

On the other hand, the issue of continued exposure to old acquaintances who engaged in undesirable activities (e.g. drug/alcohol, crime, gambling) remained a mitigating factor against recovery. It was sometimes a difficult task for support workers to help clients move away from these influences and develop more positive connections.

Increased self-efficacy in lifestyle and health management

A goal of the TTR program for many clients was to gain better control of their lifestyle and general health. Some impressive improvements were evident in terms of general health, and the support workers played an important role in facilitating access to health professionals who could assist with this. This support included, in many instances, providing transport for clients to appointments. As such, it is difficult to attribute these changes in health status directly to improvements in clients' self-efficacy.

8. Findings: Client Outcomes

Despite a focus on providing clients with training and support to complete activities of daily living (such as cooking, personal hygiene, taking public transport) the evidence that this training translated into improved self-efficacy was mixed. While the qualitative data included reports of clients who were better able to manage activities of daily living, the Client Survey findings indicated that there was minimal change in clients' confidence with shopping, cooking and maintaining their home situation.
Indeed, it is not possible, based on this evaluation, to comment on the extent to which improvements in any of the domains assessed have been maintained beyond the life of the program.

The findings discussed above raise the important issue of how best to support clients upon completion of the TTR program. The TTR program streams have been designed to be of relatively short duration. This has been viewed by clients as both positive (by creating a sense of urgency and focus) and negative (as it is difficult to achieve some clients' goals within this timeframe). Either way, a clear theme emerging from the analysis of client outcomes is the need for careful exit planning that commences soon after a client begins the program. This includes making referrals for housing assistance and facilitating other supports, to enable, where possible, a smooth transition out of the program.

A further issue that has been found to impact on the ability of clients to transition out of the programs has been dependency by clients on their support workers. Dependency has been found to be an unintended consequence of the program. A trusting, supportive and encouraging relationship with support workers is key to the success of the program, and dependency, although not desirable, may be considered the flip side of this relationship. Dependency is a problem when it interferes with clients' ability to develop their own social supports and connections, which may in turn leave clients feeling isolated and vulnerable on completion of the program.

Reduction in the need for hospitalisation to treat a deterioration in their mental health

The qualitative findings indicated that the goal of reducing the need for hospitalisation for mental health issues was being met. There were some striking examples of clients who were frequently hospitalised due to suicide attempts having no further hospital admissions after commencing the program.

Likewise, analysis of service usage data confirmed that the TTR sample had a decreased usage of inpatient services. The sample also had an increased usage of community services. This is consistent with findings from similar programs internationally. It should be noted however, that in some cases increased service usage may be a positive outcome from the program as it signifies that clients who have previously been fearful and hesitant to access mental health services re-engage with these services. The increase in community mental health service usage for TTR clients, accompanied by the reduction in acute admissions, is therefore an encouraging outcome.

Decrease or cessation of recidivism

The extent to which clients involved in the Transition from Correctional Facilities program were able to avoid further incarceration is difficult to assess from the available data. While there were a number of examples where re-incarceration was avoided as a result of the program, there were also examples of clients who breached parole and returned to prison. The findings point to the particular challenges that prisoners with mental illnesses face in terms of concurrently dealing with their mental health problems and starting a new life in a community where discrimination is common, and where adverse social influences often persist.

8.6.3 Summary of key findings

Positive client outcomes have been demonstrated across a number of domains as a result of the TTR program. These include improvements in mental and physical health, social connectedness, employment status and in some cases, housing.

Service usage data showed decreased usage of inpatient services by the TTR sample and increased usage of community services; a pattern that is consistent with findings from similar programs internationally.

Barriers to program success lie largely outside the program; the most significant of these is a limited supply of housing. A key element of program success is the strong and trusting relationship developed between clients and their support worker; however a potential negative consequence of this relationship is the development of dependency by the client on their support worker.

Due to the time-limited nature of the program, early exit planning is essential. Careful exit planning may help to reduce the likelihood of dependency developing by focusing on developing sustainable supports beyond the duration of the TTR program.

9 FINDINGS: COST ANALYSIS

This chapter provides analysis of cost and activity related data, from the six TTR funded organisations that participated in the evaluation. For each organisation, the following analysis is provided:

- Recurrent costs
- Establishment costs
- Number of clients supported, and duration of support provided
- Indicative cost per client, while in the program.

Additionally, the overall costs or savings to Queensland Health, associated with clients' participation in the TTR Program are examined in terms of:

- Cost/savings associated with changes in TTR clients' usage of other specialist mental health service.
- Total cost/savings per client to Queensland Health, associated with the TTR Program.

9.1 Recurrent costs

The following analysis identifies the direct cost of TTR services to the Queensland Government for the six serviced providers involved in the evaluation. Funding acquittal statements provided by each organisation confirms that the funding provided matches their TTR expenditure. Accordingly, funding allocation figures have been used to represent the cost of services in this analysis.

Over the four years from 2008/09 to 2011/12, the six organisations received TTR funding totalling $15.7 million, rising from $2.8 million in 2007/08 to $4.7 million in 2011/12 (Table 9.1).

Table 9.1: Program costs for six TTR service providers, 2008/09 to 2011/12

TTR Program Recurrent Costs	TFCF		TRP		RRP		TOTAL
	RFQ	SOLAS	PRA	FSG	Nextt	Footprints	
2008/09	$482,983	$200,000	-	$949,199	$591,622	$621,553	**$2,845,357**
2009/10	$498,680	$206,500	$851,455	$980,048	$610,851	$641,753	**$3,789,287**
2010/11	$562,710	$246,933	$879,127	$1,171,933	$730,450	$767,404	**$4,358,557**
2011/12	$591,801	$265,973	$912,095	$1,287,851	$802,700	$843,310	**$4,703,730**
Total	**$2,136,174**	**$919,406**	**$2,642,677**	**$4,389,031**	**$2,735,623**	**$2,874,020**	**$15,696,931**

Key: TFCF: Transition from Correctional Facilities Program; TRP: Transitional Recovery Program; RRP: Resident Recovery Program

9.1.1 Establishment costs

In addition to the above recurrent costs, a further $2.7 million was provided for capital (establishment) costs to purchase items including property, vehicles and furniture (Table 9.2). In particular, the Transitional Recovery Program (TRP) service providers incurred significant capital establishment costs ($2.3 million) to provide accommodation facilities for clients.

Table 9.2: Capital costs for six TTR service providers

TTR Program Capital (Establishment) Costs	TFCF		TRP		RRP		TOTAL
	RFQ	SOLAS	PRA	FSG	Nextt	Footprints	
Vehicles, furniture, etc.	-	$29,000	$61,000	$228,000	$40,600	$86,000	**$444,600**
Property	-	-	$625,000	$1,670,000	-	-	**$2,295,000**
Total Capital Costs	**-**	**$29,000**	**$686,000**	**$1,898,000**	**$40,600**	**$86,000**	**$2,739,600**
Annual Depreciation (note 1)	**-**	**$5,800**	**$43,450**	**$129,100**	**$8,120**	**$17,200**	**$203,670**

Key: TFCF: Transition from Correctional Facilities Program; TRP: Transitional Recovery Program; RRP: Resident Recovery Program

Note 1: Annual Depreciation has been calculated based on the following expected useful life of assets:

- 5 years for Vehicles, Furniture, etc. (20% per annum)
- 20 years for Property (5% per annum).

This is in accordance with organisation's funding agreements, which specify the expected useful life of assets.

As indicated in the above table, based on the capital expenditure of $2.7 million, it is calculated that the annual depreciation charge would total $203,670 per annum.

The above information about capital costs and annual depreciation is provided for completeness, but is not included in the calculations provided in this chapter. The Australian Institute of Health and Welfare data used in this report, about the cost per client for QH specialist mental health services, does not include capital costs (refer Table 9.5). It is therefore appropriate to exclude such capital costs from the calculation of the cost per client for the TTR program.

9.2 TTR clients and support provided

This section summarises the number of TTR clients supported by each of the six TTR service providers, and the total duration (months) of support provided to clients prior to exit from the program. This activity information provides the basis for later estimates of the cost per client for each TTR program (Section 9.3).

9.2.1 Program level client numbers

A total of 829 clients were supported by the six TTR service providers, of which 699 clients had exited the program by December 2011 (Table 9.3). The start up dates for TTR service provision varied. RFQ was the first of the six organisations to commence providing TTR support (March 2007) and PRA was the last (June 2010). The other four organisations all commenced during 2009. During the initial start up period, service providers incurred costs but had relatively few clients.

Table 9.3: Number of clients supported, by TTR service provider, to December 2011

	TFCF			TRP			RRP			GRAND TOTAL
	RFQ	SOLAS	Total	PRA	FSG	Total	Nextt	Footprints	Total	
Service commence (first client)	***Mar-07***	***Sep-09***		***Jun-10***	***Mar-09***		***Jan-09***	***Feb-09***		
Clients to December 2011										
Total	404	42	**446**	9	33	**42**	153	188	**341**	**829**
Exited	350	34	**384**	4	23	**27**	150	138	**288**	**699**

9. Findings: Cost Analysis

	TFCF			TRP			RRP			GRAND TOTAL
	RFQ	SOLAS	Total	PRA	FSG	Total	Nextt	Footprints	Total	
Clients per year										
2007/08	54	-	**54**	-	-	**-**	-	-	**-**	**54**
2008/09	112	-	**112**	-	13	**13**	67	30	**97**	**112**
2009/10	143	14	**157**	1	18	**19**	116	96	**212**	**143**
2010/11	152	25	**177**	8	26	**34**	59	111	**170**	**152**
to Dec 11	98	12	**110**	8	17	**25**	18	75	**93**	**98**
Client months (i.e. months of support provided to clients), per year										
2007/08	195	-	**195**	-	-	**-**	-	-	**-**	**195**
2008/09	418	-	**418**	-	38	**38**	234	73	**307**	**763**
2009/10	526	42	**568**	1	176	**177**	701	465	**1,166**	**1,911**
2010/11	556	88	**644**	71	179	**250**	351	612	**963**	**1,857**
to Dec 11	318	45	**363**	31	80	**111**	49	266	**315**	**789**
Average months of support per client to exit										
Months of support	4.9	4.2	**4.8**	11.2	16.1	**15.4**	8.9	7.2	**8.1**	**6.6**

Overall, there has been a steady increase in the number of clients receiving TTR support, reaching 152 for 2010/11 and estimated to reach 196 for 2011/12 (annualisation of 98 for half year).

It is important to note that the number of clients per year is an imprecise measure of activity, as it does not recognise the duration of support for each client. A more useful indicator of activity is the number of months of support provided per year (i.e. client months). A total of 1,911 client months of support were provided in 2009/10 (Table 9.3). This represents an average of 159 clients per month (1,911/12 months).

After 2009/10, the average clients per month fell marginally, to 155 clients for 2010/11 (1857/12) and 131 for 2011/12 (789/6). This reduction was due to fewer clients being supported by Nextt as a result of staffing issues.

9.2.2 Client numbers and duration of support, by program stream

There was considerable variability in the duration of support provided to clients within each program stream, reflecting the flexible nature of the support provided, as detailed in Section 7.2 of this report. The following identifies averages for each stream, which are then used for costing purposes.

Transition from Correctional Facilities (TFCF) Program

RFQ commenced providing TFCF support in March 2007 and SOLAS in September 2009. As shown in Table 9.3, for these two TFCF service providers, up to December 2011:

- 446 clients received support (RFQ 404; Solas 42), of which 384 had exited
- For 2010/11, an average of 54 clients received support each month (644/12); i.e. RFQ 46 (556/12) and SOLAS 7 (88/12)
- Average duration of support to exit was 4.8 months (RFQ 4.9; Solas 4.2).

Transitional Recovery Program (TRP)

FSG commenced providing TTR support in March 2009 and PRA commenced in June 2010. As shown in Table 9.3, for these two TRP service providers, up to December 2011:

- 42 clients received support (PRA 9; FSG 33), of which 27 had exited
- For 2010/11, an average of 21 clients received support each month (71/12); i.e. FSG 15 (179/12) and PRA 6 (88/12)
- Average duration of support to exit was 15.4 months (PRA 11.2; FSG 16.1), i.e. approximately one year and three months.

PRA and FSG had a broadly similar profile of support, i.e. both had relatively few clients and most clients received TRP support for more than a year (12 months).

Resident Recovery Program (RRP)

Nextt commenced providing RRP support in January 2009, and Footprints commenced in February 2009. As shown in *Table 9.3*, for these two RRP service providers, up to December 2011:

- 341 clients received support (Nextt 153; Footprints 188), of which 288 had exited
- For 2010/11, an average of 80 clients received support each month (963/12); i.e. Nextt 29 (351/12) and Footprints 51 (612/12)
- Average duration of support to exit was 8.1 months (Nextt 8.9; Footprints 7.2).

Overall, Nextt and Footprints had similar profiles in terms of their number of clients and the months of support provided to each client. However after 2009/10, Nextt's number of clients declined significantly. Nextt's average clients per month was 39 for January to June 2009 (234/6 months), 58 (701/12) for 2009/10, 29 (351/12) for 2010/11 and 8 for July to December 2011 (49/6). Nextt has advised that it has experienced staffing issues, which have restricted its operations (refer Section 7.2.3).

9.3 Indicative cost per TTR client, while in the program

In the previous two sections, cost data and the months of TTR support provided to clients are analysed. Using this information, the average cost per client, for each TTR program is estimated in this section.

The indicative cost of TTR support per client, from commencement until exit from the TTR program, is shown in Table 9.4 below.

9.3.1 Total cost per program stream

As shown in the following table, the total cost per client by program stream is:

- $6,035 per TFCF client (based on TFCF average support duration of 4.8 months)
- $126,345 per TRP client (based on TRP average support duration of 15.4 months)
- $9,240 per RRP client (based on RRP average support duration of 8.1 months).

9. Findings: Cost Analysis

Table 9.4: TTR cost per client, per TTR service provider and program stream

	TFCF			TRP			RRP		
	RFQ	**SOLAS**	**Total**	**PRA**	**FSG**	**Total**	**Nextt**	**Footprints**	**Total**
Total Cost and Support for 2010/11 (note 1)									
Total months of support provided	556	88	**644**	71	179	**250**	701	612	**1313**
Total TTR cost	$562,710	$246,933	**$809,643**	$879,127	$1,171,933	**$2,051,060**	$730,450	$767,404	**$1,497,854**
Cost per client month	$1,012	$2,806	**$1,257**	$12,382	$6,547	**$8,204**	$1,042	$1,254	**$1,141**
Average per Client, to December 2011 (note 2)									
Average months of support to exit	4.9	4.2	**4.8**	11.2	16.1	**15.4**	8.9	7.2	**8.1**
Cost per client	**$4,959**	**$11,785**	**$6,035**	**$138,679**	**$105,408**	**$126,345**	**$9,274**	**$9,028**	**$9,240**

Key: TFCF: Transition from Correctional Facilities Program; TRP: Transitional Recovery Program; RRP: Resident Recovery Program

Notes:

1. Cost per client month: This is the total TTR cost for 2010/11 divided by the total client months of support provided during 2010/11, to determine the average cost of a month's support for a client. 2010/11 is used as this is the first year that all six services were fully operational. The exception is Nextt, for which 2009/10 total client months (701) is used, rather than 2010/11 (351), as this appears to more accurately reflect a fully operational status for Nextt.
2. Cost per client: This is the average total cost of TTR support per client, for clients that exited the TTR program up to 31 December 2011 (i.e. average months of support to exit x cost per month).

The Transitional Recovery program provides full time community accommodation and 24 hours per day psychosocial recovery support to clients, over a period of 12 months or more. Its cost per client ($126,345) is therefore significantly greater than the other two programs ($9,240 and $6,035), which involve relatively short term flexible and responsive support to assist clients to plan and achieve their agreed personal recovery goals.

9.3.2 Total cost per client, by TTR service provider

As shown in Table 9.4, for the two service providers funded under the Transition from Correctional Facilities Program:

- Average cost per client month was $1,257 (RFQ $1,012; SOLAS $2,806)
- Average cost per client was $6,035 (RFQ $4,959; SOLAS $11,785), i.e. SOLAS cost per client was more than double that for RFQ.

The differing cost per client of these two organisations, may be due to the relative economies of scale that RFQ enjoys. Each year RFQ supported approximately six times as many TTR clients as SOLAS, but RFQ's total costs are only approximately double that of SOLAS.

As shown in Table 9.4, for the two service providers funded under the Transitional Recovery Program:

- Average cost per client month was $8,204 (PRA $12,382; FSG $6,547)
- Average cost per client was $126,345 (PRA $138,679; FSG $105,408).

PRA and FSG had a broadly similar profile of support and cost, i.e. both had relatively few clients and clients mostly received TRP support for more than a year.

9. Findings: Cost Analysis

As shown in *Table 9.4*, for the two service providers funded under the Resident Recovery Program

- Average cost per client month was $1,141 (Nextt $1,042; Footprints $1,254)
- Average cost per client was $9,240 (Nextt $9,274; Footprints $9,028).

Overall, Nextt and Footprints had similar a similar profile of support and cost. It should be noted however that this is based on Nextt's operations for 2009/10. From 2010/11, Nextt's number of clients declined significantly because of staff issues.

9.4 Costs and savings associated with changed service usage, post TTR support

As identified in section 8.5.3, TTR program clients in the 23-months after exit from the TTR program (relative to a control group of non-TTR clients) used approximately:

- 65% fewer inpatient services
- Twice as much community-based services.

This section estimates the cost or saving for Queensland Health associated with this changed service usage. Calculations are based upon:

- Data provided by Queensland Health regarding the number of inpatient (bed days) and community-based specialist mental health services (contacts) received for a sample TTR clients and for a Control Group (refer to Section 8.5 for further details).
- Data from the Australian Institute of Health and Welfare[60] identifying expenditure and costs associated with the delivery of specialist acute and community based mental health services was used to calculate the cost per inpatient bed day and the cost per community-based contact.

  It should be noted that the data used represents the average cost for each inpatient bed day and community-based contact. The actual cost for each client/service would in fact vary depending upon the intensity of the inpatient support/intervention and the staff involved in service delivery.

These calculations indicated that the cost of inpatient acute care for clients in the TTR sample was considerably lower over the 23-month period, than for those in the Control Group ($6,151 compared with $17,538, difference of $11,387) (Table 9.5). This difference reflects fewer days spent in inpatient care (bed days) for clients in the TTR sample (8.3) compared to those in the Control Group (23.8).

Table 9.5: QH specialist mental health services, usage and cost per client, TTR sample and Control Group, for 23-month period

Average per Client	INPATIENT			COMMUNITY			Inpatient and Community Total
	Bed Days	Cost per Bed Day	Total Cost	Contacts	Cost per Contact	Total Cost	
TTR sample	8.3	$738	**$6,151**	114	$385	**$43,803**	**$49,954**
Control group	23.8	$738	**$17,538**	57	$385	**$21,766**	**$39,304**
Difference	**-15.5**		**-$11,387**	**57**		**$22,037**	**$10,650**

[60] Australian Institute of Health and Welfare 2009. Mental health services in *Australia 2009/10*

Notes: 1. Figures in the table are rounded. For example total inpatient cost for TTR sample is $6,151 per client, however this is not exactly 8.3 days times $738 per day, as these numbers are rounded.

2. Cost per bed day ($738) is the average recurrent cost for general mental health services in Queensland public hospitals for 2009/10, as reported by the AIHW.[61]

3. Cost per contact ($385) is calculated based on total Queensland expenditure on ambulatory mental health services ($340,199,000) divided by total Queensland community mental health service contacts (883,458) for 2009/10, as reported by the AIHW.[62]

The situation is reversed however for community care, with the cost per client for those in the TTR sample being considerably higher than those in the Control Group ($43,803 compared with $21,766, difference $22,037). This difference reflects the higher number of community contacts utilised by former TTR clients (114) compared to the Control Group (57).

Overall, the cost per client of QH-funded specialist mental health care services for the 23-month period was $49,954 for those in the TTR sample, compared with $39,304 for the Control Group. QH-funded services for those in the TTR sample were approximately 27% higher ($10,650) compared to those in the Control Group. Higher community support costs are offset to some extent by a 65% lower cost of inpatient care.

All results and figures in this section however, should be regarded as indicative only, due to the various caveats associated with the data sources and calculation methodology as documented in this and the previous chapter.

9.5 Total costs and savings to Queensland Health associated with the TTR program

The previous two sections estimate:

- Cost per client of TTR support, i.e. the direct cost of the TTR programs funded by Queensland Health (Section 9.3)
- Costs and savings to Queensland Health arising from changed service usage of funded specialist mental health services, by clients who have accessed the TTR program (Section 9.4).

This section draws together the above information, to estimate the total cost per client for Queensland Health, in relation to the TTR program. This analysis is shown in *Table 9.6* below.

Once again, all figures in this section should be regarded as indicative only, due to the various caveats associated with the data sources and calculation methodology as documented in this and the previous chapter.

Table 9.6: Total cost and savings to Queensland Health, per TTR client, by program stream

Cost per Client	TFCF	TRP	RRP
Direct Cost: TTR program *(refer Table 9.4)*	$6,035	$126,345	$9,240
Savings: Reduced inpatient service usage *(refer Table 9.5)*	($11,387)	($11,387)	($11,387)
Cost: Increased community service usage *(refer Table 9.5)*	$22,037	$22,037	$22,037
Total QH cost per client	**$16,685**	**$136,995**	**$19,890**

[61] ibid

[62] ibid

9. Findings: Cost Analysis

The above analysis estimates that the total cost per client, to QH, for each of the three TTR programs, is as follows:

- Transition from Correctional Facilities (TFCF) Program: $16,685 per client
- Transitional Recovery Program (TRP): $136,995 per client
- Resident Recovery Program (RRP): $19,890 per client.

The Transitional Recovery Program provides full time community accommodation and 24 hours per day psychosocial recovery support to clients, over a period of 12 months or more. Its cost per client is therefore significantly greater than the other two programs, which involve relatively short term flexible and responsive support to assist clients to plan and achieve their agreed personal recovery goals.

Taking into account the various caveats regarding the estimates provided in this section, it is reasonable to conclude that in net terms costs to QH are higher as a result of the TTR Program, however the extent to which net costs are higher would require further monitoring and investigation.

It is important however, to put the overall costs of the TTR into a broader context. Evidence from the recovery-oriented literature points to the potential multiplier effect of program interventions, whereby interventions in one area of clients' lives can have significant and positive impacts upon other areas. Among the likely impacts of the TTR program are broader financial savings for:

- The Queensland Government in terms of other non QH-funded services including prison, housing, health and community services
- The Australian Government in terms of savings associated with primary medical care (GP), social security and a range of other services.

Consideration of these savings and financial benefits is out of scope for this evaluation report.

10 CONCLUSIONS

The *Community Mental Health Transition to Recovery (TTR) Program* is viewed positively by clients, staff and other stakeholders involved with the program. The Program has been implemented largely as intended, and is supported by a well-qualified and committed workforce.

The Program has resulted in a range of positive outcomes for clients in a number of important recovery domains. A notable outcome is the improved management of mental health issues, as evidenced by a shift in service usage away from the acute mental health sector to the community sector.

Although there are a range of barriers identified throughout the evaluation, strategies to minimise the impacts of the barriers have meant that services are assisting a range of clients with high support needs as was the original intention of the TTR program.

These findings support an accumulating body of evidence in the national and international literature that recovery-oriented approaches to mental health can have impressive results in terms of client outcomes.

This evaluation found that the TTR program leads to a decrease in the cost of in-patient service usage and an increase in community service use costs. It may be valuable however to also consider a wider ranging economic evaluation that takes into account a broader range of areas of a person's life, where improvements in their mental health or housing situation may translate to improvements or cost savings, such as through the person gaining employment or returning to education.

Australian Healthcare Associates

Evaluation of the Community Mental Health Transition to Recovery Programs

Final Report
Appendices

November 2012

Australian
Healthcare
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Appendix A

Appendix A: Literature Review

1.1 Introduction

A literature review was conducted to support the evaluation of the Community Mental Health Transition to Recovery programs, by presenting and discussing evidence relating to:

- The conceptual underpinnings of the recovery model
- Challenges in implementing recovery models, with specific attention to issues in the forensic mental health setting
- The Australian and international experience of implementing recovery programs
- The benefits and costs of recovery-oriented service models.

1.2 Search Strategy

Key words: Recovery, mental illness, mental health, psychiatry, symptoms, prisoner, forensic, rehabilitation

Data sources: Medline, Google Scholar, government reports and publications with additional hand searching for additional relevant references.

The initial search was conducted in November 2011 and updated in July/August 2012. The literature review was reviewed by two content experts prior to finalisation.

1.3 The concept of recovery

Recovery in the mental health context is a concept that has been plagued by confusion. In their brief history of the term, Davidson and Roe (2007) date this confusion back to the 1960s and 1970s where two quite different understandings of recovery developed in parallel. First, in the large scale mental health studies conducted at the time, recovery became synonymous with symptom reduction. Second, advocacy efforts by individuals who were ex-patients or users of the services, gave rise to a concept of recovery based not on the absence of symptoms but instead on the individual being able to overcome the effect of mental illness on their life. The convergence of these perspectives in more recent times has given rise to a situation where recovery has come to mean different things to different people.[1]

In the current literature, it is clear from the plethora of terms being used to differentiate between these two understandings that this dual notion of recovery has prevailed to recent times. These terms include clinical versus personal recovery, clinical recovery versus social recovery; scientific versus consumer models of recovery; service-based recovery versus user-based recovery, recovery 'from' versus recovery 'in'.[2] Irrespective of the terminology used, what is apparent is that recovery is no longer solely viewed through the lens of the bio-medical model, where absence or alleviation of symptoms is paramount. The inclusion of consumer perspectives means that recovery has become an overall vision and philosophy; one in which management of mental illness and the empowerment of the individual are two different but not mutually exclusive concepts. Recovery therefore is about developing individual

[1] L Davidson and D. Roe 'Recovery from versus recovery in serious mental illness: One strategy for lessening confusion plaguing recovery', *Journal of Mental Health*, vol 16, no. 4, 2007, pp. 459-470.

[2] M Slade, 'Measuring recovery in mental health services' *Israel Journal of Psychiatry and Related Sciences*, vol. 47, no.3, 2010, pp. 206-12.

ways to lead a fulfilling life whilst managing the effects of mental illness.[3] As such, recovery is a concept that has attracted considerable enthusiasm and hope in an area often characterised by disillusionment and defeat.[4]

The concept of recovery is even more complex in the context of forensic mental health. For offenders with mental illness, the principles of individual empowerment and personal growth need to be balanced with the need to prevent recidivism and protect the community[5] In addition, the contentious issue of released prisoners demonstrating moral redress, or 'paying back' to society has also been highlighted.[6] This is discussed in more detail in Section 1.6.

1.4 Recovery oriented service models

A recovery oriented mental health system is one that aims to "support an individual in their own personal development, building self esteem and finding a meaningful role in society".[7] This requires shifting the emphasis of service delivery from a care model to one of enabling service users to reach their full potential. Within the context of recovery, the relationship between the person with a mental illness and their informal and formal supports is therefore characterised by experiences of collaboration and partnership. By developing and maintaining mutually respectful relationships including open and constructive dialogue and shared decision making between the person with a mental illness and the mental health professional, it is supposed that service users will develop their sense of self-efficacy, further enhancing their capacity to overcome future hurdles and thereby realise their potential.[8]

Anthony (1993) in his review of the recovery literature summarised some basics assumptions of a recovery-oriented mental health system:

1. recovery can occur without professional intervention: professionals do not hold the key to recovery. Their task is to facilitate recovery.
2. a common denominator of recovery is the presence of people who believe in and stand by the person in need of recovery: central to recovery is having a network of people who are there to support the person through recovery
3. a recovery vision is not a function of one's theory about causes of mental illness: recovery focuses on hope for the future rather than the causes of any illness
4. recovery can occur even though symptoms reoccur: as recovery takes place the symptoms of mental illness interfere with functioning less often and for briefer periods.
5. recovery is a unique process: recovery is a highly personal journey inherently different for each individual

[3] Mental Health Coordinating Council, *Social Inclusion: Its Importance to Mental Health*, Mental Health Coordinating Council, Sydney, 2007.

[4] Care Services Improvement Partnership, Royal College of Psychiatrists & Social Care Institute for Excellence. *A common purpose: Recovery in future mental health services,* Social Care Institute for Excellence, London, 2007.

[5] P Robertson, M Barnao & T Ward. 'Rehabilitation frameworks in forensic mental health', *Aggression and Violent Behavior*, vol. 16, 2011, pp. 472-484.

[6] F McNeill . 'Four forms of 'offender' rehabilitation: Towards an interdisciplinary perspective', Legal *and Criminological Psychology,* vol. 17, no. 1, 2012, pp.18-36.

[7] Allott et al, p.3

[8] Queensland Health, *Sharing the Responsibility for Recovery: creating and sustaining recovery oriented systems of care for mental health,* Queensland Government, Brisbane, 2005.

6. recovery demands a person has choice: the notion of choice and allowing people to take risks as they move forward is important in the recovery process
7. recovery from the consequences of the illness is sometimes more difficult than recovering from the illness itself: potential consequences of discrimination, poverty and isolation for those with a mental illness are directly addressed through a recovery-orientated service model.[9]

Consistent throughout the recovery literature is the idea that, above all, professionals, families, friends and the person's support network need to share the hope that people with a mental illness can achieve a better quality of life.[10]

The importance of looking beyond the traditional mental health system to provide services and supports to assist a person in the recovery process is also clear. This implicates primary health care, community supports, housing and employment support and hospital-based care in the recovery-orientated service model. The full spectrum of options needs to be available to the person with a mental illness to effectively facilitate the recovery process.[11]

1.5 Challenges to recovery-oriented policy and practice: common issues

The recovery literature has arisen largely from personal experience, and the dynamics and essential components of the recovery process are yet to be fully understood or evaluated.[12] A number of challenges have arisen in relation to putting recovery into practice and measuring recovery outcomes.

These challenges can be categorised into four main domains (Figure 1):

- Service level
- Consumer level
- Community level
- The broader health and social services context.

These challenges also apply to forensic mental health settings; additional considerations for this distinct population are discussed in Section 4.5.

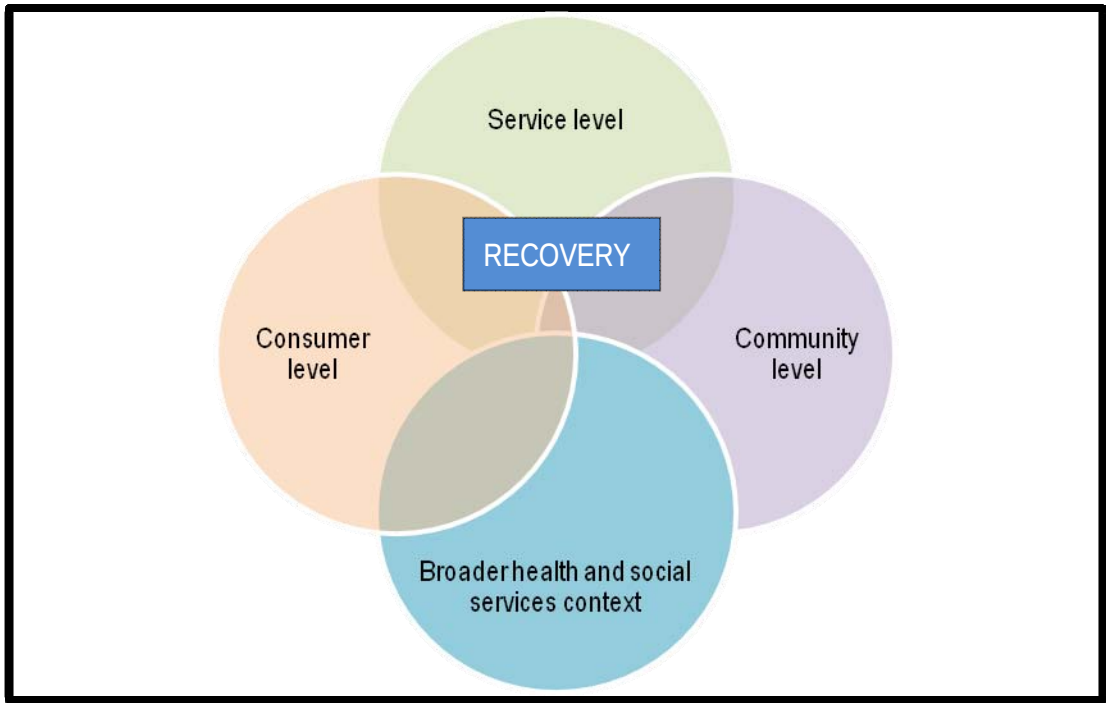
[9] W Anthony, 'Recovery from mental illness: The guiding vision of the mental health service system in the 1990's', *Psychosocial Rehabilitation Journal,* vol.16, no. 4, 1993, pp.11 -23.

[10] L Davidson, C Harding & L Spaniol (eds), *Recovery from severe mental illnesses: Research evidence and implications for practice,* Boston University, Boston University Center for Psychiatric Rehabilitation , 2005.

[11] Davidson et al.

[12] Care Services Improvement Partnership et al.

Figure 1: Domains for implementation of recovery-oriented services



Service Level Challenges

Changes in how recovery is conceptualised have implications for those who are delivering mental health services. Slade (2009) has argued that mental health services need to address four key recovery support tasks if they are to maximise recovery: fostering relationships, promoting well-being, offering treatments and improving social inclusion.[13] For many services, this represents a significant shift from their traditional modes of practice.

For many service providers, changes in attitude are needed in order to support consumer rights and provide the types of services that maximise wellbeing for people with mental illness.[14] For some, the rhetoric of recovery is 'esoteric nonsense'.[15] This is largely because recovery orientation emphasises concepts such as agency, empowerment, strengths and purpose while clinical training, by contrast, focuses on issues such as deficit, dysfunction, symptomatology and risk.[16] Some professionals fear that promoting the hope of recovery for everyone with severe mental illness is false and unrealistic, and is akin to denial of illness. This problem may arise from a misunderstanding that equates recovery with cure.[17]

[13] M Slade, 'The contribution of mental health services to recovery' *Journal of Mental Health*, Vol. 18, No. 5, 2009, p.370.

[14] D Rickwood, ' Recovery in Australia: Slowly but surely', *Australian e-Journal for the Advancement of Mental Health* (AeJAMH), Vol. 3, No.1, 2004, pp. 1-3.

[15] M O'Hagan, 'Recovery in New Zealand: Lessons for Australia?' *Australian e-Journal for the Advancement of Mental Health* (AeJAMH), Vol. 3, No.1, 2004, pp.1-3.

[16] M Slade, 2009, p. 367.

[17] Care Services Improvement Partnership et al.

Staff buy-in to recovery programs is crucial. Studies have shown that where professionals have low expectations for service users, they delay the recovery journey and in fact encourage learned helplessness among consumers.[18] Training can play an important role in improving staff attitudes.[19] Indeed, workforce training and development has been identified as fundamental to the roll-out of a recovery orientation in any service.[20]

Another important service-level challenge relates to how recovery is measured. Traditional outcomes of service delivery (readmissions, symptom reduction, improved functioning etc.) can be objectively defined and reliably measured. However, the constructs central to recovery such as personal growth, hope, autonomy, and spirituality are individually defined and their subjectivity makes measurement more difficult.[21] Using tools such as the Recovery Self-Assessment[22] may help in this regard[23], and narrative inquiry, which describes the 'lived experience' of recovery, has also been identified in the literature as a valuable research method.[24]

Consumer Level Challenges

Just as some professionals have struggled with their understanding of recovery, so too have consumers. Former New Zealand Mental Health Commissioner Mary O'Hanlon provided insightful examples of the diversity of client user responses to the word: "Recovery takes you back to where you were, but my experience transformed me.' 'I'll always have mental health problems so I'll never recover.' 'I don't believe I had an illness but recovery implies I did have one.' 'I don't see my madness as undesirable, so what is it I need to recover from?' 'To recover means to cover up again, but I don't want to cover up my distress".[25]

Two themes dominate these examples. First, not all consumers may want to engage in recovery; second, mental illness and recovery is clearly a personal journey for clients. Central to this journey is the client's sense of mastery over their lives (also described as internal locus of control[26]). People with mental illness may feel disempowered because of involuntary confinement, the attitudes of service providers or because, by accepting they have a mental illness, they feel driven to conform to a stereotypical image of incapacity and worthlessness. As a result, they may become more socially withdrawn, adopt a disabled role and become dependent on treatment providers.[27] Empowerment involves changing the locus of control from being external and dependent, to being internal.

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[18] A Cleary & M Dowling, 'Knowledge and attitudes of mental health professionals in Ireland to the concept of recovery in mental health: a questionnaire survey', *Journal of Psychiatric and Mental Health Nursing*, vol. 16, 2009, pp. 539-545.

[19] TP Crowe, FP Deane, LG Oades, P Caputi,. & KG Morland, 'Effectiveness of a collaborative recovery training program in Australia in promoting positive views about recovery', *Psychiatric Services*, vol. 57, 2006, pp. 1497–1500.

[20] Rickwood, 2004.

[21] TJ Meehan, RJ King, PH Beavis & JD Robinson, 'Recovery-based practice: do we know what we mean or mean what we know? *Australian and New Zealand Journal of Psychiatry*, vol. 42, 2008, pp.177-182.

[22] M O'Connell, J Tandora, G Croog, A Evans & L Davidson. 'From rhetoric to routine: Assessing perceptions of recovery-oriented practices in a state mental health and addiction system', *Psychiatric Rehabilitation Journal, vol. 28, no. 4,* 2005, pp. 378-386.

[23] Meehan et al.

[24] Care Services Improvement Partnership et al.

[25] O'Hagan.

[26] J Rotter. Generalised experiences for internal versus external control of reinforcement. *Psychological Monographs, vol. 33, no.1,*1966, pp. 300-303.

[27] R Warner, 'Does the scientific evidence support the recovery model?' *The Psychiatrist*, vol.34, 2010, pp. 3-5.

Accounts of people who describe their own recovery journey identified several key factors that are important in that journey. These included hope, self-identity (including current and future self-image), meaning in life (including life purpose and goals), and the ability to take personal responsibility for one's own recovery.[28] A challenge for recovery-oriented models is to ensure that clients do not develop a false sense of hope regarding what recovery means. Given that a full recovery may not be achievable in clinical terms, there is a potential for false hope and as a consequence, the risk of failure and harm to the person.[29] One route to simultaneously mitigate against this and to promote empowerment is to offer consumers peer support through user-operated services.[30]

Community Level Challenges

For a person with mental illness to lead a fulfilling life, social inclusion is important. Social inclusion is defined as the ability "to participate in and contribute to social life – in economic, social, psychological, and political terms. To do this requires having personal capacity as well as access to employment and/or other social roles".[31]

However, for many people, mental illness more often means social exclusion rather than social inclusion. Among the reasons for this are community "fear, misunderstanding, stigma, discrimination, and an entrenched belief that the appropriate medical and social response [to mental illness] is separation from society".[32]

Stigma and discrimination work directly against recovery.[33] For people with mental illness, experiences (and anticipation) of discrimination can adversely impact on their lives.[34] Being stigmatised as a mental health service user can damage social identity.[35] This in turn can have repercussions for a key component of social inclusion, employment:

> *Unemployment is a health hazard for general populations, but is particularly hazardous for people with a psychiatric disability, contributing to lower self esteem; higher levels of psychiatric disturbance; severe social isolation; stigmatisation; and further marginalisation within society".*[36]

Notwithstanding this, it is important to recognise that employment is not an option for all clients. While having a job can facilitate recovery, having a job is not essential to the recovery process. Satisfaction, self-esteem and purpose in life can also be obtained from other activities and forms of social engagement such as parenthood, study, art, caring for family members, or volunteering. Likewise, education, and participation in recreational, leisure, and/or work-readiness programs, have all been

[28] M Slade, 2009.

[29] S Tilley & S Cowan, 'Recovery in mental health policy: good strategy or bad rhetoric?', *Critical Public Health,* vol. 21, no. 1, 2011, pp. 95-101.

[30] R Warner.

[31] Mental Health Coordinating Council, p. 17.

[32] Mental Health Coordinating Council,

[33] Mental Health Coordinating Council, p. 11.

[34] M Slade, 2009.

[35] M Slade, 2009.

[36] Mental Health Coordinating Council, 2007, p. 26.

shown to contribute to improved self esteem and quality of life.[37] The key factor is to achieve reconnection with society as this promotes recovery and decreases the likelihood of relapse.[38]

Community reaction to mental health means that services that operate with a recovery orientation are faced with the challenge of balancing the tension between working with the priorities and goals of clients and addressing the expectations and anxieties of the community, rather than simply responding to one or the other.[39] This is a particular challenge for those transitioning from correctional facilities.[40]

The Broader Health and Social Services Context

For recovery–oriented services to achieve their ultimate aim of enabling people with mental illness to be self-empowered and live as contributing members of society, program success does not solely lie in the domain of the mental health services. As already discussed, social inclusion and employment are determined by broader community-based factors.

Another critical aspect of a person's recovery process is having suitable, stable, affordable accommodation.[41] People with mental disorders who are homeless are prone to multiple, wide-ranging disadvantages and social exclusion. Not only do they experience unstable and unsafe accommodation, but they are likely to have poor education, poor general health, extremely low income and experience high imprisonment rates. Furthermore, they often fall victim to 'iterative homelessness'; a constant movement through many different forms of accommodation, from rough sleeping to private rental to imprisonment.[42]

In contrast, recipients of housing and accommodation support have been shown to experience improvements in their mental health, significantly decreased their average number of hospital admissions and attained higher levels of social and community participation.[43] Homelessness programs have also achieved a reduction in the use and associated cost of justice services.[44] Development of integrated approaches between mental health, housing, justice and aged care sectors services are therefore vital in recovery-oriented models.

It is also important to recognise that within the mental health system itself implementation of a recovery-oriented service modeldoes not eliminate the need for acute hospital care. This is because it is almost universally acknowledged in the literature that consumers in recovery programs require

[37] Mental Health Coordinating Council, 2007, p. 26.

[38] Mental Health Coordinating Council, 2007, p. 8.

[39] Meehan et al.

[40] S Lamberti, 'Understanding and preventing criminal recidivism among adults with psychotic disorders. *Psychiatric Services.* vol. 58, no. 6, pp.773-781.

[41] Mental Health Coordinating Council, 2007, p. 22.

[42] C Robinson, *Understanding iterative homelessness: the case of people with mental disorders,* AHURI Final Report No. 45, Australian Housing and Urban Research Institute, Melbourne, 2003.

[43] S McDermott, J Bruce, I Oprea, KR Fisher, & K Muir, *Evaluation of the Whole of Mental Health, Housing and Accommodation Support Initiative (HASI)*, Second Report', *SPRC Report 5/11,* prepared for NSW Health and Housing NSW, Sydney, 2011.

[44] P Flatau, K Zaretzky, M Brady, Y Haigh & R Martin, *The cost-effectiveness of homelessness programs: a first assessment Volume 1* – main report for the Australian Housing and Urban Research Institute Western Australia Research Centre (AHURI Final Report No.119), Australian Housing and Urban Research Institute, WA, 2008.

ongoing access to clinical services.[45] Linkages between community based and acute care therefore need to be maintained.

1.6 Transition from Correctional Services: special considerations for the implementation of recovery-oriented models

The prison population warrants special consideration in the implementation of a recovery model. Each year in Australia, an estimated 50 000 prisoners are released back into the community.[46] Given the high rates of mental illness (and other health problems) amongst prisoners, this distinct population requires specific focus. However, there is a lack of literature to guide the rehabilitation of forensic mental health patients, and this, coupled with difficulties providing adequate levels of service within correctional facilities and the complex health and social needs of this group, makes implementation of a recovery–oriented approach difficult.[47]

Service-level challenges exist with the delivery of mental health services within the criminal justice system. Of the roughly 15 000 people with major mental illnesses in Australian institutions in 2001, around one third were in prisons.[48] Despite this, there are deficiencies in both the screening processes and treatment for mentally ill offenders within prisons. Furthermore, it has been suggested that a lack of coordination between mental health and justice agencies has meant that mentally ill offenders often do not receive the mental health support that they need upon release.[49] This is particularly concerning given that the period immediately after release is a very vulnerable time. A recent Australian study estimated that between 380 and 527 people released from prison in 2007–08 died within one year of release, with a disproportionate number dying in the first four weeks. Many of these deaths are drug-related. Indeed, the annual number of deaths among recently released prisoners is far greater than the annual number of deaths in custody, further highlighting the extreme vulnerability of this population on return to the community. [50] Furthermore, a Western Australia study found that prisoners are vulnerable to hospitalisation in the 12-month period following their release from prison, particularly Aboriginals, females and those with known mental health problems.[51]

The Good Lives Model (GLM) is one example of a holistic, positive approach to offender rehabilitation. It takes into account individuals' strengths, interests, values, social and personal circumstances and their environment. Through its focus on developing skills, values, attitudes and resources to lead a live that is meaningful and satisfying without inflicting harm on others, the GLM is aligned with recovery

[45] Mental Health Coordinating Council, 2007, p. 18.

[46] AIHW, *Australia's Health 2012.*

[47] J Ogloff, M Davis, G Rivers and S Ross. *Trends and Issues in Crime and Criminal Justice: The identification of mental disorders in the criminal justice system.* Australian Institute of Criminology, Canberra, 2007.

[48] Ogloff et al.

[49] Ogloff et al.

[50] SA Kinner, DB Preen, A Kariminia, T Butler, JY Andrews, M Stoové and M Law, 'Counting the cost: estimating the number of deaths among recently released prisoners in Australia'

Medical Journal of Australia, vol. 195, no. 2, 2011, pp.64-68

[51] J Alan, M Burmas, D Preen, J Pfaff, 'Inpatient hospital use in the first year after release from prison: a Western Australian population-based record linkage study', *Australian & New Zealand Journal of Public Health,* vol. 35, no.3, 2011, pp. 264-269

perspectives.[52] The GLM contrasts with other approaches that place stronger emphasis on addressing offenders' risk factors, or 'criminogenic needs' that are associated with recidivism.[53]

Robertson and colleagues (2009) have argued that strength-based, client-centred recovery-oriented approaches need to be carefully balanced with a focus on decreasing the risk of re-offending and the imperative of protecting society. In many cases, a goal of intervention may be to divert individuals with mental illness away from the criminal justice system and into mainstream mental health services.[54] Access to competent care, adequate supports (including housing assistance), vocational programs and legal leverage (the use of potential legal consequences to promote adherence to treatment) are considered important in improving outcomes and reducing recidivism in this population.[55] The importance of effective discharge, planning activities and meaningful community linkages to make services immediately available on release are emphasised in the literature.[56]

Stable housing has been found to play a particularly important role in averting re-incarceration. A longitudinal study of ex-prisoners over a nine-month period found that the factors most highly predictive of return to prison were worsening problems with use of heroin and moving often. Of those who did not move or moved just once, only 22% had been re-incarcerated at nine months whereas 59% of those who moved twice or more were back in prison.[57]

1.7 Implementing Recovery Programs: Lessons from the International Experience

Originating in the United States in the early 1990s, principles of the recovery model are now evident in the delivery of mental health services in the United States, New Zealand, Canada and England. While definitions of recovery differ somewhat between countries, each emphasise the basic tenets of individual hope, empowerment, and choice, and not just being synonymous with cure.

A common theme in the literature relating to these programs is the need to adapt recovery concepts to local circumstances.[58, 59] In Scotland, this was described as a 'dual drive' process, whereby ideology and evidence from other countries were drawn on while at the same time, an effort was made to produce a program that addressed specifically Scottish aspects of recovery.[60]

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[52] T Ward, R Mann, & T Gannon, 'The good lives model of offender rehabilitation: Clinical Implications', *Aggression and Violent Behaviour,* vol 12, 2007, pp. 87-107.

[53] F McNeill. 'Four forms of 'offender' rehabilitation: Towards an interdisciplinary perspective' *Legal and Criminological Psychology*, vol.17, no.1, pp.18-36.

[54] D Loveland & M Boyle. 'Intensive case management as a jail diversion program for people with a serious mental illness: A review of the literature. *International Journal of Offender Therapy and Comparative Criminology.* vol 51, 2007, pp.130-150.

[55] P Robertson, M Barnao and T Ward. 'Rehabilitation frameworks in forensic mental health', *Aggression and Violent Behavior* , vol. 16, 2011, pp.472-484.

[56] J Wormith, R Althouse, M Simpson, L Reitzel, T Fagan & R Morgan, 'The rehabilitation and reintegration of offenders: The current landscape and some future directions for correctional psychology', *Criminal Justice and Behaviour*, vol. 34, no.7, 2007, pp. 879-892.

[57] E Baldry, D McDonnell, P Maplestone & M Peeters, 'Ex-prisoners and accommodation: what bearing do different forms of housing have on social reintegration for ex-prisoners?' *AHURI Research & Policy Bulletin* Vol 36 , 2004

[58] O'Hagan, 2004.

[59] Tilley & Cowan, p. 98.

[60] Tilley & Cowan, p. 98.

Key lessons from the New Zealand experience include the need to set the individual process of recovery in the broader social, economic and political processes. Acknowledgement of cultural diversity and the individual's connection to their own culture was also seen as particularly critical. A series of 10 key major competencies were developed for mental health workers which were not only applied in setting curricula but also for quality improvement by services.[61]

Piat, Sabetti and Bloom (2010) reviewed Canada's experience in transforming its mental health services to a recovery-orientated system of care.[62] From their interviews with decision makers, they identify six key themes that emerged as critical in this process:

- Agree on the definition of recovery

  Lack of agreement on the definition of recovery could, in itself, jeopardise system transformation.

- Implement recovery in the community

  Nearly all decision makers viewed the recovery approach as more relevant and more easily implemented in community-based services rather than in hospital services because hospitals are associated with illness and therefore not the most appropriate setting for recovery. Also hospital staff rarely develops meaningful relationships with clients, and frequent staff turnover and 24/7 shifts make it difficult to train staff in recovery-orientated practices.

- Hold providers responsible for recovery implementation

  Service providers are best positioned to incorporate recovery values into services.

- Foster a new professionalism

  Decision makers agreed that recovery training needs to occur at all levels of the system.

- Get users involved

  Decision makers identified users as the most credible spokespersons for recovery, citing user involvement on government planning committees in particular as being important in a recovery model. They also highlighted the need to provide authentic opportunities for users to infuse the knowledge of 'lived experience' at all levels of the system.

- Create recovery standards and outcome measures

  Decision makers identified the need to measure how recovery was being implemented in services, using outcome measures to demonstrate that recovery is possible for everyone.

Most decision makers did not foresee a leadership role for themselves in transforming the system, instead offering overall orientation and funding, while leaving implementation to providers. However, Piat, Sabetti and Bloom (2010) questioned the wisdom of this perspective and argued that decision makers must play an active leadership role as catalysts of change.[63]

[61] O'Hagan, 2004.

[62] M Piat, J Sabetti & D Bloom, 'The transformation of mental health services to a recovery-oriented system of care: Canadian decision maker perspectives, *International Journal of Social Psychiatry,* vol. 56, 2010, pp.168-177.

[63] Piat et al.

1.8 Recovery in Australia

Recovery oriented service provision in Australia is recognised in the National Mental Health Plan 2009-2014, that stated "services should be delivered with a commitment to a recovery approach". This recovery orientation is evident within the four key aims of the National Mental Health Policy 2008 which are to:

- promote the mental health and wellbeing of the Australian community and, where possible, prevent the development of mental health problems and mental illness;
- reduce the impact of mental health problems and mental illness, including the effects of stigma on individuals, families and the community;
- promote recovery from mental health problems and mental illness; and
- assure the rights of people with mental health problems and mental illness, and enable them to participate meaningfully in society.

The plan also acknowledged this may require significant cultural and philosophical shift from existing mental health service delivery.[64]

1.9 Recovery in the Queensland context

The Queensland Government's Sharing Responsibility for Recovery document (2005) uses the following definition of recovery:

> *Recovery is the journey toward a new and valued sense of identity, role and purpose outside the parameters of mental illness; and living well despite any limitations resulting from the illness, its treatment, and personal and environmental conditions.*[65]

It lists a wide range of elements that are more likely to have an impact on the individual and their journey of recovery. These include:

- Peer support, self help
- Family education and support
- Mental health services
- Primary health care
- Disability support
- Community infrastructure
- Housing
- Vocational rehabilitation/employment
- Drug and alcohol services
- Trauma and abuse services.[66]

[64] Commonwealth of Australia, *Fourth National Mental Health Plan - An agenda for collaborative government action in mental health 2009–2014*. Commonwealth of Australia, Canberra, 2009.

[65] Queensland Health, Sharing *the Responsibility for Recovery: creating and sustaining recovery oriented systems of care for mental health,* Queensland Government, Brisbane, 2005.

[66] Queensland Health, 2005.

This list emphasises the extent of supports and services needed in the recovery process. It also prioritises engaging and educating people's support networks as well as ensuring the accessibility of services appropriate to individual need. The development of a comprehensive and integrated service response requires mental health services to be well informed about their local service system and have partnerships and referral arrangements in place.

1.10 The benefits and costs of recovery-oriented service models

This section assesses recovery-oriented service models from two key perspectives, firstly, client outcomes and secondly, the service delivery costs and effectiveness.

Client outcomes

The benefits of a recovery-focused service model for people experiencing mental illness can perhaps be best illustrated through the example of the Housing and Accommodation Support Initiative (HASI) in NSW.[67] The HASI program aimed to assist people with mental health problems who required accommodation and support to participate in the community, maintain successful tenancies, improve quality of life and most importantly, to assist in the recovery from mental illness. An evaluation of the first stage of the program found improvements across a range of areas including:

- Stabilised tenancies
- Decreased hospital admissions and days spent in hospital per admission
- Improved mental health: decreased psychological distress; improved behaviour and reduced impairment, symptoms and social problems
- Increased occupational, social and educational functioning
- Improved life skills
- Increased social, economic and educational participation
- Decreased imprisonment rates.[68]

Clearly interventions of these kinds not only yielded substantial benefits to the individual participants but can also have positive ripple effects throughout the health care sector and society generally.

The findings of the HASI program are largely consistent with other Australian supported housing models, including Project 300 (Queensland), Individual Tenant Support Program (South Australia), and the NEAMI Community Housing Program (Victoria). These programs highlight the value of offering flexible packages of support that are responsive to clients' changing needs, directed towards their priorities, and sustained as long as is needed.[69]

A recent systematic review considered the patient outcomes associated with personalised support delivered by support workers for people with severe and persistent mental illness. Consistent with a recovery model, personalised support services aim to help consumers overcome functional deficits by

[67] Social Policy Research Centre, *Housing and Accommodation Support Initiative -Stage 1 Evaluation report.* University of New South Wales, Sydney, 2007.

[68] Social Policy Research Centre.

[69] T Meehan, K Madson, N Shepherd & D Siskind. *Housing and Support Program (HASP) Final Evaluation Report*, University of Queensland and The Park Centre for Mental Health, Brisbane, 2010.

providing assistance with living skills, emotional support, community access and advocacy. The review found moderate evidence for reducing illness acuity (especially for chronically depressed women and patients transitioning from long-term hospitalisation) and improving satisfaction with services, however the authors called for more comprehensive evaluation of programs in this area.[70]

Cost and cost effectiveness

The economic costs of mental illness in the community are high. In 2006–07, the cumulative costs of mental health service provision to governments and health insurers in Australia were $4.7 billion. This figure would be even higher if the costs of providing housing, community services and income support were also included. Added to this are productivity losses attributable to mental illness through reduced workforce participation and impaired productivity among those who are employed ; a figure that is estimated to range from $10 to $15 billion annually.[71]

As outlined in earlier sections, various strategies have been used to reduce the burden of mental illness to the individual and to society. These include interventions such as providing housing, stable employment and community-based support services, all of which represent components of a recovery-based approach. While the implications and benefits of these interventions have already been discussed in this review, the question of the cost effectiveness of these interventions remains to be addressed.

Given the multiplicity of components involved in a recovery-based approach, it is difficult to place a precise monetary value on the impact of such an approach. However, strong evidence exists from studies conducted in Australia and overseas to suggest that cost savings achieved by individual interventions have the cumulative potential to render recovery-based approaches cost effectiveness. *Table 1 p*rovides a summary of some key studies and the savings achieved therein.

One of the striking features of this table is the multiplier effect of individual interventions. Provision of stable housing for example, was found to be instrumental in reducing costs to the hospital and judicial systems, as did securing stable employment. Other important benefits of these interventions included clients' self-reported improvements in quality of life and progress towards achieving goals. While these latter benefits cannot be measured in tangible monetary terms, their importance in sustaining clients in their recovery journey has been repeatedly illustrated in this review. By default, therefore, achievement of monetary saving is contingent of achieving these less tangible client outcomes.

An assessment of the cost and cost effectiveness of recovery-based approaches not only involves reviewing the costs of providing particular interventions but also considering the broader ramifications of these interventions. Recovery-based approaches must be integrated into a diverse range of services in order to meet their clients' needs. Consequently, this is likely to trigger a transfer of costs from one system to another. For example, as outlined earlier, providing secure housing can result in reduced costs to the hospital and judicial systems. However, these savings come at a monetary cost to the housing sector itself. Likewise, providing community-based mental may reduce the need for and therefore the costs of acute hospital care. However, in addition to increasing costs to the community mental health sector, this change may also involve a transfer of costs from the acute hospital setting to out-patient services.

[70] D Siskind, M Harris, J Pirkis & P Whiteford. Personalised support delivered by support workers for people with severe and persistent mental illness: a systematic review of patient outcomes. *Epidemiology and Psychiatric Services*, vol. 21, 2012, pp.97-110.

[71] Commonwealth of Australia, *4th national mental health plan*, p.17.

Paradoxically, despite their community-based orientation, recovery programs may actually generate an increase in the use of acute services. This appropriate increase generally occurs in the case of clients who, prior to being involved in a recovery program, had been inadequately accessing services they needed.

Determining whether these cost transfers ultimately yield cost savings, cost increases or represents the most cost effective solution to delivering mental health services is therefore a complex issue. Delivering services at community level is generally less expensive than providing acute hospital services. So too is providing services in an outpatient rather than an acute setting. Failure to provide appropriate services also comes with its own costs, particularly when the outcomes for this potential client group are increased homelessness, recidivism, unemployment, social exclusion and mental illness.

1.11 Conclusions from the literature

The body of literature supporting recovery-oriented approaches to mental health service delivery is growing rapidly. Despite strong enthusiasm for the concept, precise definitions of recovery vary. Nevertheless, most interpretations emphasise a shift away from a 'care model' of service delivery to a collaborative model that supports and enables mental health consumers to improve their quality of life and fulfil their potential.

Challenges exist with the implementation of recovery oriented services. These include barriers at the level of clients, service providers, the community and the broader health and social context. Challenges also exist in the evaluation and measurement of recovery oriented approaches. Specific challenges have been identified for the implementation of recovery oriented programs within the correctional services system; these stem from the complex health and social needs of this population group, often compounded by societal attitudes towards ex-prisoners.

Despite these complexities, there is evidence of a range of benefits stemming from recovery-focused interventions. These include reductions in hospital admissions, decreased length of hospital stay, improved mental health, improved housing stability, improved occupational health and social functioning and decreased rates of imprisonment. Nevertheless, it is difficult, from the available literature, to put a precise monetary figure on the cost-effectiveness of these interventions. A number of programs have demonstrated impressive cost savings through reduced hospital admissions and reduced length of stay, however effective implementation of recovery oriented models will often result in increased use of a range of health and social services (including, in some cases, increased use of acute mental health services).

Appendix A: Literature Review

Table 1: Client outcomes and cost savings demonstrated through recovery-oriented programs in Australia and internationally

Study	Year published	Country	Intervention	Outcomes	Savings
Dual diagnosis patients in community or hospital care: One-year outcomes and health care utilisation and costs[72]	2006	USA	Community-based versus hospital-based acute residential treatment for dual diagnosis patients (substance use and psychiatric disorders)	▪ Better substance use and psychiatric outcomes for patients assigned to care in community residential facilities (CRF) rather than hospital acute care ▪ Shorter, but more costly, stays for patients in hospital acute care ▪ Patients in hospital acute care had more expensive mental health follow-up stays over the next 12 months.	▪ For those patients considered to be in remission at 1 year follow-up, the average cost for hospitalised patients was US$25 462, and the cost for CRF patients was US$12 174 (these findings should be treated with caution due to small numbers of patients involved).
Mental health peer support for hospital avoidance and early discharge: An Australian example of consumer driven and operated service[73]	2008	Australia (SA)	Mental health peer support service (Hospital avoidance and early discharge support).	▪ Overwhelmingly positive feedback from all stakeholders ▪ Only 17% of referrals relapsed to hospital either during or directly after the support period (n=8); the expected relapse rate prior to the project was 30%.	In first 3 months of operation 49 support packages were provided : ▪ 300 bed days saved ▪ Saving of AU$93 150 after project set up, delivery and administration costs of approximately AU$19850.
The cost-effectiveness of homelessness programs: a first assessment : Volume 1 Main report for the Australian Housing and Urban Research Institute Western Australia Research Centre[74]	2008	Australia (WA)	Homeless programs (43% of sample had mental health condition).	▪ Reduced use and associated cost of all justice services ▪ Appropriate increase in use of services	▪ Annual cost reduction of AU$1739 per client. because of reduced use and associated cost of all justice services ▪ Potential annual whole-of-government savings of at least twice the annual cost of delivering effective homelessness programs; e.g. single male homelessness assistance costs only AU$4625 per client compared to average health and justice costs of AU$10 212 above the normal population rate while homeless.

[72] C Timko, S Chen, J Sempel, P Barnett, 'Dual diagnosis patients in community or hospital care: One-year outcomes and health care utilization and costs'. *Journal of Mental Health*, 2006, vol. 15, no.2, pp.163-177.

[73] S Lawn, A Smith, & K Hunter, 'Mental health peer support for hospital avoidance and early discharge: An Australian example of consumer driven and operated service', *Journal of Mental Health*, vol. 17, no. 5, pp.498-508.

[74] P Flatau, K Zaretzky, M Brady, Y Haigh & R Martin, *The cost-effectiveness of homelessness programs: a first assessment Volume 1* – main report for the Australian Housing and Urban Research Institute Western Australia Research Centre (AHURI Final Report No.119), Australian Housing and Urban Research Institute, WA, 2008.

Appendix A: Literature Review

Study	Year published	Country	Intervention	Outcomes	Savings
The long-term impact of employment on mental health service use and costs for persons with severe mental illness[75]	2009	USA	Stable employment (observational study)	▪ Significantly greater decline in use of outpatient services for the steady-work group than minimum-work group ▪ Institutional (hospital, jail, or prison) stays declined for both groups .	▪ Average cost per participant for outpatient services and institutional stays for those in the steady-work group was US $166 350 less than the minimum-work group over ten years.
Housing and Support Program (HASP) Final Evaluation Report [76]	2010	Australia (QLD)	Housing and support (including clinical support)	▪ 82.2% of clients helped or were currently being helped to achieve their goals through HASP. ▪ The majority of HASP tenancies remained stable; 82.5% living in the initial accommodation provided through HASP. ▪ Number of support hours provided each week decreased by 7.13 hours from an average of 27.6 hours on entry into HASP to an average of 20.4 hours at the follow up time point. ▪ Average inpatient care time per individual decreased from an average of 227 days in the 12 months prior to HASP to an average of 18.9 days in the 12 months post-HASP. ▪ Decrease in average number of admissions from 1.22 admissions in the 12 months prior to HASP to an average of 0.66 admissions per individual in the following 12 months.	▪ Overall, the recurrent cost of keeping the 'average' client in HASP for 12 months appears to be: - AU$74 000 less expensive than keeping the same client in a community care unit (CCU) and - AU$178 000 less expensive than keeping the same client in an acute inpatient unit. The findings suggest that ▪ two clients could be maintained in HASP for the cost of keeping one client in a CCU ▪ almost 3 clients could be maintained in HASP for the cost of keeping one client in an acute inpatient unit. *

[75] P Bush, R Drake, H Xie, G McHugo & W Haslett, 'The long-term impact of employment on mental health service use and costs for persons with severe mental illness', *Psychiatric Services*, vol. 60, no. 8, pp.1024-31.

[76] T Meehan, K Madson, N Shepherd & D Siskind. *Housing and Support Program (HASP) Final Evaluation Report*, University of Queensland and The Park Centre for Mental Health, Brisbane, 2010.

Appendix A: Literature Review

Study	Year published	Country	Intervention	Outcomes	Savings
Effect of Full-Service Partnerships on Homelessness, Use and Costs of Mental Health Services, and Quality of Life Among Adults With Serious Mental Illness[77]	2010	USA	Housing to reduce homelessness Also engaging and retaining clients using team-based services.	▪ Mean number of days spent homeless per year declined 129 days from 191 to 62 days ▪ the probability of receiving inpatient services declined by 14% ▪ the probability of emergency services declined by 32% ▪ the probability of receiving inpatient services declined by 17% ▪ outpatient mental health visits increased by 78 visits ▪ Quality of life was greater among participants than among homeless clients per person receiving services in outpatient programs.	▪ Inpatient costs declined by US$6882 per person ▪ Emergency service costs declined by US$1721 per person ▪ Jail mental health services costs declined by US$1641 per person. ▪ Reductions in costs of inpatient/emergency and justice system services offset 82% of the cost of the intervention. - Housing costs increased by US$3180 per person - Outpatient costs increased by US$9180
Evaluation of the Whole of Mental Health, Housing and Accommodation Support Initiative (HASI), Second Report'[78]	2011	Australia (NSW)	Access to secure housing and support to maintain their tenancy. Facilitate improved mental and physical health through access to appropriate services.	▪ average number of hospital admissions each year decreased by 24% ▪ mean number of days spent in hospital per person per year decreased by 60% ▪ average number of days hospitalised per admission decreased by 68 % ▪ 54% of consumers independently participating in social and recreational activities	The total program budget over four years was: ▪ $118 million accommodation support costs ▪ $1 million project management costs Previous housing capital investment 2002-07 was AU$26 million. This is equivalent to an annual unit cost per consumer ranging from AU$11,000 to AU$58,000, plus project management costs of between $200 to $500 per person, depending on the level of accommodation support and the method of calculating the annual unit costs. *Note: The final report will assess the cost of HASI against the outcomes experienced by HASI consumers*

[77] T Gilmer, A Stefancic, S Ettner, W Manning, S Tsemberis, 'Effect of Full-Service Partnerships on Homelessness, Use and Costs of Mental Health Services, and Quality of Life Among Adults With Serious Mental Illness', *Archives of General Psychiatry*, vol. 67, no. 6, 2010, pp. 645-52.

[78] S McDermott, J Bruce, I Oprea, K Fisher & and K Muir, *Evaluation of the Whole of Mental Health, Housing and Accommodation Support Initiative (HASI), Second Report*, prepared for NSW Health and Housing , Sydney, 2010.

Appendix A: Literature Review

Study	Year published	Country	Intervention	Outcomes	Savings
Does supported accommodation improve the clinical and social outcomes for people with severe psychiatric disability? The Project 300 experience[79]	2011	Australia (QLD)	Providing long-stay hospitalised patients with their own home in the community and an average 20 hours/week non-clinical support.	▪ Improved freedom and autonomy (most were still living in the community at 7 years follow-up) ▪ 40% had not had acute hospital admission after 7 years. ▪ Little impact on social inclusion, clinical functioning and overall disability	▪ Average cost per Project 300 client per annum: AU$61 580 (includes allocated 20 hours personal care, GP/case management services and allocation for 10 day admission to acute care). ▪ This compares favourably with cost of keeping the same client in an acute inpatient unit (AU$246700) or a community care unit (AU$133 225)

**Costs based on recurrent costs only. Initial costs involved in selecting clients for the program, securing housing options and establishing infrastructure in the community to support each*

[79] T Meehan, T Stedman, S Robertson, S Drake & R King, 'Does supported accommodation improve the clinical and social outcomes for people with severe psychiatric disability? The Project 300 experience', Australian *and New Zealand Journal of Psychiatry* vol.45, pp.586-92.

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Appendix B

Appendix B. Comparison of TTR Program Service Models

Comparison of TTR Program Models[1]			
Program Model	Transition from Correctional Facilities Program	Transitional Recovery Program	Resident Recovery Program
Goal and Aims	▪ To provide short term recovery oriented support to people with mental illness who are being released from correctional facilities to develop skills to live independently in the community	▪ Provide individualised, flexible and responsive services that assist in the development of skills to live independently in the community through: - Development of psychosocial rehabilitative program in recovery framework - Provision of support for agreed individualised outcomes - Foster links with community stakeholders to promote community integration/social connectedness	▪ Individual recovery planning to meet personal outcomes ▪ Support to assist individuals to build links with community stakeholders to promote community integration/social connectedness ▪ Provision of short term to medium term support to break cycle of moving through acute care, boarding house/hostel/homelessness ▪ Provides individualised, flexible and responsive support to clients who are living in boarding house/hostel

[1] Modified table from Queensland Department of Communities, *ITO Final: Evaluation of the Community Mental Health Transition to Recovery Programs.* Queensland Government, Brisbane, 2009.

Appendix B. Comparison of TTR Program Service Models

Comparison of TTR Program Models[1]			
Program Model	Transition from Correctional Facilities Program	Transitional Recovery Program	Resident Recovery Program
Target Group	Adults aged 18+, with a primary diagnosis of moderate to severe mental illness as assessed by Prison Mental Health, who: ▪ meet the eligibility criteria ▪ are about to be released from a correctional facility back to the community ▪ are referred to the service by Prison Mental Health service ▪ require short term (up to 6 months) psychosocial support to live in the community ▪ agree to participate in a recovery oriented support program to work towards achieving personally identified goals ▪ have support needs which the service provider has the capacity and/or resources available to support the individual	Adults aged 18+, who have a moderate to severe mental illness who require short/medium term psychosocial rehabilitation support to live in the community and who: ▪ meet the eligibility criteria ▪ have a mental illness with medium to high support needs ▪ have a stable mental health status/mental health needs that can be met within a community based environment ▪ agree to fully participate in a recovery-based program and to work towards achieving independence in the community including stable, long-term community housing solutions	Adults aged 18+, with a primary diagnosis of moderate to severe mental illness who: ▪ meet the eligibility criteria ▪ are about to be discharged from inpatient mental health care to boarding house/hostel or are receiving clinical case management services while living in boarding house/hostel accommodation ▪ will be vulnerable/exposed to a range of risks in this type of accommodation and recognises that this accommodation is not conducive to recovery
Locations and target numbers	▪ South East Queensland: 60 places/year ▪ Maryborough: 15 places/year ▪ Cairns: 15 places/year ▪ Townsville: 15 places/year ▪ Rockhampton: 15 places /year	▪ Gold Coast: 24 places/year ▪ Caboolture: 24 places/year ▪ Logan: 24 places/year ▪ Sunshine Coast: 27 places /year	▪ South Brisbane: 72 places /year ▪ North Brisbane: 100 places/year ▪ Ipswich: 38 places /year ▪ Toowoomba: 35 places/year

Appendix B. Comparison of TTR Program Service Models

Comparison of TTR Program Models[1]			
Program Model	Transition from Correctional Facilities Program	Transitional Recovery Program	Resident Recovery Program
Services Provided	Two phases of service delivery*: Phase 1 – Prior to release from correctional facility (approx 2 weeks before):* ▪ service providers collaborate with Queensland corrective service, Queensland Health and Prison Mental Health ▪ work with client to identify goals and develop a transition plan for return to the community *Phase 2 – Post Release Support (up to 6 months)* ▪ NGOs work with Integrated Mental Health Service, housing and other stakeholders required on an individual client basis ▪ support provided to help client achieve goals in the transition plan *The program provides services to:* ▪ develop lifestyle skills and skills to self-manage mental/general health ▪ access appropriate accommodation/ housing ▪ connect with services (mental health, GP, centrelink, employment agencies) ▪ improve quality of life	Two phases of service delivery*: Phase 1 - short/medium term recovery based support/accommodation (up to 12 months) includes:* ▪ more structured environment to achieve goals/lifestyle needs ▪ non-identifying/non-stigmatised accommodation ▪ safe environment ▪ private living/meeting spaces ▪ access to appropriate spaces for peer support ▪ planned exit from the program accommodation *Phase 2 - time limited transitional outreach support post departure to own accommodation (up to 6 months) includes*: ▪ needs-based plan for outreach support after moving into own long-term accommodation ▪ regular review and monitoring of personal goals ▪ phasing out of support and planned exit from	A range of services provided to: ▪ assist with the development of lifestyle skills to maintain personally meaningful lifestyle/community tenure ▪ support to develop skills to self-manage mental/general health care ▪ improved access to social interactions/community inclusion ▪ links to vocational/employment support or meaningful occupation ▪ promote access to opportunities which support full citizenship (i.e. social, recreational and other community roles/connections) ▪ assist with breaking the cycle of homelessness/readmission to acute care ▪ reduce length of stay in inappropriate accommodation and linking individuals to alternate housing that is more conducive to recovery ▪ development of individualised plans which include personal goals/outcomes related to skills for living, self-management, general

Appendix B. Comparison of TTR Program Service Models

Comparison of TTR Program Models[1]			
Program Model	Transition from Correctional Facilities Program	Transitional Recovery Program	Resident Recovery Program
	▪ be supported to enhance their mental health and recovery ▪ assist with enhancing community connections to reduce social isolation ▪ attend court hearings/meet parole obligations ▪ link to longer term formal/informal supports in community	the program *Other services delivered as part of this program may include:* ▪ links to vocational/employment support or meaningful occupation ▪ improved access to social interactions/community inclusion ▪ support to develop skills to self-manage mental/general health care and lifestyle skills *Other:* Accommodation is provided as part of program.	mental health/wellbeing, social participation/connectedness
Referrals and Pathways	▪ Referral is through Queensland Health	▪ Referrals are typically through public mental health services although they may also occur through private psychologists and other mental health clinicians.	▪ Referral is through Queensland Health

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Appendix C

Appendix C. Client Support and Outcomes Information Request

Service Providers: Client Support and Outcomes Information Request

Name of Service Provider:	

This form is collecting information about how support is provided to program participants, for different areas of their life and whether or not it has made a difference. The information will only be used for the purpose of the Transition to Recovery Program evaluation and will not be used to evaluate individual organisations.

*Please only provide information about **people that have exited** from the program.*

1. Number of people supported through the program

Total number of clients that have exited the program since commencement | |

2. Client Support: How do people in the program gain access to appropriate supports?

Areas that may require support	Provided in-house	Referred out or other provider comes in (Type of provider)
Mental health needs		E.g. MH team visit, &/or GP, &/or private Psychiatrist or MH Nurse in private practice) or...
Physical health needs		E.g. GP &/or Community Health Service Nurse comes in &/or...
Alcohol and Other Drug issues	E.g. Employ qualified AOD worker &/or...	E.g. AOD service comes in &/or GP or private Psychiatrist &/or...
Exercise for fitness, health, recreation	E.g. Contract fitness provider to deliver sessions in house &/or...	E.g. Gym program, &/or Swimming program &/or Community walking program &/or...
Education, training, employment, volunteering opportunities	E.g. Employ volunteer coordinator &/or...	E.g. Specialist Employment assistance program comes in &/or...
Social/community activities	E.g. Organise activities with other programs in our organisation &/or incorporated into support worker role &/or...	E.g. Volunteers from a local church group that have been trained take people on outings &/or...
Opportunities to develop/pursue hobbies	E.g. Contract people to deliver hobby programs &/or...	E.g. People are linked into a variety of options in the community &/or...
Domestic and self care skills	E.g. Incorporated into support worker role &/or...	
Appropriate accommodation	E.g. Incorporated into support worker role &/or...	E.g. Supported Housing Program, &/or...

Client Support and Outcomes Information Request *(continued)*

3. Profile of clients that have used the program since commencement

Client No. 1	Date commenced	Date of Exit	Age when commenced	Gender	ATSI (Yes or No)	Country of Birth	Mental Health Diagnosis 1	Mental Health Diagnosis 2	Mental Health Diagnosis 3	Other Disability
Client No. 2	Date commenced	Date of Exit	Age when commenced	Gender	ATSI (Yes or No)	Country of Birth	Mental Health Diagnosis 1	Mental Health Diagnosis 2	Mental Health Diagnosis 3	
Client No. 3	Date commenced	Date of Exit	Age when commenced	Gender	ATSI (Yes or No)	Country of Birth	Mental Health Diagnosis 1	Mental Health Diagnosis 2	Mental Health Diagnosis 3	
Etc.	Date commenced	Date of Exit	Age when commenced	Gender	ATSI (Yes or No)	Country of Birth	Mental Health Diagnosis 1	Mental Health Diagnosis 2	Mental Health Diagnosis 3	

4. Client Outcomes: Have clearly identifiable, positive changes occurred for participants in the following areas for those clients that were exited in the previous 3 months?

Outcomes in relation to the following:	No. of clients that needed assistance with this area	No. of clients that received assistance	No. of clients that achieved improvements
Impact of mental ill health			
Impact of physical health needs			
Impact of Alcohol and Other Drug issues			
Participation in education, training, employment, volunteering opportunities			
Participation in Social/community activities			
Development/pursuit of hobbies			
Development of domestic and self care skills			
Establishment of appropriate accommodation			

5. Are there specific tools, assessment methods, or other that you use to determine change in clients' situations? If so what are they (please send a copy with the completed survey)?

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Appendix D

Appendix D. Recovery Self Assessment Survey – Staff Version

Service Providers

RECOVERY SELF ASSESSMENT (RSA) – SERVICE PROVIDER VERSION (STAFF)

Please indicate the degree to which you feel the following items reflect the activities, values, and practices of your agency.

		1 Strongly disagree	2	3	4	5 Strongly agree	
1.	Helping people build connections in their neighbourhoods and communities is one of the primary activities in which staff at this service provider are involved	1	2	3	4	5	N/A
2.	This service provider offers specific services and programs for individuals with different cultures, life experiences, interests, and needs	1	2	3	4	5	N/A
3.	People in recovery have access to all of their records	1	2	3	4	5	N/A
4.	This service provider provides education to community employers about employing people with mental illness and/or addictions	1	2	3	4	5	N/A
5.	Every effort is made to involve significant others (spouses, friends, family members) and other natural supports (i.e., clergy, neighbours, landlords) in the planning of a person's services, if so desired	1	2	3	4	5	N/A
6.	People in recovery can choose and change, if desired, the person with whom they work	1	2	3	4	5	N/A
7.	Most services are provided in a person's natural environment (i.e., home, community, workplace)	1	2	3	4	5	N/A
8.	People in recovery are given the opportunity to discuss their sexual and spiritual needs and interests	1	2	3	4	5	N/A
9.	All staff at this service provider regularly attend training on cultural competency	1	2	3	4	5	N/A
10.	Staff at this service provider listen to and follow the choices and preferences of participants	1	2	3	4	5	N/A
11.	Progress made towards goals (as defined by the person in recovery) is monitored on a regular basis	1	2	3	4	5	N/A
12.	This service provider provides structured educational activities to the community about mental illness and addictions	1	2	3	4	5	N/A
13.	Service provider staff do not use threats, bribes, or other forms of coercion to influence the behaviour or choices	1	2	3	4	5	N/A
14.	Staff and service provider participants are encouraged to take risks and try new things	1	2	3	4	5	N/A
15.	Persons in recovery are involved with facilitating staff trainings and education programs at this service provider	1	2	3	4	5	N/A
16.	Staff are knowledgeable about special interest groups and activities in the community	1	2	3	4	5	N/A
17.	Groups, meetings, and other activities can be scheduled in the evenings or on weekends so as not to conflict with other recovery-oriented activities such as employment or school	1	2	3	4	5	N/A
18.	This service provider actively attempts to link people in recovery with other persons in recovery who can serve as role models or mentors by making referrals to self-help, peer support, or consumer advocacy groups or programs	1	2	3	4	5	N/A
19.	This service provider provides a variety of support options from which service	1	2	3	4	5	N/A

	provider participants may choose						
20.	The achievement of goals by people in recovery is formally acknowledged and celebrated by the service provider	1	2	3	4	5	N/A
21.	People in recovery are routinely involved in the evaluation of the service provider's programs, services, and service providers	1	2	3	4	5	N/A
22.	Staff use a language of recovery (i.e., hope, high expectations, respect) in everyday conversations	1	2	3	4	5	N/A
23.	Staff play a primary role in helping people in recovery to become involved in non-mental health/addiction related activities, such as church groups, special interest groups, and adult education	1	2	3	4	5	N/A
24.	Procedures are in place to facilitate referrals to other programs and services if the service provider cannot meet a person's needs	1	2	3	4	5	N/A
25.	Staff actively assist people in recovery with the development of career and life goals that go beyond symptom management and stabilization	1	2	3	4	5	N/A
26.	Service provider staff are diverse in terms of culture, ethnicity, lifestyle, and interests	1	2	3	4	5	N/A
27.	People in recovery are regular members of service provider advisory boards and management meetings	1	2	3	4	5	N/A
28.	At this service provider, participants who are doing well get as much attention as those who are having difficulties	1	2	3	4	5	N/A
29.	Staff routinely assist individuals in the pursuit of their educational and/or employment goals	1	2	3	4	5	N/A
30.	People in recovery work along side service provider staff on the development and provision of new programs and services	1	2	3	4	5	N/A
31.	Service provider staff actively help people become involved with activities that give back to their communities (i.e., volunteering, community services, neighbourhood watch/cleanup)	1	2	3	4	5	N/A
32.	This service provider provides formal opportunities for people in recovery, family and significant others, service providers, and administrators to learn about recovery	1	2	3	4	5	N/A
33.	The role of service provider staff is to assist a person with fulfilling their individually-defined goals and aspirations	1	2	3	4	5	N/A
34.	Criteria for exiting or completing the program are clearly defined and discussed with participants upon entry to the service	1	2	3	4	5	N/A
35.	The development of a person's leisure interests and hobbies is a primary focus of services	1	2	3	4	5	N/A
36.	Service provider staff believe that people can recover and make their own treatment and life choices	1	2	3	4	5	N/A

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Appendix E

Appendix E. Recovery Self Assessment Survey – CEO Version

Service Providers

RECOVERY SELF ASSESSMENT (RSA) – SERVICE PROVIDER VERSION (CEO/Director)

Please indicate the degree to which you feel the following items reflect the activities, values, and practices of your agency.

		1 Strongly disagree	2	3	4	5 Strongly agree	
1.	Helping people build connections in their neighbourhoods and communities is one of the primary activities in which staff at this service provider are involved	1	2	3	4	5	N/A
2.	This service provider offers specific services and programs for individuals with different cultures, life experiences, interests, and needs	1	2	3	4	5	N/A
3.	People in recovery have access to all of their records	1	2	3	4	5	N/A
4.	This service provider provides education to community employers about employing people with mental illness and/or addictions	1	2	3	4	5	N/A
5.	Every effort is made to involve significant others (spouses, friends, family members) and other natural supports (i.e., clergy, neighbours, landlords) in the planning of a person's services, if so desired	1	2	3	4	5	N/A
6.	People in recovery can choose and change, if desired, the person with whom they work	1	2	3	4	5	N/A
7.	Most services are provided in a person's natural environment (i.e., home, community, workplace)	1	2	3	4	5	N/A
8.	People in recovery are given the opportunity to discuss their sexual and spiritual needs and interests	1	2	3	4	5	N/A
9.	All staff at this service provider regularly attend training on cultural competency	1	2	3	4	5	N/A
10.	Staff at this service provider listen to and follow the choices and preferences of participants	1	2	3	4	5	N/A
11.	Progress made towards goals (as defined by the person in recovery) is monitored on a regular basis	1	2	3	4	5	N/A
12.	This service provider provides structured educational activities to the community about mental illness and addictions	1	2	3	4	5	N/A
13.	Service provider staff do not use threats, bribes, or other forms of coercion to influence the behaviour or choices	1	2	3	4	5	N/A
14.	Staff and service provider participants are encouraged to take risks and try new things	1	2	3	4	5	N/A
15.	Persons in recovery are involved with facilitating staff trainings and education programs at this service provider	1	2	3	4	5	N/A
16.	Staff are knowledgeable about special interest groups and activities in the community	1	2	3	4	5	N/A
17.	Groups, meetings, and other activities can be scheduled in the evenings or on weekends so as not to conflict with other recovery-oriented activities such as employment or school	1	2	3	4	5	N/A
18.	This service provider actively attempts to link people in recovery with other persons in recovery who can serve as role models or mentors by making referrals to self-help, peer support, or consumer advocacy groups or programs	1	2	3	4	5	N/A
19.	This service provider provides a variety of support options from which service	1	2	3	4	5	N/A

	provider participants may choose						
20.	The achievement of goals by people in recovery is formally acknowledged and celebrated by the service provider	1	2	3	4	5	N/A
21.	People in recovery are routinely involved in the evaluation of the service provider's programs, services, and service providers	1	2	3	4	5	N/A
22.	Staff use a language of recovery (i.e., hope, high expectations, respect) in everyday conversations	1	2	3	4	5	N/A
23.	Staff play a primary role in helping people in recovery to become involved in non-mental health/addiction related activities, such as church groups, special interest groups, and adult education	1	2	3	4	5	N/A
24.	Procedures are in place to facilitate referrals to other programs and services if the service provider cannot meet a person's needs	1	2	3	4	5	N/A
25.	Staff actively assist people in recovery with the development of career and life goals that go beyond symptom management and stabilization	1	2	3	4	5	N/A
26.	Service provider staff are diverse in terms of culture, ethnicity, lifestyle, and interests	1	2	3	4	5	N/A
27.	People in recovery are regular members of service provider advisory boards and management meetings	1	2	3	4	5	N/A
28.	At this service provider, participants who are doing well get as much attention as those who are having difficulties	1	2	3	4	5	N/A
29.	Staff routinely assist individuals in the pursuit of their educational and/or employment goals	1	2	3	4	5	N/A
30.	People in recovery work along side service provider staff on the development and provision of new programs and services	1	2	3	4	5	N/A
31.	Service provider staff actively help people become involved with activities that give back to their communities (i.e., volunteering, community services, neighbourhood watch/cleanup)	1	2	3	4	5	N/A
32.	This service provider provides formal opportunities for people in recovery, family and significant others, service providers, and administrators to learn about recovery	1	2	3	4	5	N/A
33.	The role of service provider staff is to assist a person with fulfilling their individually-defined goals and aspirations	1	2	3	4	5	N/A
34.	Criteria for exiting or completing the program are clearly defined and discussed with participants upon entry to the service	1	2	3	4	5	N/A
35.	The development of a person's leisure interests and hobbies is a primary focus of services	1	2	3	4	5	N/A
36.	Service provider staff believe that people can recover and make their own treatment and life choices	1	2	3	4	5	N/A

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Appendix F

Client Questionnaire (Entry and Exit)

AHA provided – Client ID number	
Date questionnaire completed	

We are asking if you can assist the evaluation of the Transition to Recovery program by answering the following questions.

There are three sets of questions, including:

- *Your background (6 questions, only answer these the first time you complete the survey)*
- *Recovery Assessment Scale – Questions about your recovery (24 questions, which need to answered when you start the program and again when you leave or in February 2012, if you are still in the program)*
- *Other questions about the support that you have had from the program (9 questions, 2 of which only need to be answered the second time that you do the survey)*

Please feel free to be as honest as you can as this will be the way that we can best work out how well people's needs are being met by the program.

If you are unsure about a question, you can move on to the next question and then come back to the one that you were unsure about.

Thank you for your help with this,

Australian Healthcare Associates Evaluation Team

Background Information

ENTRY ONLY QUESTIONS

1.	Date when you started with this program?			
2.	Age when commenced with this program			
3.	Gender		*Male*	*Female*
4.	Aboriginal and Torres Strait Islander		*Yes*	*No*
5.	Country of birth			

6.	Mental Health diagnosis(es)	Diagnosis 1	Diagnosis 2	Diagnosis 3

Client Questionnaire *(continued)*

Recovery Assessment Scale (RAS) – 24 item version

ENTRY AND EXIT QUESTIONS

Instructions: Below is a list of statements that describe how people sometimes feel about themselves and their lives. Please read each one carefully and circle the number to the right that best describes the extent to which you agree or disagree with the statement. Circle only one number for each statement and do not skip any items.

		Strongly Disagree	Disagree	Not sure	Agree	Strongly Agree
1.	I have goals in life that I want to reach	1	2	3	4	5
2.	I have a desire to succeed	1	2	3	4	5
3.	I believe I can meet my current personal goals	1	2	3	4	5
4.	I have an idea of who I want to become	1	2	3	4	5
5.	I am hopeful about my future	1	2	3	4	5
6.	I have my own plan for how to stay or become well	1	2	3	4	5
7.	I continue to have new interests	1	2	3	4	5
8.	I have a purpose in life	1	2	3	4	5
9.	Something good will eventually happen	1	2	3	4	5
10.	Even when I don't believe in myself, other people do	1	2	3	4	5
11.	Even when I don't care about myself, other people do	1	2	3	4	5
12.	I have people I can count on	1	2	3	4	5
13.	I ask for help, when I need it	1	2	3	4	5
14.	I can handle what happens in my life	1	2	3	4	5
15.	I like myself	1	2	3	4	5
16.	I can handle stress	1	2	3	4	5
17.	If people really knew me, they would like me	1	2	3	4	5
18.	Fear doesn't stop me from living the way I want to	1	2	3	4	5
19.	My symptoms interfere less and less with my life	1	2	3	4	5
20.	My symptoms seem to be a problem for shorter periods of time each time they occur	1	2	3	4	5
21.	I am willing to ask for help	1	2	3	4	5
22.	Coping with mental illness is no longer the main focus of my life	1	2	3	4	5
23.	I know when to ask for help	1	2	3	4	5
24.	It is important to have a variety of friends	1	2	3	4	5

Client Questionnaire *(continued)*

Other questions

ENTRY AND EXIT QUESTIONS

		Strongly Disagree	Disagree	Not sure	Agree	Strongly Agree
1.	I have ongoing support for my mental health	1	2	3	4	5
2.	I feel safe in my accommodation	1	2	3	4	5
3.	I feel confident with shopping, cooking and maintaining my home situation	1	2	3	4	5

		Weeks	Months	Years
4.	How long have you been in your current accommodation (Number of weeks, months, or years approximately)?			

		Excellent	Very Good	Good	Fair	Poor
5.	In general would you say that your health is:	1	2	3	4	5

		Number of times (Please circle one)						
6.	How many times did you exercise for fitness, recreation or sport in the last week?	1	2	3	4	5	6	7

		Fulltime employment	*Part time Employment*	*Not employed*	*In education or training*	*Voluntary work*
7.	Do you have any involvement in Employment, Education, Training and/or Volunteering? (can circle more than one)					

EXIT ONLY QUESTIONS

		Strongly Disagree	Disagree	Not sure	Agree	Strongly Agree
	Staff have been assisting me or have linked me to an organisation that has been assisting me with finding appropriate education, training, employment and/or volunteering opportunities (Exit only)	1	2	3	4	5
	Staff have been assisting me with obtaining appropriate housing/accommodation (Exit only)	1	2	3	4	5

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Appendix G

Participant Information and Consent Form

New clients – Consent to do Survey

[Insert name of service provider]

Project Title: *Evaluation of Community Mental Health Transition to Recovery Programs*

Principal Researchers:	Mr Peter Orchard Associate Professor Eóin Killackey
Associate Researchers:	Ms Rossi Lyons Ms Judy Addison Ms Jessica Small Ms Tess Lethborg

1. Introduction

Australian Healthcare Associates (AHA) would like to invite you to take part in this evaluation of Community Mental Health Transition to Recovery Programs. This form provides information about the evaluation and what is involved, so that you can decide if you want to take part.

Please read this information carefully. If you have any questions or would like more information about the project, please contact Peter Orchard or Judy Addison (Ph: 1300 788 667).

The Department of Communities has appointed AHA to conduct an evaluation of Community Mental Health Transition to Recovery Programs. These programs are the Transitional Recovery Program, Resident Recovery Program and the Transition from Correctional Facilities Program.

The three Transition to Recovery programs are designed to assist people with a mental illness to achieve a range of outcomes that will assist in their recovery journey.

These programs have not been funded by the Department before, so they would like to see if the programs are helping people's recovery from mental illness, in the best possible way. AHA's job as the evaluator, is to look at relevant data and then talk to people that use the programs, those that provide the programs, and other relevant services, to see what is working and what could be improved.

2. What does participation in this project involve?

[insert name of provider] will ask you a short survey about different aspects of your life. They will ask the questions now, when you are starting with them, and later, when you are planning to leave the program, or in February next year if you are still with the program.

The idea of asking you twice is to see whether things in your life have changed for better or worse since being involved in the Recovery program. [insert name of provider] will then provide your responses to AHA but not your name so we won't know that the data is about you specifically.

3. What are the possible benefits?

You may or may not directly benefit from your involvement in this project. However many individuals appreciate having an opportunity to have their opinion about the services they receive heard and acknowledged. Also what you say about the program can help to make a difference to the way the program works in the future.

4. What are the possible risks?

There should not be any negative reactions to your involvement in this project. However if for some reason you feel anxious or upset at any time during the survey, please tell the person from [insert name of provider] asking you the questions.

5. Do I have to take part in this project?

AHA welcomes your involvement in this project, but your participation is voluntary. You do not have to take part. You are also free to withdraw at any time throughout this project.

If you decide to withdraw, please notify a member of the AHA project team. They will tell you about any special requirements linked to withdrawing. AHA would like to keep the information about you that has already been collected. This is to help them make sure that the results of the research can be measured properly. However, if you do not want AHA to do this, then it is important to tell us before you withdraw from the project.

Your decision whether to take part, or to withdraw, will not affect your relationship with the AHA project team, [Insert service provider name], the Department of Communities or Queensland Health.

6. What will happen to information about me?

The completed survey will be sent to AHA with a number instead of your name on it. This means that we won't know who you are, but the number will allow us to compare the results of your first survey with the second survey that you do. Your surveys will remain confidential and will only be used for this project. All documents related to this project will be stored securely in the AHA office in a locked filing cabinet and password protected computer. No-one apart from the project team will have access to this information.

We will be combining the results of all of the surveys so no reports or presentations related to this evaluation will identify you in any way. We will use the combined results to help us with deciding on how well the three Transition to Recovery programs are assisting their clients. The information held by AHA will only be disclosed with your permission, except as required by law.

On completion of the project, the data will be securely stored by AHA for seven years. Following this period the data will be deleted from the computer system and any paper records will be shredded by AHA. AHA and Department of Communities have no future plans for the use of this data and it will not be part of an ongoing databank.

7. Can I access the information kept about me?

Consistent with relevant Australian and Queensland laws, you have the right to access the information collected and stored by the AHA team about you. Please contact one of the AHA project members if you would like to access your information.

8. Is this project approved?

This project has been approved by a Human Research Ethics Committee of Queensland Health and will be carried out according to the *National Statement on Human Research.*

9. Who can I contact?

The person you may need to contact will depend on the nature of your query. Therefore, please note the following:

- **For help with your mental health**

Speak to your Transition to Recovery Program support worker or local mental health service or telephone Lifeline on 13 11 14

- **For further information about the project:**

If you want any further information concerning this project or if you have any concerns that may be related to your involvement in the project, you can contact the following people:

Name: ***Peter Orchard***
Role: Project Manager, Australian Healthcare Associates

Name: ***Judy Addison***
Role: Senior Consultant, Australian Healthcare Associates

Name: ***Jessica Small***
Role: Consultant, Australian Healthcare Associates

Telephone: 1300 788 667 (cost of a local call) or (03) 9663 1950.

Evaluation of Community Mental Health Transition to Recovery Programs

New Clients

Consent Form – Participation in client survey

I have read, or have had this document read to me in a language that I understand. I understand the purposes, procedures and risks of this project.

I have had an opportunity to ask questions and I am satisfied with the answers I have received.

I understand that my consent is only for the purposes of this project and will not be used for any further research.

I freely agree to participate in this research project, as described.

I consent to [service provider] asking me a short survey and providing de-identified data to AHA.

I understand that I will be given a signed copy of this document to keep.

Name (printed): ……..

Signature: …… Date: …….

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Appendix H

Appendix H. Service Provider Interview Tool

Service Provider interviews/focus group

NB: Client Support and Outcomes survey and the RSAs need to be completed by the service provider prior to conducting this interview with them.

CEO/Senior manager interview

Recovery orientation

1. How has the organisation incorporated the Recovery framework?
2. How difficult has it been to recruit appropriately qualified/experienced people for the program?
3. Has training in the Recovery framework been provided? What did that involve?
4. Discussion of the findings from the Recovery Self Assessment.
5. What are the ways in which staff are supported with their Recovery work (e.g. Supervision, case discussions etc.)

Implementation of the program

1. What are the key features of the way that you have implemented the program? E.g. way support is delivered, use of brokerage, etc.
2. Has the implementation differed from what was originally planned? If so, how, and what were the factors contributing to this?
3. Please describe any formal or informal partnerships, networks or linkages to other service providers/stakeholders that assist in achieving desired outcomes for clients? How were these established and how effective have these relationships been?
4. What support have you received from the Department in implementing the program?

Management/staff focus group

Entry to the program

1. What are the entry criteria?
2. What is the process for gaining entry to the program?
3. Where do referrals come from and in what proportion?
4. What is the percentage of successful referrals?
5. What is the percentage of clients that have been in a Recovery Program before?

Appendix H. Service Provider Interview Tool

Program outcomes and challenges

1. Are outcomes in line with your expectations?
2. What is the percentage of unplanned exits?
3. Have there been other unintended outcomes for clients, either negative or positive?
4. What have been key barriers or challenges to achieving expected outcomes for clients?
5. What have been the key enablers to achieving expected outcomes for clients?
6. Are there some case studies that illustrate program outcomes (without providing people's actual names or who could be readily identified) that would be good to include?

Options for enhancements

1. Knowing what you do now, if you were to roll this program out again in the future, what would need to be done differently?
2. What could be done to enhance the program from this point forward?

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Appendix I

Appendix I. Consumer Case Study Proforma

Demographic overview (age, gender, cultural background if ATSI or CALD)
Diagnosis (es) and other health/wellbeing concerns at time of entry
Describe situation of client prior to entry to program (e.g. frequent inpatient admissions; time in correctional facility; employment status; housing stability/instability; relationships to significant others etc.)
What were the client's goals/what was the client hoping to achieve or work towards through involvement with your Recovery program?
What types of assistance did you provide to the client?
What were the outcomes for the client? Were there any unexpected outcomes for the client? Were any goals not achieved?
What were some of the key factors that contributed to successfully achieving the client's goals?
What were some of the challenges or barriers faced in working towards this client's goals?

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Appendix J

Appendix J. Client Interview Tool

Client Interview

Part 1 - Demographics

1.	Date when you started with this program?			
2.	Age when commenced with this program			
3.	Gender		Male	Female
4.	Aboriginal and Torres Strait Islander		Yes	No
5.	Country of birth			

6.	Mental Health diagnosis(es)	Diagnosis 1	Diagnosis 2	Diagnosis 3

Part 2 - Experience prior to being in the program

How did you come to be involved in this program?

What was life like before being involved in the program? Do you feel like you can talk about how your...

- Mental health was then?
- Housing was then?
- Involvement in Employment/Education/Training was then?
- Relationships with families and friends were then?
- Involvement in social activities and/or hobbies was then?
- Ability to look after yourself; shopping, cooking, cleaning was then?
- Your thoughts about your life then?

Part 3 - Experience of being in the program

Part 1

Have any of these things changed since you have been part of this program?

Which ones and how are they different now?

Appendix J. Client Interview Tool

Client Interview *(continued)*

Part 4 – What is this organisation like?

Recovery Self Assessment (RSA) – Person in recovery version

Please indicate the degree to which you feel the following items reflect the activities, values, and practices of your agency.

1 Strongly disagree 2 3 4 5 Strongly agree

1.	Staff focus on helping me to build connections in my neighbourhood and community	1	2	3	4	5	N/A
3.	I have access to all my records	1	2	3	4	5	N/A
5.	My service provider makes every effort to involve my significant others (spouses, friends, family members) and other sources of natural support (i.e., clergy, neighbours, landlords) in the planning of my services, if this is my preference	1	2	3	4	5	N/A
6.	I can choose and change, if desired, the person with whom I work	1	2	3	4	5	N/A
10.	Staff at this agency listen to and follow my choices and preferences	1	2	3	4	5	N/A
11.	Staff at this agency help to monitor the progress I am making towards my personal goals on a regular basis	1	2	3	4	5	N/A
13.	Agency staff do not use threats, bribes, or other forms of coercion to influence my behaviour or choices	1	2	3	4	5	N/A
14.	Staff at this agency encourage me to take risks and try new things	1	2	3	4	5	N/A
15.	I am/can be involved with facilitating staff trainings and education programs at this agency	1	2	3	4	5	N/A
16.	Staff are knowledgeable about special interest groups and activities in the community	1	2	3	4	5	N/A
18.	This agency actively attempts to link me with other persons in recovery who can serve as role models or mentors by making referrals to self-help, peer support, or consumer advocacy groups or programs	1	2	3	4	5	N/A
20.	The achievement of my goals is formally acknowledged and celebrated by the agency	1	2	3	4	5	N/A
21.	I am/can be routinely involved in the evaluation of the agency's programs, services, and service providers	1	2	3	4	5	N/A
22.	Staff use a language of recovery (i.e., hope, high expectations, respect) in everyday conversations	1	2	3	4	5	N/A
25.	Staff actively assist me with the development of career and life goals that go beyond symptom management and stabilization	1	2	3	4	5	N/A
27.	I am/can be a regular member of agency advisory boards and management meetings	1	2	3	4	5	N/A
29.	Staff routinely assist me in the pursuit of my educational and/or employment goals	1	2	3	4	5	N/A
31.	Agency staff actively help me become involved with activities that give back to my community (i.e., volunteering, community services, neighbourhood watch/cleanup)	1	2	3	4	5	N/A
33.	The role of agency staff is to assist me, and other people in recovery with fulfilling my individually-defined goals and aspirations	1	2	3	4	5	N/A
35.	The development of my leisure interests and hobbies is a primary focus of my services	1	2	3	4	5	N/A
36.	Agency staff believe that I can recover and make my own treatment and life choices	1	2	3	4	5	N/A

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Appendix K

Appendix K. Other Stakeholders Interview Tool

Other Stakeholder Interviews

1. How would you describe your organisation?

2. How would you describe the role of (Service Provider)?

3. Has your organisation worked with (Service Provider) in meeting client needs prior to the Recovery program?

   If so what has the interaction involved?

4. How many of (Service Provider)'s clients have been supported by your organisation?

5. Briefly describe what assistance your organisation has provided to these clients?

6. Have the clients' needs and concerns been as you expected?

7. How do you and (Service Provider) communicate about meeting clients' needs?

8. What are the challenges associated with meeting these clients' needs?

9. Is the (Program name) working well for these clients? If so, in what way?

10. Could the (Program name) be enhanced in some way? If so, in what way?

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Appendix L

Appendix L. Department of Communities Interview Tool

Department of Communities – Community Mental Health

1. Which client groups are intended to be assisted by each of:
    - Resident Recovery Program?
    - Transition from Correctional Facilities Program?
    - Transitional Recovery Program?
2. Have the models of implementation for each of the three program streams been as you envisaged? If they have shifted from what was intended, how and why?
3. What are the expectations of service providers in each of:
    - Resident Recovery Program?
    - Transition from Correctional Facilities Program?
    - Transitional Recovery Program?
4. Have these changed since the inception of the three transition programs?
5. What are the challenges in establishing these programs?
6. Is the intended client group for each of the programs being assisted or is it a broader/narrower group than envisaged? If so why?
7. Would additional resources make a difference, if so what would they include?
8. What is the difference between these three transition programs and the Housing and Support Program?
9. Where would you like to see each of the program streams going in the future?
10. Are there opportunities for partnerships between these programs and programs funded by other sections of this department or other departments?

Post initial evaluation findings

11. What are your reflections on the evaluation findings? Are you surprised, if so in relation to what aspects?
12. What does this suggest about where the programs need to go from here?

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Appendix M

Appendix M. Queensland Health Mental Health Interview Tool

Queensland Health Community Mental Health services / Prison Mental Health Services - Interview/Focus Group schedule

Queensland Health Community Mental Health services

Role

1. How would you describe the role of the Service Provider)?

Referral process

1. Is the referral process effective?
    a. Clarity around criteria for entry
    b. Quantity and appropriateness of information sought
    c. Timeliness of response
    d. Communication about needs of person referred
    e. Adequacy of explanation around decisions not to accept referrals

2. How many clients have referred in the past year?

Ongoing working relationship

1. How effective is the working relationship around those clients that you continue to be involved with? What makes it effective? / if not, why isn't it as effective as it ought to be?

2. What are the challenges associated with meeting the clients' needs?

3. Does the program appear to be meeting the needs of clients? What areas of clients' lives in particular appear to benefit from involvement in the program?

4. Are you seeing clients of the program reducing in their need for support by the Queensland Health Community Mental Health services?

5. What options were available prior to this program?

6. Does this appear to be the best model for meeting clients' needs? Is there anything that could make it more effective or assist with better meeting clients' needs? Is there an alternative?

Other options for MH support in the community

1. What are the other options for supporting people's mental health issues in this community and how accessible, available are they?

Appendix M. Queensland Health Mental Health Interview Tool

Prison Mental Health Services

Role

1. How would you describe the role of the Service Provider?

Referral process

1. Is the referral process effective?
    a. Clarity around criteria for entry
    b. Quantity and appropriateness of information sought
    c. Timeliness of response
    d. Communication about needs of person referred
    e. Adequacy of explanation around decisions not to accept referrals

2. Are clients being picked up by the Service Provider 2 weeks prior to leaving the correctional facilities?

3. How many clients have you referred in the past year?

Program effectiveness

1. Are you seeing clients of the program returning to correctional facilities?

2. Does this appear to be the best model for meeting clients' needs? Is there anything that could make it more effective or assist with better meeting clients' needs? Is there an alternative?

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Appendix N

Participant Information and Consent Form

Existing clients – Consent to Interview

[Insert name of service provider]

Project Title: *Evaluation of Community Mental Health Transition to Recovery Programs*

Principal Researchers:	Mr Peter Orchard Associate Professor Eóin Killackey
Associate Researchers:	Ms Rossi Lyons Ms Judy Addison Ms Jessica Small Ms Tess Lethborg

1. Introduction

Australian Healthcare Associates (AHA) would like to invite you to take part in this evaluation of Community Mental Health Transition to Recovery Programs. This form provides information about the evaluation and what is involved, so that you can decide if you want to take part.

Please read this information carefully. If you have any questions or would like more information about the project, please contact Peter Orchard or Judy Addison (Ph: 1300 788 667).

The Department of Communities has appointed AHA to conduct an evaluation of Community Mental Health Transition to Recovery Programs. These programs are the Transitional Recovery Program, Resident Recovery Program and the Transition from Correctional Facilities Program.

The three Transition to Recovery programs are designed to assist people with a mental illness to achieve a range of outcomes that will assist in their recovery journey.

These programs have not been funded by the Department before, so they would like to see if the programs are helping people's recovery from mental illness, in the best possible way. AHA's job as the evaluator, is to look at relevant data and then talk to people that use the programs, those that provide the programs, and other relevant services, to see what is working and what could be improved.

2. What does participation in this project involve?

AHA would like to hear about your experience of the Recovery program at [insert service provider name]. We are seeking clients from across the three Transition to Recovery programs who are happy to participate in a 45-minute interview. You will be asked to talk about how different parts of your life were before commencing with the Recovery Program compared to now. You will also be asked a short survey about the way that the Recovery program is provided.

We will agree a convenient time to meet at [insert service provider name]. If you would like to participate and will require assistance (such as an interpreter), we will be happy to make the necessary arrangements. You may also involve a support person in the interview if you wish.

3. What are the possible benefits?

You may or may not directly benefit from your involvement in this project. However many individuals appreciate having an opportunity to have their opinion about the services they receive heard and acknowledged. Also what you say about the program can help to make a difference to the way the program works in the future.

4. What are the possible risks?

There should not be any negative reactions to your involvement in this project. However if for some reason you feel anxious or upset at any time during the survey, please tell the person from [insert name of provider] asking you the questions.

5. Do I have to take part in this project?

AHA welcomes your involvement in this project, but your participation is voluntary. You do not have to take part. You are also free to withdraw at any time throughout this project.

If you decide to withdraw, please notify a member of the AHA project team. They will tell you about any special requirements linked to withdrawing. AHA would like to keep the information about you that has already been collected. This is to help them make sure that the results of the research can be measured properly. However, if you do not want AHA to do this, then it is important to tell us before you withdraw from the project.

Your decision whether to take part, or to withdraw, will not affect your relationship with the AHA project team, [Insert service provider name], the Department of Communities or Queensland Health.

6. What will happen to information about me?

During the interview, the AHA interviewers will take notes and provide you with a short survey to complete. These notes will remain confidential and will only be used for this project. All documents related to this project will be stored securely in the AHA office in a locked filing cabinet and password protected computer.

No-one apart from the project team will have access to this information. We will be combining the information from all interviews, so no reports or presentations related to this evaluation will identify you in any way. The information held by AHA will only be disclosed with your permission, except as required by law.

On completion of the project, the data will be securely stored by AHA for seven years. Following this period the data will be deleted from the computer system and any paper records will be shredded by AHA. AHA and Department of Communities have no future plans for the use of this data and it will not be part of an ongoing databank.

7. Can I access the information kept about me?

Consistent with relevant Australian and Queensland laws, you have the right to access the information collected and stored by the AHA team about you. Please contact one of the AHA project team if you would like to access your information.

8. Is this project approved?

This project has been approved by a Human Research Ethics Committee of Queensland Health and will be carried out according to the *National Statement on Human Research.*

9. Who can I contact?

The person you may need to contact will depend on the nature of your query. Therefore, please note the following:

- **For help with your mental health**

Speak to your Recovery Program support worker or local mental health service or telephone Lifeline on 13 11 14

- **For further information about the project:**

If you want any further information concerning this project or if you have any concerns that may be related to your involvement in the project, you can contact the following people:

Name: ***Peter Orchard***
Role: Project Manager, Australian Healthcare Associates

Name: ***Judy Addison***
Role: Senior Consultant, Australian Healthcare Associates

Name: ***Jessica Small***
Role: Consultant, Australian Healthcare Associates

Telephone: 1300 788 667 (cost of a local call) or (03) 9663 1950.

Evaluation of Community Mental Health Transition to Recovery Programs

Existing Clients

Consent Form - Participation in an interview

I have read, or have had this document read to me in a language that I understand. I understand what my involvement in the project will be.

I have had an opportunity to ask questions and I am satisfied with the answers I have received.

I freely consent to:

- participating in an interview, as described, about my experiences before and since participating in the Recovery Program at [Insert name of service provider]
- completing a short survey about the Recovery program at [Insert name of service provider], as part of the interview.

I understand that I will be given a signed copy of this document to keep.

Name (printed): ……..

Signature: …… Date: …….

Evaluation of Community Mental Health Transition to Recovery Programs

Consent Form – to participate in an interview

Note: *Only to be completed once AHA has discussed participation in an interview with client and client has decided to participate in the interview.*

I have read, or have had this document read to me in a language that I understand. I understand what my involvement in the project will be.

I have had an opportunity to ask questions and I am satisfied with the answers I have received.

I understand that my consent is only for the purposes of this project and will not be used for any further research.

I freely agree to participate in this research project, as described.

I consent to participating in an interview with AHA to discuss my experiences with the Recovery Program at [insert service provider name]

I understand that I will be given a signed copy of this document to keep.

Name (printed): ……

Signature: …… Date: …….

Office use only

Declaration by researcher*: I have given a verbal explanation of the project, its procedures and risks and I believe that the participant has understood that explanation.

AHA researcher's name (printed): ……

Signature: …… Date: …….

Note: All parties signing the consent section must date their own signature

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Appendix O

Appendix O: TTR Program Service Models

1.1 Transition from Correctional Facilities Program

1.1.1 Transition from Corrections: RFQ

Context

Richmond Fellowship Queensland (RFQ) is a specialist provider of psychiatric disability support and community rehabilitation services for people with moderate to severe mental illness. At the time of interview (August/September 2011), their Transition from Correctional Facilities program had been established for approximately four years. Like all the services across their organisation, the Transition from Correctional Facilities program had adopted a recovery orientation. RFQ is also involved in new and ongoing research with tertiary institutions, with the aim of supporting staff to use evidence-based skills with consumers.[1]

Mode of delivery pre-release

A team leader and five support workers made up the RFQ team. RFQ established ongoing collaboration with PMHS from program inception. Each of the six prisons of the region[2] had its own Transitions Coordination team and RFQ needed to establish relationships with each team.

Both RFQ and the Department of Communities emphasised the ongoing work required by RFQ to keep the pre and post release support stakeholders working cooperatively. For example, stakeholder engagement among pre-release stakeholders in the establishment phase saw:

- RFQ and PMHS collaborate on a trial of the first referral/intake form.
- RFQ adopt a case coordination role among emergency departments, district mental health services, police, Disability Services, Correctional Services, and so on.
- Trials to determine which part of PMHS made the referrals to RFQ across each prison (i.e. the Transitions Coordination team of each prison).

The schedule of meetings between RFQ, PMHS and correctional staff was less intense than in the establishment phase. The focus remained on bridging the gap between clinical and non-clinical staff involved in the program. Success of the model in this regard was reported to be variable across districts, but overall collaboration between RFQ and PMHS was consistently achieved by August/September 2011 – RFQ measured success here in terms of, “almost all referrals are appropriate”.

Mode of delivery post-release

Fostering networks, linkages and collaboration amongst stakeholders in the post release stage was ongoing. This was due to the large catchment area in which RFQ operates, the number of community support services needed by clients plus the requirement to work with both parole and mental health services. Staff and management both reported that their consumers’ double stigma of mental ill health

[1] RFQ advised AHA at consultation that the Transition from Correctional Facilities program forms part of RFQ’s engagement with Wollongong University and that University’s Collaborative Recovery Model.

[2] RFQ powerpoint presentation, provided to AHA in February 2011, noted the following Correctional Centres: Brisbane, Brisbane Women’s, Wolston, Woodford, Borallion and Arthur Gorrie.

and a prison background was a barrier which necessitated added effort by RFQ in engaging appropriate community supports and links. This was a particular issue with housing providers. RFQ reported that interaction with consumers with anti-social Personality Disorder diagnoses and or histories of violence was often resisted by local mental health service and AOD providers alike.

Examples of engagement strategies used by RFQ with stakeholders included: negotiating MOUs with mental health and AOD organisations, building relationships with housing providers or ex-prisoner support services, providing informal education to address the double stigma, adopting an advocacy role for consumers, allocating financial resources for emergency accommodation, networking with other community agencies or developing Day of Release activities for consumers. Also, sometimes forensic mental health would arrange the mental health follow up in one of the eleven Health Districts the RFQ area covers, if the consumer had stable accommodation.

Duration of Support

The original service model outlined a minimum of two weeks pre-release support by the NGO, however RFQ was often informed at the last minute. Nevertheless, PMHS did tend to work with consumers for up to three months before release, and the good communication established between RFQ and PMHS allowed handover of necessary information to occur. RFQ also kept PMHS informed of consumer progress post release, and this was relevant as at least 12% of consumers were frequent users of the program.[3][4]

The time limit of six months of support post-release was generally adhered to. Staff reported the transient nature of the consumer group meant all available services were not always taken up, or consumers required an admission for acute mental health issues during the six months.

1.1.2 Transition from Corrections: SOLAS

Context

SOLAS is a Townsville based organisation which works with people who live with mental illness in North Queensland. The Transition from Correctional Facilities program had been established for two years in August/September 2011. SOLAS worked in a regionally based interagency network consortium which chose SOLAS as the most suitable organisation to establish this program, as SOLAS had adopted a recovery focus since 1995.

Mode of delivery pre-release

A team leader and five support workers made up the team, with support from an operations manager, services director and CEO.

Like RFQ, SOLAS had ongoing work to keep the program's pre release support stakeholders working cooperatively. This challenge intensified as the program took on a wider catchment area and a new women's prison in mid – late 2011.

[3] RFQ advised AHA at consultation that they had trended data kept on referrals to the program, including numbers of people referred more than once.

[4] RFQ powerpoint presentation, provided to AHA in February 2011, noted that of 395 people through the program, 46 people, or 12%, had been referred more than once.

Initial difficulties engaging PMHS sufficiently to receive referrals to the program proved a major stumbling block. A very low average of 1.4 referrals per month was received, and many of these included insufficient information on consumers. Despite trial of a number of strategies, referrals did not flow until an internal change in correctional services allowed PMHS clinicians and NGO non-clinical staff to begin working together.

A reference group for the program was then established. It comprised Queensland Health/ PMHS, Probation and Parole, Correctional Services and Prisoner's Aid. The group implemented a process whereby SOLAS' consortium member organisations flagged potential program consumers to Corrections at intake stage, and broadened which clinicians within PMHS could make referrals. The group also improved referral information by ensuring mental health status and cultural safety assessment information was included (67% of the prison population in the area were Aboriginal). Regular, productive meetings between clinical and non-clinical program stakeholders were set up to manage pre-release issues.

Mode of delivery post-release

In the post release phase, community mental health service providers were not providing clinical management to Transition from Correctional Facilities consumers. Instead, forensic mental health outreach service could sometimes follow through with post release clients for six weeks, or SOLAS utilised GPs, the Mental Health Nurse Incentive Program or psychologists.

Community support linkages were in place by the end of 2011. Peer support workers and short term accommodation pathways were both reported as of particular success. Access to long term housing was cited as the major challenge.

Overall SOLAS found the original geographic area they were to cover too large. This meant an uneven service delivery, with consumers in smaller communities receiving a less direct service. SOLAS had addressed this via use of the Personal Helpers and Mentor Support (PHaMS) program in outer regions and through design of a community development project, which was still unfolding in August/September 2011. This aimed to improve mental health service delivery to individuals in small communities

Duration of support

Like RFQ, referral did not always happen in time for a pre-release plan to be negotiated. SOLAS also flagged concern that the Queensland Government's new Growing Stronger Initiative[5] would, in the future, slow down the referral process and absorb planning time (under this Initiative all potential disability consumers were to be triaged through a 1300 number and undergo a generic assessment process before becoming eligible for services).[6]

[5] The QLD Government's reform *Growing Stronger: Investing in a better disability service system*, came into effect in July 2011. Its three main improvements encompassed: a new way for prioritising requests for support; a process of review to ensure that the services and support people receive continues to meet their needs; changes to service provider funding. Source: The QLD Government Department Communities, Child Safety and Disability Services Accessed 27th August 2012 http://www.communities.qld.gov.au/disability/key-projects/growing-stronger-investing-in-a-better-disability-service-system

[6] Ibid. http://www.communities.qld.gov.au/disability/key-projects/growing-stronger-investing-in-a-better-disability-service-system

The time limit of six months of support post-release is generally adhered to, but SOLAS staff found this "is way too short", as their consumers take "a long time to engage". SOLAS did have the option of referring on exiting consumers to other SOLAS programs, including peer supports.

1.2 Transitional Recovery Program

1.2.1 Transitional Recovery Program: FSG

Context

FSG is a Queensland based organisation offering a wide range of mental health, housing, family, carer, children's and disability services. The Transitional Recovery program had been in operation for approximately two years in August/September 2011. The Recovery philosophy was built into the program's staffing establishment through nine days of recovery-specific training. This training was initially funded by the Department as part of the 2007-2008 Queensland Government budget allocation to the TTR Initiative. Training was provided by Helen Glover *enLightened Consultants*[7].

Mode of Delivery and recommendations

A team leader and six support workers made up the team. The Reference Group, which included Queensland Health and Housing representatives, oversaw the development of an entry and assessment process and a written agreement outlining referral and entry processes between FSG and Queensland Health. The process included consumers formally applying to join the program, and all applications being discussed by Reference Group members at regular panel meetings. When necessary, the Department joined panel meetings.

FSG describes the process of establishing the referral process with Queensland Health as "hard won", because not all mental health clinicians they encountered valued the NGO community mental health sector role in the service system. It was for this reason that FSG accessed the service of Helen Glover to assist in forging the partnership on recovery terms. Another feature of the entry process, also as a result of Helen Glover's intervention, was setting written expectations with consumers, including an application form, including accommodation 'rules', the time limit of 12 months of intensive support, the extent of practical supports needed such as bond money, furniture and bed linen, or how preparation for independence commenced when consumers joined the program.

The requirement for each consumer to have a clinical community mental health case manager was maintained. Staff reported at August/September 2011 that following "a lot of education" by FSG about the program, case managers were more likely to stay in touch with FSG during case management, and appropriate referrals were becoming the norm.

Service delivery

The purchase and rental of properties to set up the first stage of 24 hour psychosocial support in a group accommodation based environment, occurred collaboratively and as planned between FSG, the Department of Communities and Department of Housing. Department of Housing later offered an additional block of housing units as transitional housing stock, to assist in provision of the second stage of the program, when psychosocial support is pulled back and consumers live more independently. The housing units were provided to ensure consumer throughput was not blocked by lack of accommodation at the second stage. Consumers could also access private rental.

[7] AHA consultations with Department of Communities personnel

Duration of support

Length and duration of support was in alignment with the original service model guidelines, although in three instances consumers had unplanned crisis readmissions to the acute health sector. All consumers however have completed and exited the program.

FSG flagged concern about the Queensland Government's Growing Stronger Initiative,[8] and about its deficit-based assessment method undermining the Transitional Recovery program's strengths-based assessment process.[9] FSG also predicted that those with mental health needs in the community would find they had less access to supports than before the introduction of the Growing Stronger Initiative.

1.2.2 Transitional Recovery Program: PRA

Context

PRA is a NSW based psychiatric disability services organisation. The Transitional Recovery program had been in operation in Caboolture/Redcliffe for approximately one year in August/September 2011. The organisation was very experienced[10] in incorporating the recovery philosophy into their long standing psychosocial rehabilitation programs, and particularly understood the importance of developing effective relationships with clinical mental health referrers. The program coordinator was undertaking Helen Glover leadership training and recovery principles were embedded in the team's supervision processes.

Mode of delivery and recommendations

A coordinator, two team leaders and nine support workers made up the two teams, which worked in housing located in Caboolture and Redcliffe respectively. Sydney based management provide the teams with support on final decisions about who is accepted into the program.

PRA established the program in two key ways:

- through developing a partnership with FSG to "learn from their strengths", including accessing FSG program documentation
- by delaying staff recruitment until the key relationships with all local stakeholders, including Queensland Health and Housing Services, were established in writing as agreements, and mutually understood. The Department was actively involved in supporting this process and promoting a recovery-based partnership between clinical and non-clinical service providers.

[8] Ibid.

[9] The Australian Social Inclusion Board was established in 2008 to advise the Commonwealth Government on ways to achieve better outcomes for the most disadvantaged in the community. They note that: "Strengths-based approaches are an organising principle for theories and strategies which focus on the untapped gifts, positive attributes and underdeveloped capabilities of people who have been in some way compromised in their abilities or are seeking help for problems. They are an alternative to problem- or deficit-based approaches, which are characterised by negative labelling, a focus on what is 'wrong' with a person and practitioner-driven interventions. Strengths-based approaches actively find, direct and amplify a client's capabilities and potential for positive functioning". Source: http://www.socialinclusion.gov.au/australian-social-inclusion-board Accessed 28th August 2012

[10] The Housing and Accommodation Support Initiative (HASI) is well established in New South Wales (NSW), Australia. It is a partnership program funded by the NSW Government which ensures stable housing is linked to specialist support for people with mental illness. Source: http://www.health.nsw.gov.au/pubs/2007/hasi_intiative.html Accessed 28th August 2012. PRA had and has some years experience managing and implementing a wide variety of HASI programs in NSW – HASI Aged, HASI High Needs, HASI Low Needs, etc.

The PRA entry and assessment process was subsequently implemented in a very similar way to FSG's program, with a stakeholder Reference Group and emphasis on the client's motivation and willingness to commit to a sustained recovery. All referrals were sourced through Queensland Health and when a vacancy in the PRA program was flagged, an agreed priority process was implemented.

Service delivery

Negotiation with clinical mental health services was ongoing as shared consumer support practices were not yet consistent. On the one hand, PRA had just negotiated that PRA staff participate in clinical case managers' ninety day reviews of consumers. On the other hand, staff reported that it could sometimes take two months to access a consumer's case manager.

Duration of support

Set up of the houses which provided the environment for the intensive support in the first stage of the program was straightforward. Establishing pathways for consumers to move into the outreach support component of the program took longer. Lack of housing stock in the region was a major program tension such that staff worked intensively with consumers to assist them to find accommodation beyond the 12 month limit, or to develop lifestyle skills to live independently. Partnership agreements with other NGOs, housing providers and regional networks were in place. The lack of regional housing availability issue also meant that PRA staff continued to pro-actively develop new relationships and pathways with housing and other community support providers.

Despite this major pressure on the model, combined with the tendency for consumers to "get comfortable with the program", implementation by PRA had met the service model requirements on duration and intensity of support.

1.3 Resident Recovery Program

1.3.1 Resident Recovery: Nextt Health

Context

Nextt Health is a national organisation providing a range of non-clinical, community or home based aged care and mental health services in Victoria, NSW and Queensland. The Resident Recovery program had been established for approximately two and a half years in August/September 2011. By this stage the recovery philosophy was incorporated into all systems of consumer care. For example, the service had adapted a Quality of Life assessment and planning tool, for use by both consumer and support worker, into the Individual Recovery Plans which are developed with each consumer.

Mode of Delivery

Two program coordinators were supported by a program manager and an operations manager. Four support workers and one community development worker made up the team. Nextt Health also established a Reference Group from the program's inception, with representatives from Queensland Health, boarding houses, Division of General Practice and Government Disability Services.

Eligibility and Referrals

Both Nextt Health and the Department reported that the original requirement for consumers to have a clinical case manager had been "broadened". "As long as there is some clinical involvement, they can be eligible"; although Nextt Health reported the regular instance of case managers exiting consumers but failing to inform Nextt Health. In practice, consumers without a clinical case manager were linked or re-linked to a General Practitioner (GP) by either Queensland Health or Nextt Health. By August/September 2011, referrals were accepted from GPs, hostel managers or consumers, as well as the local mental health service, with Nextt Health reporting, "we can usually work with most referrals".

Nextt Health reported that insufficient information was sometimes provided by the referrer or the referrer failed to explain to the potential consumer that their willing participation was necessary to join the program. Nextt Health had addressed the issue of inappropriate referrals since the program's inception by regularly explaining the role of their service to their Queensland Health referrers; this explanation emphasised that referral to the Resident Recovery program requires ongoing clinical involvement and communication from the clinical case manager with Nextt Health, about the consumer. The requirement for individuals to actively participate in the support program continued to be strongly upheld by Nextt Health with referrers, potential consumers and consumers.

Duration of support

Nextt Health reported having learnt to focus on the time limited nature of support on offer at the very first meeting with consumers, in order to keep to the service model's requirement of short to medium term support for consumers. The team had adopted, "up to 12 months" of support as their guideline. A few consumers with very complex needs had been supported beyond the 12 month limit, but it was more likely that where needs were assessed as complex, Nextt Health would negotiate providing a component of support in a shared care arrangement with referrers and consumers early in the referral process.

Service delivery

Establishment of community networks and partnerships, which underpin the Resident Recovery program capacity to support consumers to build social connection, achieve community integration and find personally meaningful relationships, had been robust. Nextt Health cited the Reference Group as a successful, ongoing means of fostering positive relationships, particularly with boarding house managers. This stakeholder group had feared loss of business from the Resident Recovery program transiting consumers to other accommodation, but through their involvement in the Reference Group became supporters of the program.

Nextt Health's community development staff position was cited as invaluable in fostering partnerships which lead to pathways for consumers; these included housing, peer support, vocational, income generation and community links. Partnerships with housing providers are of high priority and demand regular updating, but overall access to housing for consumers has been well managed.

1.3.2 *Resident Recovery: Footprints*

Context

Footprints is a Brisbane based organisation providing aged care, mental health and homelessness services. The Resident Recovery program had been established for approximately two and a half years in August/September 2011. Awareness of the recovery philosophy extended across all the Footprints programs, and the organisation's manager of mental health programs actively cultivated reflection on recovery practice among mental health program workers.

Mode of Delivery

A full staffing complement in the Resident Recovery program of one team leader and eight support workers was reached in mid 2010, once Footprints had built up program participant numbers. A unique feature of the support provided by the Resident Recovery program at Footprints at this time was the inclusion of two peer support workers as part of the implementing team. Footprints also established a Reference Group from the program's inception, with representatives drawn from Queensland Health and relevant NGOs in the region. Government Disability Services were also strongly supportive of this Group

Eligibility and Referrals

Eligibility and referral processes had rolled out in a similar way to Nextt Health. That is, as long as a consumer had "someone" suitably qualified to oversee clinical management, and the consumer lived in or was to be discharged to marginalised circumstances, they were deemed eligible for the Footprints program. While referrals were accepted as planned from the local mental health service, these made up only 40% of referrals. An additional 30% were received from hostel managers and 30% from a combination of other NGOs and the consumers themselves.

Staff and management reported using persistence to explain the program to clinical staff of mental health services, in order to achieve both sufficient and appropriate referrals. In 2009 the team addressed local mental health service team meetings weekly, but this had decreased to bi-monthly by 2011. Staff believed that the validity of their non-clinical, community based role in the mental health service system needed both constant explanation and justification to clinical mental health service providers. As the following comments from staff indicate, staff perceived that their role had earned

some acceptance from clinical mental health service providers, and that the Resident Recovery program had become better understood:

- "Not that we have proved ourselves yet, but we have some credibility".
- "It remains hit and miss sometimes with their case managers, but we have established relationships between our team leaders".

Duration of support

Footprints described the length of the support they provided as often extending beyond 12 months. One reason was that consumers did not necessarily transition out of boarding house accommodation and so continued to require support, although the intensity of support provided may lessen. This was due to increasing difficulties, and competition, in accessing appropriate housing stock, particularly for those residents who struggled to maintain shared tenancies. "Once they do get appropriate accommodation, we need an additional three months to help them to maintain it".

Service delivery

The networks and partnerships which underpin the Resident Recovery program capacity to support consumers to build social connections, achieve community integration and find personally meaningful relationships, "are really well established". An additional strength was reported as consumer access to the organisation's social activities clubhouse program during and after exit from the program.

Australian
Healthcare
Associates

Appendix P

Appendix P. Case Studies

The case studies that were submitted with the final report have been removed from this version of the report, to ensure the privacy and anonymity of clients in the public domain.

Australian
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Associates

Appendix Q

Appendix Q. Staffing Profile

	Qualification 1	Qualification 2	Qualification 3	Recovery specific training	Mental health specific training	AOD specific training	Dual Diagnosis specific training	Time in this Transition Program (months)	Time in working in NGO MH programs	Time working in AOD	Time working in clinical MH	Placement in AOD	Placement in Clinical MH	COMMENTS	COMMENTS
Team Leader															
Worker 1															
Worker 2															
Worker 3															
Worker 4															
Worker 5															
Worker 6															
Worker 7															
Worker 8															
Worker 9															
Worker 10															
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