



**QCMHR**  
Queensland Centre for  
Mental Health Research

# **Adult Step Up Step Down Evaluation**

## **FINAL REPORT**



The evaluation of the Adult Step Up Step Down Program was commissioned by the Mental Health Alcohol and Other Drugs Strategy and Planning Branch (MHAODSPB), Clinical Planning and Services Strategy Division, Queensland Health and conducted by the Mental Health Evaluation Stream at the Queensland Centre for Mental Health Research (QCMHR).



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# Executive Summary

## Introduction

This report details the findings of an independent evaluation of Queensland Health's Adult Step Up Step Down (SUSD) services, undertaken by the Queensland Centre for Mental Health Research (QCMHR) from 2020 to 2023. The evaluation was commissioned by the Mental Health, Alcohol and Other Drugs Strategy and Planning Branch (MHAODSPB) to inform the future design, delivery, and sustainability of Adult Step Up Step Down services.

SUSD are short-term residential mental health programs designed to provide support for adult consumers experiencing a mental health crisis. Currently, there are five Adult SUSD services across Queensland, located in five Hospital and Health Services (HHSs), based in Cairns, Mackay, Central Queensland, Bundaberg and the Brisbane suburb of Nundah.

SUSD are designed to help consumers:

- **step up** to increased support in times of crisis, without needing to be hospitalised, or
- **step down** after discharge from an inpatient mental health facility to facilitate reintegration back into the community and prevent relapse and re-hospitalisation.

SUSD aim to prevent unnecessary hospital admissions and offer intensive, short-term treatment and support for consumers in a residential setting. The environment is less restrictive than a hospital setting, and SUSD services provide a mix of clinical, psychosocial and other support including crisis intervention and stabilisation, individual and group therapy, medication management, skills development for independent living, support for social reintegration, and connection to community-based services.

The terms of reference for the evaluation were to:

1. Review the existing Adult SUSD evaluation framework currently in operation across Queensland and work with stakeholders (including people with lived experience) to refine the framework and co-produce the evaluation methods; and
2. Co-produce an evaluation that assesses the implementation and outcomes of the state-wide SUSD model, drawing upon data from five Adult SUSD sites across Queensland.

The evaluation was governed by an Adult SUSD Evaluation Steering Group comprising stakeholders from across the delivery of SUSD in Queensland.

## Methods

To ensure the evaluation was feasible, acceptable, and met the needs of Queensland Health's MHAODSPB, the research team collaborated with multiple key stakeholders and experts throughout the course of the evaluation including lived experience co-researchers and SUSD staff.

Development of the evaluation framework was theoretically underpinned by two robust, empirically validated and widely used evaluation models: the Socioecological Model (Bronfenbrenner, 1979) and the RE-AIM framework (Glasgow, Vogt, & Boles, 1999).

The key evaluation questions that underpinned the evaluation were co-designed with members of the Steering Group and the project's lived experience co-researchers, and addressed the domains of Reach, Adoption, Implementation, Effectiveness, and Maintenance (as per the RE-AIM framework).

A mixed methods approach to data collection was then undertaken, commencing with a review of the state-wide Model of Service (MOS) documentation and Service Guidelines for each of the five SUSD sites, and incorporating the analysis of existing quantitative data, as well as the collection and analysis of primary qualitative data collected via semi-structured interviews from across all five SUSD sites in Queensland.

## Summary of Findings

### KEY TAKEAWAYS

- ❖ **Enhanced experience of mental health care:** Consumers have a positive service experience when accessing the SUSD and find it beneficial for their recovery, with many preferring SUSD over a hospital inpatient admission.
- ❖ **Improved health status and functioning:** The SUSD is helping to reduce consumers' mental health symptoms and improve their day-to-day functioning.
- ❖ **Reduced inpatient admissions:** The SUSD is helping to reduce the number of times consumers require a mental health inpatient admission.
- ❖ **Reduced ED presentations:** The SUSD is helping to reduce the number of times that consumers present to the ED for mental health care.

## Reach

- There were 2,295 unique consumers that accessed a SUSD from January 2020 to December 2023. The age distribution of consumers was similar across groups, except for fewer consumers aged 55 and older. Just over half of consumers were female (55%), with 14% identifying as Aboriginal and/or Torres Strait Islander, and 13% born overseas.
- Analysis of qualitative data suggested some groups of consumers may be less likely to be reached by the SUSD, including consumers aged 50 years and above, Culturally and Linguistically Diverse (CALD) populations and First Nations peoples.
- Interviews revealed that consumers often presented to the SUSD due to exacerbation of psychological distress, precipitated by situational crises.
- Analysis of Residential Mental Health Care Data Collection (RMHCDC) data showed that paranoid schizophrenia and borderline personality disorder were the most common mental health diagnoses for consumers entering the SUSD.

- Referral from the hospital or “stepping down” was the most common pathway into SUSD on consumers’ first visit (64%). For subsequent visits, it was 50/50 whether the consumer came from the hospital (step down) or community (step up).
- From 2020 – 2023 there was an increase in “step up” (community) referrals (32.6% to 47.4%) and a decrease in “step down” (hospital) referrals (67.4% to 52.6%).
- The evaluation identified four key factors that impact the reach of the SUSD: referral pathways into the service, consumer awareness of SUSD, referrer awareness of SUSD, and the appropriateness of referrals to SUSD. Several opportunities for improvement were identified across each domain which may serve to enhance the reach of the SUSD.

## Adoption

- Very few staff and stakeholders interviewed for the evaluation were working at the SUSD when it was first established, thus making it difficult to determine site-specific strategies that aided or inhibited service implementation. However, those interviewed reported that SUSD establishment was aided by hosting partnership days and involving staff who had previously worked in, or established, a SUSD service.
- Interviews revealed that buy-in from Hospital and Health Service (HHS) staff was initially limited across sites, but tended to improve in staff who had longer exposure to the service and understood its value.
- Service usage data showed that SUSD service episodes decreased across 2020 to 2023, consistent with decreases in admissions and provisions of service in key referring services state-wide.
- In line with the decrease in service episodes, between 2020 and 2023 the statewide occupancy of SUSD services decreased from 74.7% to 69.2%.
- Statewide data on acceptance of SUSD referrals were not available. However, interviews identified that consumers tend to have misconceptions and fears of the SUSD when referrers failed to provide accurate information to them about the service. This was a primary barrier to consumers accepting referrals. Strategies used by SUSD services to improve service uptake included brochures, assessments, and facility tours. Consumers were also inhibited from accepting SUSD referrals due to practical barriers such as family and work responsibilities that they did not feel able to delegate to others, and/or transportation issues. SUSD services were found to be providing additional support to address these barriers.
- Most consumers visited the SUSD only once, but nearly a quarter of consumers used the service more than once. Most repeat presenters visited SUSD services twice, most commonly to receive support for a subsequent crisis and avoid going to hospital. Staff and stakeholders agreed that consumers may benefit from visiting the service on multiple occasions to support recovery but emphasised that repeat presenters demonstrating a reliance on the service should be linked to other appropriate community services for long-term care.

## Implementation

- A number of variations were identified in the implementation of the SUSD model across services including HHS nursing and allied health profiles; hours of clinical coverage; location of medical teams (internal vs in reach); standard length of stay; availability of individual and group interventions; expectations of attendance at group sessions and medication management.
- The evaluation identified several factors which underpin the successful implementation of the SUSD including sufficient staffing capacity; strong HHS and NGO leadership; strong partnerships with referring teams and broader HHS; appropriate cohort mix; adequate staff training, supervision and support; appropriate facilities; and sustainable funding source. Gaps and areas for improvement were identified across several of these factors.

## Effectiveness

- The SUSD is effective at improving consumers' health status and functioning, with consumers experiencing a statistically significant reduction on their Health of the Nation Outcome Scales (HoNOS) total score from pre- to post- their SUSD stay (median change -3 for adults and -4 for older adults).
- The SUSD is effective at improving consumers' general day-to-day functioning as indicated by statistically significant reductions in the total Life Skills Profile (LSP-16) scores from pre- to post- SUSD stay (median change = -1).
- Findings indicate that SUSD may be helping to prevent inpatient admissions; those consumers with a history of inpatient admissions had a statistically significant reduction in their number of inpatient admissions (median change = -1) in the 12-month period following their first visit to the SUSD in comparison to 12 months prior. Those who previously had two or more acute admissions experienced an even greater reduction (median change = -2).
- Findings suggest that SUSD service episodes may also be helping to prevent mental health related ED presentations. Consumers with a history of ED presentations had a statistically significant reduction in mental health related ED presentations in the 12-month period following their first visit to SUSD in comparison to 12 months prior (median change = -1). Those who had previously had two or more ED admissions had an even greater reduction (median change = -2).
- Consumer satisfaction as measured by the Your Experience of Service (YES) survey indicate that approximately 90% of surveyed SUSD consumers report a positive experience.
- Interview data shows that most consumers find a SUSD stay beneficial for their recovery and report positive mental health outcomes. Consumers particularly value the care and support provided by staff and the warm and welcoming SUSD environment. Furthermore, the SUSD was the preferred option for mental health care, over a hospital inpatient admission.

## Maintenance

- SUSD services assist consumers to develop skills, knowledge and resources that are beneficial for their personal recovery and ongoing mental health management. Whilst many consumers maintain gains made at the SUSD, others could benefit from additional follow-up after exiting the service.
- SUSD services connect family and/or carers to valuable information, resources and support, that are beneficial for themselves and their loved one.
- Ongoing sustainability of the SUSD is dependent on recruitment and retention of suitably experienced and qualified staff. Maintenance of the NGO staffing profile is of particular importance due to the NGO's responsibility for 24/7 operation of the service.
- Whilst many SUSD staff reported high levels of satisfaction in their role, services have experienced periods of high turnover at various stages since being established. Turnover has been attributed to COVID-19, Queensland Health secondments, leadership challenges, and staff burnout.
- Continuous improvement of SUSD services is supported by ongoing benchmarking, networking and training activities undertaken by The Queensland Mental Health Benchmarking Unit (QMHBU), The Clinical Improvement Team (CIT), Mind Australia and Neami National.

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# Acronyms

Acronym	Definition
ACT	Acute Care Team
CCT	Community Care Team
CES	Carer Experience Survey
CIMHA	Consumer Integrated Mental Health and Addiction
COVID-19	Coronavirus Disease 2019
EDC	Emergency Data Collection
HHS(s)	Hospital and Health Service(s)
HoNOS	Health of the Nation Outcome Scale
ICD-10	International Classification of Diseases, Tenth Revision
MOS	Model of Service
MHE NMDS	Mental Health Establishments National Minimum Data Set
MHAODSPB	Mental Health, Alcohol, and Other Drugs Strategy and Planning Branch
NGO(s)	Non-Governmental Organisation(s)
QCMHR	Queensland Centre for Mental Health Research
RE-AIM	Reach, Efficacy, Adoption, Implementation and Maintenance
RMHCDC	Residential Mental Health Care Data Collection
SEIFA	Socio-Economic Indexes for Areas
SUSD	Step Up Step Down
YES	Your Experience of Service (survey)

# Glossary

Term	Definition
<b>Gatekeeper</b>	The Gatekeepers were SUSD staff members identified by each service to act as the contact person for participant recruitment of consumers and staff from each SUSD.
<b>RE-AIM Framework</b>	The RE-AIM (Reach, Effectiveness, Adoption, Implementation, Maintenance) framework provides a practical means of evaluating health interventions. This framework was developed by Glasgow, Vogt and Boles (1999).
<b>Socioecological Model</b>	The Socioecological Model is a framework put in place to understand the multifaceted levels within a society and how individuals and the environment interact within a social system. This model was developed by Bronfenbrenner (1979).
<b>Thematic Analysis</b>	Thematic analysis is an approach to qualitative data analysis that facilitates the identification and analysis of patterns or themes in a given data set. This method was devised by Braun and Clarke (2013) and updated to include reflexivity in 2021.

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# 1. Introduction

## 1.1. Evaluation background and context

Mental disorders are a leading cause of human and economic burden globally (GBD 2019 Mental Disorders Collaborators, 2022). In Australia, mental illness is estimated to cost more than \$200 billion per year (Australian Government Productivity Commission, 2020) with the most recent National Study of Mental Health and Wellbeing (Australian Bureau of Statistics, 2020-22) reporting that one in five Australians aged 16-85 years experienced a mental disorder in the previous year, and more than two in five had experienced a mental disorder during their lifetime. The most common mental disorders are anxiety disorders (17.2%), mood-affective disorders including depression and bipolar (7.5%), and substance use disorders (3.3%) (Australian Bureau of Statistics, 2020-22). Approaches to mental health care in Australia over the last 50 years have shifted away from institutionalisation in favour of community-based mental health care models (Doessel et al., 2005). The rationale for this shift stems from both the aim to more efficiently allocate public healthcare funds given the expensive nature of acute hospitalisation, and a need to advocate for the rights of people with mental illness to undertake treatment and recovery in less restrictive ways that value greater autonomy, accessibility, and maintenance of social bonds. Over the last fifteen years, stepped-care alternatives have been increasingly implemented across a spectrum of mental health care services that encompass not only acute hospitalisation and community-based care, but also sub-acute alternatives (Commonwealth of Australia, 2021).

### 1.1.1. Step Up Step Down services

SUSD services provide sub-acute treatment for people with mental illness in residential facilities which cater for 10-20 residents at any one time. These facilities aim to provide a home-like environment with a clinical and recovery-oriented focus, meaning that residents can receive clinical interventions as well as psychosocial support for their wellbeing. SUSD services are termed as such because they are designed to support people with mental health problems from two broad directions along the spectrum of care, by 1) helping those from community care settings to avoid progressing to an acute hospital inpatient admission during times of illness exacerbation (“step up”), and 2) providing a recovery environment for those leaving a mental health inpatient admission before transitioning back to community care (“step down”).

SUSD services are staffed 24 hours per day and are intended to be inclusive of a broad range of residents in terms of diagnostic and demographic characteristics. For example, in a broad examination of 19 SUSD facilities throughout Victoria, Australia, Sutherland et al. (2020) found that just over half of all residents were female, with a comparable proportion of consumers across age groups between 20 and 60, and common primary diagnoses being mood disorders, schizophrenia, and anxiety disorders. The vast majority of SUSD residents are voluntary (Sutherland et al., 2020) and many facilities have exclusionary criteria that do not allow for consumers who do not provide consent, people who present a safety risk to other residents/staff, or people without suitable stable housing outside the facility.

SUSD facilities are not intended to be long term places of residence. Most SUSD services allow for stays of 1-4 weeks to engage in recovery (with some models of service embracing a cap of 21 or 28 days). Sutherland et al. (2020) found that SUSD services in Victoria had a median length of stay of 16 days, whereas median length of stay for acute inpatient admission was 8 days. Similarly, in a North Queensland service, Heyeres et al. (2018) found the average length of stay to be 15 days. Sutherland et al. (2020) also found that length of stay varied across diagnoses,

and appeared to be longer for women, people with problems with daily living, and those with problematic substance use, or psychosis. Given that a significant driver of SUSD services is a focus on recovery, some clinicians working in these units have suggested that caps on the duration of a consumer's stay (e.g. a 21-day cap) is "anti-recovery" in practice, and that the needs of each individual consumer should determine length of stay (Tibrewal, 2015). To that end, SUSD services in Australia are based on principles of personal wellbeing and recovery, with a focus on everyday functioning, and "self-determination and living a meaningful life, with or without symptoms" (Isobel et al., 2021).

### **1.1.2. Clinical and recovery outcomes of SUSD services**

In reviewing the available evidence regarding the efficacy of SUSD facilities in Australia, the majority of studies have explored the operational profile and clinical outcomes of SUSD facilities across Victoria where they have operated since 2003 (and are known as Prevention and Recovery Centres, or PARCs) (Brophy et al., 2024; Farhall et al., 2021; Fletcher et al., 2019; Harvey et al., 2019; Hopkins et al., 2022) with a smaller number of studies having evaluated facilities in Western Australia (Coleman et al., 2023; Ngo et al., 2020), New South Wales (Isobel et al., 2021; Sly et al., 2020), and Queensland (Heyeres et al., 2018; Siskind et al., 2013).

This emerging body of research suggests that admissions to SUSD type services can be associated with improvements in clinical and recovery outcomes. For example, data from several recent studies have shown reductions in consumers' self-reported psychological distress as measured by the Kessler 10 psychological screening tool (Brophy et al., 2024; Coleman et al., 2023; Ngo et al., 2020). Significant improvements have also been observed in self-efficacy, and work and social adjustment as part of research conducted at rural and urban SUSDs in WA (Coleman et al., 2023; Ngo et al., 2020). Additionally, admissions to PARCs in Victoria have been associated with positive outcomes in personal recovery, quality of life, and well-being (Brophy et al., 2024) and improvements in clinician-rated symptoms, behavioural and social difficulties as measured by the Health of the Nation Outcome Scales (HoNOS) (Farhall et al., 2021; Lee et al., 2014).

While most research to date has focused on examining changes in outcomes from SUSD entry to exit, Brophy et al. (2024) recently conducted a longitudinal study examining the trajectory of outcomes over a 12-month follow-up period and found that improvements to psychological distress were sustained over 12-months post-exit. However, gains made in personal recovery, quality of life and well-being tended to plateau in the long term.

## **1.2. Evaluation Terms of Reference**

Queensland Health's Mental Health, Alcohol and Other Drugs Strategy and Planning Branch (MHAODSPB) commissioned the Queensland Centre for Mental Health Research (QCMHR) to:

- 1.** Review the existing Adult SUSD evaluation framework currently in operation across Queensland and work with stakeholders (including people with lived experience) to refine the framework and co-produce the evaluation methods.
- 2.** Co-produce an evaluation that assesses the implementation and outcomes of the state-wide SUSD model, drawing upon data from five Adult SUSD sites across Queensland.

The rationale for undertaking this evaluation was to inform the future design, delivery, and sustainability of these services.

# 2. Queensland Health's Adult Step Up Step Down Model of Service

## 2.1. Overview

Adult SUSD services in Queensland are bed-based (sub-acute) mental health services for people aged 18 to 64 years that operate in a rehabilitative and residential environment in the community, 24 hours per day, 7 days a week. Adult SUSD services operate as an integrated model with the HHSs providing clinical services and non-government organisations (NGOs) providing non-clinical support services. SUSD services aim to:

- a) Prevent further deterioration of a person's mental health and associated disability, and so reduce the likelihood of admission to an acute mental health inpatient unit (step up), and
- b) Enable timely discharge from acute mental health inpatient units through provision of an intensive safe and supportive sub-acute residential community program (step down).

*Connecting Care to Recovery 2016–2021: A plan for Queensland's state funded mental health, alcohol and other drug services* outlined the Queensland Government's plan to expand mental health care and treatment, rehabilitation, and support delivered in the community. A key action from this plan was to expand the range of service models across the care continuum, with a focus on person-centred and recovery-oriented service models. From this action, recurrent operational funding was provided for five Adult SUSD services in Queensland (see Table 1). Additional SUSDs are planned under *Better Care Together: A plan for Queensland's state-funded mental health, alcohol and other drug services to 2027*, subject to a committed capital funding source.

## 2.2. Existing services

Currently, there are five Adult SUSD services across Queensland across five HHSs, as outlined in Table 1.

**Table 1 | Adult SUSD services in Queensland by HHS and NGO**

HHS	Name of SUSD service	Affiliated NGO	Service commencement
Cairns and Hinterland	Adult Step Up Step Down - Cairns	Mind Australia	May 2015
Mackay	Step Up Step Down - Mackay	Mind Australia	July 2017
Central Queensland	Step Up Step Down - Gladstone	Mind Australia	November 2018
Wide Bay	Step Up Step Down - Bundaberg	Mind Australia	November 2018
Metro North	Nundah House	Neami National	March 2018

## 2.3. Service aims and objectives

### Aims

- Improve the mental health outcomes of people with severe mental illness who become acutely unwell.
- Prevent avoidable admissions to acute units and avoidable re-admissions following an acute episode.

### Objectives

- Provide a service option for people with severe mental illness, both in the inpatient setting and in the community, whose treatment and recovery is better suited to intensive, short-term treatment and support in a residential setting.
- Provide a mix of clinical, psychosocial and other support that:
  - enables gains from the period in the inpatient setting to be strengthened,
  - consolidates community transition and treatment plans,
  - minimises the trauma and disruption for consumers and carers that may arise from an acute episode of mental health concerns.
- Supplement crisis intervention and enhance access to inpatient services through the prevention of unnecessary inpatient admissions and the provision of an intensively supported early discharge alternative.

### Functions contribute to:

- Reducing unplanned patient admissions and re-admissions.
- Decreasing stigma and discrimination within the local community and reducing barriers to social inclusion.
- Building stronger links with consumer communities and families and fostering consumer participation in treatment and use least restrictive treatment practices.
- Supporting consumers and their families/carers across the broad continuum of care, including facilitating smooth transition to, and from, other services.

### Provide:

- A range of assessment, treatment and rehabilitation programs, aimed at treating mental illness, reducing emotional distress, and promoting functionality within the community.
- Phased treatment programs that are developed in partnership with consumers and, where appropriate, their family and/or carers.
- Access to Aboriginal and Torres Strait Islander and transcultural support services as required.
- Negotiated assertive discharge planning to integrate consumers back into their community of choice, including appropriate local mental health treatment, education or vocational services, functional and living skill development.

## 2.4. Eligibility for referral to SUSD

Adult SUSD services in Queensland are for people aged 18 - 64 years who have recently experienced, or who are at increased risk of experiencing, an acute episode of mental illness or further deterioration of mental health.

Specifically, Adult SUSD is aimed at people who no longer require acute inpatient level clinical intervention and treatment but would benefit from short-term, intensive treatment and support in a residential setting after discharge from an acute inpatient admission (step down); and people who are living in the community and require short-term, intensive treatment and support in a residential setting to prevent the risk of further deterioration, relapse and possible acute inpatient admission (step up).

People who access the SUSD services will present with a range of mental health problems and/or disorders at the moderate to severe end of the spectrum.

## 2.5. Access pathways

Access to the Adult SUSD is voluntary and referrals can be received from a range of clinical sources including community mental health services, acute care teams, acute mental health inpatient units, consultation liaison and private psychiatrists. The decision to admit to a SUSD is made by the service intake coordinator in consultation with the consultant psychiatrist. All access to the SUSD services is considered from the needs perspective of the person experiencing the acute episode of mental health or mental health deterioration. Adult SUSD services operate 24 hours a day, 7 days a week.

## 2.6. SUSD workforce

A key element of the Adult SUSD service is the collaboration between clinical services provided by HHSs alongside non-clinical support services provided by NGOs. This partnership enables the blend of knowledge and skills that is required to deliver a recovery focused model encompassing both clinical and psychosocial aspects of treatment and care. A clinical lead and a multi-disciplinary team including nurses and allied health staff provide clinical coverage between 8am and 10pm, 7 days a week. The NGO community mental health worker staffing profile is comprised of a service manager, community mental health workers, peer workers and other specialist roles as required, i.e. Aboriginal and Torres Strait Islander mental health workers and/or family workers. The NGO non-clinical staff provide 24-hour service coverage. Additionally, the SUSD service is supported by administrative officers and other HHS staff as appropriate to assist with the day-to-day operations of the unit. The roles and responsibilities of each provider are negotiated and clearly established to ensure best practice (see Table 2).

*Table 2 | Roles and responsibilities of SUSD staff*

Roles and responsibilities of SUSD staff	
Shared	<ul style="list-style-type: none"><li>• management of the entry and discharge of consumers in and out of the SUSD</li><li>• provision of consumer focused, recovery-oriented environment and treatment planning</li><li>• development of individual recovery-oriented care plans</li><li>• provision of alcohol, tobacco and other drug interventions, including motivational interviewing</li><li>• maintenance of a safe environment, including psychological, physical and sexual safety</li><li>• weekly clinical reviews and ad hoc clinical meetings</li><li>• routine monitoring and evaluation of consumer progress</li></ul>

	<ul style="list-style-type: none"> <li>• routine collection of data, record keeping and documentation</li> <li>• provision of education, information and support services to the consumer's family and/or carer/s</li> </ul>
<b>NGO Staff</b>	<ul style="list-style-type: none"> <li>• provision of 24-hour care and supervision of the consumer</li> <li>• day-to-day program structure including facilitating groups and community linkages</li> <li>• psychosocial rehabilitation and assistance with activities of daily living</li> <li>• provision of psychoeducation, peer support and advocacy to consumers, family and/or carers and significant others</li> <li>• provision of support of educational and vocational needs</li> </ul>
<b>Clinical Staff</b>	<ul style="list-style-type: none"> <li>• assessments and formulations using a bio-psychosocial, developmental framework</li> <li>• mental state and risk assessments including risk management plans and management of mental health crises</li> <li>• delivery of clinical interventions including medication management, supportive psychotherapy and psychoeducation with the consumer and their families, carers and significant others</li> </ul>

## 2.7. La Trobe evaluation framework

In July 2018, La Trobe University was engaged by Mind Australia, Neami National, and the Mental Health Alcohol and Other Drugs Branch at Queensland Health to develop and trial an evaluation framework for SUSD services in Queensland (Lewis & Ratnaike, 2019). The authors noted that the framework was designed for ongoing reflection and analysis to enable service improvement (as opposed to an independent one-off service evaluation), with recommendations provided at both the state and service level for Queensland Health and NGO partners. The La Trobe evaluation framework informed the current evaluation questions, methodology, and program logic (see section 3.2).

# 3. Method

## 3.1. Stakeholder consultation

To ensure the evaluation was feasible, acceptable, and met the needs of Queensland Health's MHAODSPB, the research team collaborated with several key stakeholders and experts throughout the course of the evaluation.

### 3.1.1. Adult SUSD Evaluation Steering Group

The research team convened a Steering Group of individuals from stakeholder groups across the delivery of SUSD in Queensland (see Appendix A for Steering Group membership). The role of the SUSD Evaluation Steering Group was to provide guidance to the research team as they undertook the evaluation. Members were asked to use their expertise and experience within the space of SUSD and across wider mental health services in Queensland to inform, guide, reflect, and enhance the evaluation's design, methodology (feasibility and acceptability), data collection, and findings. The SUSD Evaluation Steering Group members attended and actively participated in Steering Group meetings on a regular basis for the duration of the project.

### 3.1.2. Lived experience co-researchers

Three co-researchers with lived experience of mental illness and/or caring for someone with a lived experience of mental illness contributed to the co-design of the evaluation. Specifically, these co-researchers assisted with the development of the evaluation framework and questions; provided input on project documentation, including recruitment materials, interview schedules and participant information and consent forms; and reviewed the findings from the evaluation to provide a sense check and ensure face validity. They attended the Steering Group meetings and provided guidance out-of-session, as required.

### 3.1.3. SUSD service visits

As part of the project's stakeholder engagement work, the team visited each existing SUSD in Queensland between February and March 2023 to meet with SUSD staff. The information collected through these site visits informed logistics for conducting the evaluation at these sites, including processes for participant recruitment; and provided important context to areas such as nuances in service delivery and challenges experienced by SUSD staff that were then formally captured through the semi-structured interview questions.

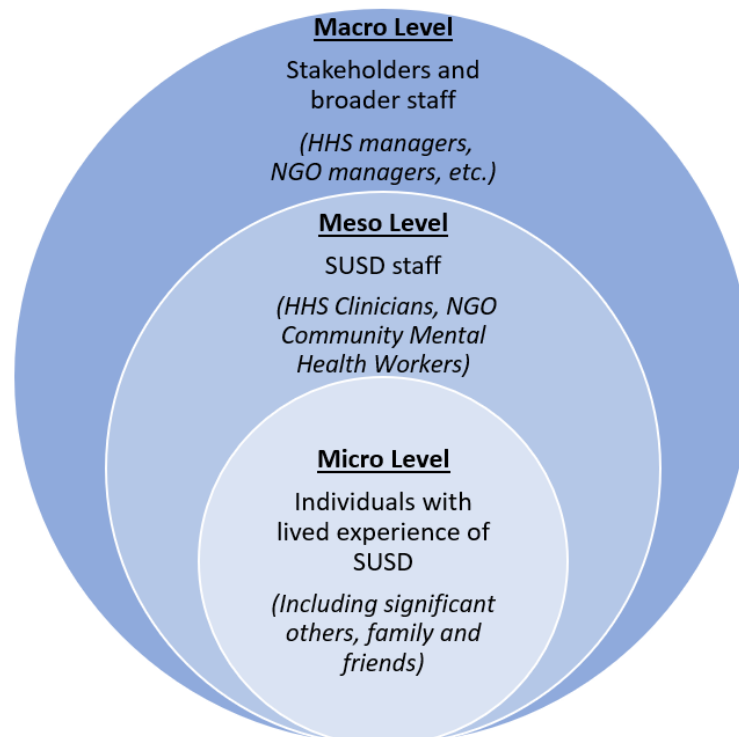
## 3.2. Evaluation framework

Leveraging the previous work undertaken in 2019 (see section 2.7), the current evaluation framework was designed to enable QCMHR to undertake a mixed-methods process and outcomes evaluation of the state-wide SUSD model, to understand how well it has been implemented to date and the extent to which it has achieved its intended outcomes, with the view to provide recommendations that will enhance the future design, delivery, and sustainability of the services. The resulting evaluation framework also drew upon the key tenets of two robust, empirically validated and widely used evaluation models: the Socioecological Model (Bronfenbrenner, 1979) and the RE-AIM framework (Glasgow, Vogt, & Boles, 1999).

### 3.2.1. Socioecological model

The Socioecological Model (SEM) provides a useful framework to structure interventions and evaluations through understanding how the micro-, meso- and macro- levels of a system interact with each another and their environment in order to work effectively (Bronfenbrenner, 1979; World Health Organization, 2002). As shown in Figure 1, the micro-level consists of individuals with lived experience of SUSD; the meso-level is comprised of the SUSD staff who deliver the service; and the macro-level contains broader staff and stakeholders within the health system that interact with and influence the delivery of SUSD. SUSDs form one part of a complex mental health care system for individuals within Queensland and the evaluation of the state-wide SUSD model was designed to consider this complexity and to better understand the bi-directional interactions between each of these socio-ecological levels that underpin its delivery.

*Figure 1 | Interactions between the micro, meso and macro levels in the state-wide SUSD model.*



### 3.2.2. RE-AIM framework

The RE-AIM framework is an empirically validated and widely used model for planning and evaluating public health and community services (Glasgow et al., 2019). It provides structure and depth to evaluations by examining five key domains: Reach, Effectiveness, Adoption, Implementation and Maintenance. The RE-AIM framework complements the SEM through assessing the RE-AIM domains at the micro, meso and macro levels (Holtrop et al., 2021), allowing researchers to observe the service end-to-end and across the complex system. An overview of the RE-AIM domains applied to the evaluation of the state-wide SUSD model is provided below in Table 3.

**Table 3 | Definitions of the RE-AIM domains as applied to the state-wide SUSD model evaluation**

RE-AIM domain	Definition
Reach	The extent to which the SUSD reaches the eligible population. If so, how and why? If not, why not?
Effectiveness	The impact of the SUSD on individual and system outcomes, including the reasons why or why not the SUSD was effective.
Adoption	The extent to which consumers, staff and settings adopted the SUSD, and the reasons why or why not.
Implementation	The extent to which sites have implemented the SUSD model with fidelity, local adaptations that have been made to the service, and the use of implementation strategies.
Maintenance	The extent to which the individual effects of the SUSD are sustained, and the factors impacting on the ongoing sustainability of SUSD services.

### 3.2.3. Multi-site approach

The evaluation framework used a multi-site approach in which quantitative and qualitative data was collected and analysed from the five sites across Queensland where the state-wide SUSD model has been implemented (Straw & Herrell, 2002). To ensure that the findings were generalisable and relevant to the state-wide SUSD model (rather than focused on the individual trial sites), the evaluation used a consistent set of measures across each of the trial sites to enable the data to be pooled and then analysed at the state-wide level. These data sources are described in detail in section 3.3.2.

### 3.2.4. Key evaluation questions

The key evaluation questions that guided this research were co-designed with members of the Steering Group and the project’s lived experience co-researchers. These key evaluation questions, mapped against the RE-AIM domains, levels of the SEM and the data sources that were used to assess them, are presented below in Table 4.

**Table 4 | Key evaluation questions mapped against data sources**

RE-AIM Domain	SEM Level	Key Evaluation Question	Data source		
			Document review	Quantitative data	Semi-structured interviews
Reach	Micro	What are the demographic characteristics of consumers?		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
		What are the details of consumers' presentation to the SUSD?		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
	Meso/Macro	Where are SUSD referrals coming from?		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
		What factors impact the reach of the service?			<input checked="" type="checkbox"/>
Adoption	Meso/Macro	What are the key lessons learnt from setting up current SUSD sites?			<input checked="" type="checkbox"/>
		What is the extent to which there is buy-in and support for the SUSD from referring ED and HHS staff, and why/why not?			<input checked="" type="checkbox"/>

RE-AIM Domain	SEM Level	Key Evaluation Question	Data source		
			Document review	Quantitative data	Semi-structured interviews
		Has there been an increase in referral numbers to the SUSD over time, and why/why not?		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
	Micro	Are eligible consumers engaging with the SUSD service when offered, and why do/don't they decide to take up the offer?			<input checked="" type="checkbox"/>
Implementation	Meso/Macro	How does the SUSD function in practice, and what are the variations in service delivery across the five sites?	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
		What are the factors impacting the implementation of the SUSD for health services?			<input checked="" type="checkbox"/>
Effectiveness	Micro/Meso/Macro	Has the SUSD improved the mental health outcomes of consumers, and why/why not?		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
		Has the SUSD improved consumers' experiences of mental health care, and why/why not?		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
		What impact has the SUSD had for carers, how and why?			<input checked="" type="checkbox"/>
		Has the SUSD led to a reduction in ED presentations, and why/why not?		<input checked="" type="checkbox"/>	
		Has the SUSD led to a reduction in mental health admissions, and why/why not?		<input checked="" type="checkbox"/>	
Maintenance	Micro	To what extent did consumers and carers develop knowledge and skills during their time at the SUSD, and have they used these knowledge and skills since?			<input checked="" type="checkbox"/>
	Meso/Macro	What are the factors impacting the ongoing sustainability of the SUSD for health services?			<input checked="" type="checkbox"/>

### 3.3. Data sources

#### 3.3.1. Document review

To evaluate the implementation of the SUSD, QCMHR undertook a document review of the state-wide Model of Service (MOS) documentation and Service Guidelines for each of the five SUSD sites.

#### 3.3.2. Quantitative data

To evaluate the reach, adoption, and effectiveness of the SUSD, de-identified individual-level quantitative data was accessed from Queensland Health's Consumer Integrated Mental Health and Addiction (CIMHA) application,

Emergency Data Collection (EDC) and Residential Mental Health Care Data Collection (RMHCDC), and Queensland Mental Health Establishments National Minimum Data Set (MHE NMDS) for each of the five sites. In addition, data was obtained from the Your Experience of Service (YES) survey and Carer Experience Survey (CES). A description of these datasets is provided below:

- **CIMHA** is a consumer-central clinical information system designed to support Queensland Health’s MHAOD services in the provision of safe and quality health services; and is the primary source of data for the activity of community and residential MHAOD services, clinical and consumer rated mental health outcome measures and Queensland’s Mental Health Act 2016.
- The **EDC** is a dataset of patients who have had an emergency stay at an emergency department (ED) in one of Queensland’s public hospitals; and collects demographic, service provision and performance information required to meet national reporting requirements.
- The **RMHCDC** is a dataset of episodes of care from any Queensland specialised residential mental health care facility treating consumers. The RMHCDC complements the range of activity, diagnostic, demographic and outcome information collected to support understanding of mental health service delivery in Queensland.
- The **MHE NMDS** collects consistent information on the activity of specialised mental health services at the service level, which aim to provide reliable data to better inform policy, practice, and planning of specialised mental health service activities at a state and national level. Organisations are required to report against the MHE NMDS data elements to meet their contractual agreements. MHE NMDS captures a range of aggregate service data including number of clients, number of attendances, number of individuals by length of treatment and full time equivalent (FTE) paid staff.
- The **YES** survey and **CES** collect information about the experiences of care received by consumers and carers when engaged with Queensland public mental health services. The YES survey is offered for a six-week period annually whereas the CES is offered on a continuous basis throughout the year. Completion of the experience surveys is voluntary. The YES and CES surveys produce an overall experience and outcome score and discrete scores for seven domains including Respect, Safety and Fairness, Participation, Valuing Individuality, Information and Support, and Making a Difference.

A description of the cohorts and data items that were accessed through the CIMHA, EDC, RMHCDC, MHE NMDS, YES/CES data sets are summarised in Table 5 below.

**Table 5 | Overview of state-wide quantitative data sources utilised in the evaluation.**

Data source	Cohort	Data items
<b>CIMHA</b>	All consumers aged 18+ years who accessed a SUSD between 01/01/2020 and 31/12/2023.	<ul style="list-style-type: none"> <li>• Consumer demographics at time of SUSD presentation (sex, Indigenous status, country of birth, accommodation type, marital status, living with, education, alerts recorded, alert description, NDIS plan existence)</li> <li>• Presentation details (date, treating unit)</li> </ul>

		<ul style="list-style-type: none"> <li>• Primary and additional ICD-10-AM mental health diagnosis at time of SUSD presentation</li> <li>• Outcomes file (HoNOS/HoNOS 65, Phase of care, LSP-16, Mental Health Inventory)</li> <li>• Acute admitted service episodes in the 12-months pre- and post- SUSD presentation</li> </ul>
<b>EDC</b>	All consumers aged 18+ years who accessed a SUSD between 01/01/2020 and 31/12/2023.	<ul style="list-style-type: none"> <li>• Encounter details (presentation date, length of stay, presenting problem)</li> </ul>
<b>RMHCDC</b>	All consumers aged 18+ years who accessed a SUSD between 01/01/2020 and 31/12/2023.	<ul style="list-style-type: none"> <li>• Consumer demographics at time of SUSD presentation (age, sex, Indigenous status, Australian South Sea Islander, country of birth, preferred language, marital status, hospital insurance status, mental health legal status)</li> <li>• Geographic information at time of SUSD presentation (HHS, SEIFA, ARIA)</li> <li>• Principal and other diagnosis at time of SUSD presentation</li> <li>• Episode information (start date, end date, mode of separation, source of referral, facility transferred from/to, length of stay, leave)</li> </ul>
<b>MHE NMDS</b>	All SUSD site reports between 01/01/2020 and 31/12/2023.	<ul style="list-style-type: none"> <li>• Staff profile</li> <li>• Occupancy</li> </ul>
<b>YES/CES</b>	Consumers and carers who accessed a SUSD during 2020 to 2023 data collection periods and completed a survey.	<ul style="list-style-type: none"> <li>• YES/CES survey item responses</li> <li>• Treating unit</li> <li>• Year</li> </ul>

### 3.4. Semi-structured interviews

To evaluate the reach, adoption, implementation, effectiveness and maintenance of the SUSD, semi-structured interviews were undertaken with several participant groups, including: consumers and their carers who had accessed the SUSD, SUSD staff, HHS staff who refer consumers to the SUSD, and broader staff and stakeholders involved in the delivery and/or management of the service. Semi-structured interviews were used as they enable the gathering of specific information, while providing scope to explore additional lines of enquiry raised by participants.

### 3.4.1. Recruitment

Across the different groups of stakeholders, individuals were eligible to take part in an interview if they were aged 18 years or older and demonstrated capacity to consent. Consumers and carers were recruited through each of the SUSD sites, with SUSD staff acting as gatekeepers. Recruitment posters and flyers advertising the evaluation were displayed at the five SUSD locations. In addition, SUSD staff informed consumers and carers of the evaluation while visiting the SUSD. SUSD staff were recruited via an email sent from the research team to relevant individuals who were identified by the SUSD team leaders. Similarly, referring HHS staff and broader staff and stakeholders were invited to participate via an email sent by the SUSD team leaders to relevant individuals they identified.

All participants provided informed consent to take part in the semi-structured interviews and completed a participant information and consent form either on paper or through the online platform Qualtrics. Consenting consumers and carers completed a demographics survey as part of this process.

### 3.4.2. Participant characteristics

A total of 77 interviews were completed with a convenience sample of consumers and carers who had accessed a SUSD (n = 32) or declined a referral to a SUSD (n = 1), SUSD staff (n = 30), broader HHS staff (n = 7) and NGO stakeholders (n = 7). The demographic characteristics of the 33 consumers and carers who participated in the interviews are provided in Table 6. A breakdown of the roles of the staff and stakeholders that were interviewed is provided in Table 7.

*Table 6 | Demographic characteristics of consumer and carer interview participants.*

Characteristic	n (%)
<b>Participant sub-group</b>	
Consumer	29 (88%)
Carer	3 (9%)
Declined referral	1 (3%)
<b>Gender</b>	
Male	10 (30%)
Female	23 (70%)
<b>Age Group</b>	
18-25	2 (6%)
26-35	6 (18%)
36-45	11 (33%)
46-55	9 (27%)
56-65	5 (15%)
<b>Aboriginal and/or Torres Strait Islander</b>	
Yes	3 (9%)
No	30 (91%)
<b>Non-English Speaking Background</b>	

Yes	3 (9%)
No	30 (91%)
<b>Part of LGBTQI+ Community</b>	
Yes	6 (18%)
No	26 (79%)
Not specified	1 (3%)
<b>Number of SUSD Admissions</b>	
Single admission	21 (72%)
Repeat admissions (up to 4)	8 (28%)
<b>Referral Type</b>	
Step down	17 (59%)
Step up	5 (17%)
Both (across multiple visits)	7 (24%)

**Table 7 | Employment roles of staff and stakeholder interview participants.**

Role	n
<b><i>SUSD NGO Staff</i></b>	
Community Mental Health Practitioner ( <i>Mind</i> )/Community Recovery Support Worker ( <i>Neami</i> )	5
Family Engagement Worker	2
Peer Worker ( <i>Mind</i> )/Peer Support Worker ( <i>Neami</i> )	4
Service Manager	5
Team Leader	2
Other	1
<b><i>SUSD HHS Staff</i></b>	
Allied Health	3
Clinical Nurse	3
Clinical Lead	3
Other	2
<b><i>Broader Staff/Stakeholders</i></b>	
Broader HHS Staff	7
NGO Stakeholders	7

### **3.4.3. Interview procedure**

Once informed consent was obtained, participants were contacted via phone and/or email to organise an interview at a time and location of their convenience. These interviews were conducted by two members of the evaluation team who were experienced in qualitative research and were guided by semi-structured schedules. Participants completed the interviews either in-person (n = 37), over-the-phone (n = 12) or via video teleconferencing (n = 28). The interviews lasted from 10 to 60 minutes, were audio-recorded and then transcribed verbatim by a professional transcription company. Consumers and carers who participated in an interview were given a \$40 gift card as a thank you for their time.

## **3.5. Data analysis**

### **3.5.1. Quantitative data**

CIMHA, RMHCDC and EDC data were analysed in R (version 4.2.3) using the dplyr, tidyr, AMR, psych, and ggplot2 packages. Extensive data cleaning and manipulation was undertaken to transform the CIMHA, RMHCDC and EDC data into a usable format and to compute new variables as required by the evaluation plan. Descriptive statistics (e.g., frequency counts, proportions, averages) were generated for demographic characteristics and presentation details. Wilcoxon signed rank tests were used to examine pre-post changes in outcome measures, ED presentations and inpatient admissions due to the non-normal distribution of differences. YES and CES survey data was analysed in Excel.

### **3.5.2. Semi-structured interviews**

The semi-structured interviews were analysed in NVivo (version 14) using thematic analysis (Braun & Clarke, 2006; Guest, MacQueen, & Namey, 2012). The interviews were coded independently by three QCMHR researchers (GS, AS and AL) who each analysed a portion of the interviews. First, a deductive approach was used to code the interview data against the key domains of the RE-AIM framework and their corresponding evaluation questions. A deductive coding framework was developed by the coders to guide this initial phase of the analysis and maintain inter-coder consistency. Second, an inductive approach was used to open-code the data within each of the RE-AIM domains and evaluation questions. This process involved coding data content and categorisation into potential themes and sub-themes. Themes most cited in the data and with the most significant information to answer the evaluation questions were selected as the final themes after a process of discussion and agreement by coders.

## **3.6. Ethics and research governance**

Ethics approval was obtained from the Metro South Human Research Ethics Committee (HREC/2023/QMS/ 94331) and The University of Queensland Human Research Ethics Committee (2023/HE001257). Site Specific Assessments were obtained with each of the HHSs involved in the evaluation. Public Health Act (PHA) approval was obtained to access the CIMHA, EDC and RMHCDC data from Queensland Health.

## 3.7. Strengths of the methodology

A key strength of this evaluation is that it utilised a robust, mixed-methods research methodology to deliver high-quality findings to Queensland Health regarding the effectiveness of the SUSD model; and contributes high-quality evidence to the broader SUSD literature. The evaluation framework was informed by the key tenants of two robust, empirically validated and widely used evaluation models: the Socioecological Model (Bronfenbrenner, 1979) and the RE-AIM framework (Glasgow, Vogt, & Boles, 1999) Additionally, the evaluation framework was designed in collaboration with the SUSD Evaluation Steering Group (see Appendix A) which included three members with lived experience of mental illness and/or caring for someone with lived experience of mental illness. Furthermore, the evaluation built on a previously trialled evaluation framework designed specifically for Queensland SUSD services. These approaches assured that the research asked the right questions, and collected and analysed the data in the most appropriate way.

For the qualitative interviews there was a large and broad representation of consumers, staff, and stakeholder interviews across the five SUSD sites and data was collected to saturation point. In addition, the present evaluation used state-wide quantitative data on ED presentations and inpatient admissions to understand the actual impacts of SUSD on these intended outcomes (versus relying on self-reported outcomes). This was a strength as there is currently limited research reporting on longitudinal state-wide outcomes of SUSD in the Australian context.

## 3.8. Data collection challenges

Despite the methodological strengths of the evaluation, there were several challenges in collecting the data that are important to consider when reviewing the findings of this report.

Firstly, recruitment was challenging, as appropriate consents were not in place at the SUSD services to enable staff to contact consumers and carers after they had left the service. This meant that recruitment opportunities were limited to those consumers and carers who physically presented to the SUSD during the 3-month recruitment period, or those involved in HHS consumer representative groups. The evaluation sought to interview consumers and carers from a range of cohorts to achieve a representative sample of the consumers and carers who access SUSD. However, Aboriginal and Torres Strait Islander people and carers were under-represented in the interview sample. There may also be a positive response bias evident in the interview data collected from consumers, carers, and staff as SUSD staff acted as gatekeepers to recruitment. Indeed, when using gatekeepers there is a risk that they may only invite people to participate in the evaluation if they think they will have positive things to say about the service.

An additional challenge was that the evaluation was unable to access de-identified individual level NGO data for the evaluation, which limited the quantitative recovery outcomes reported on in this evaluation.

# 4. Reach findings

## Defining and evaluating consumer reach

Reach explores the extent to which the SUSD reaches the eligible population and the reasons why or why not. It considers who is accessing the service, how and why; and examines whether users are representative of the target group and if there are groups who the service may not be reaching.

This section of the report answers the following key evaluation questions:

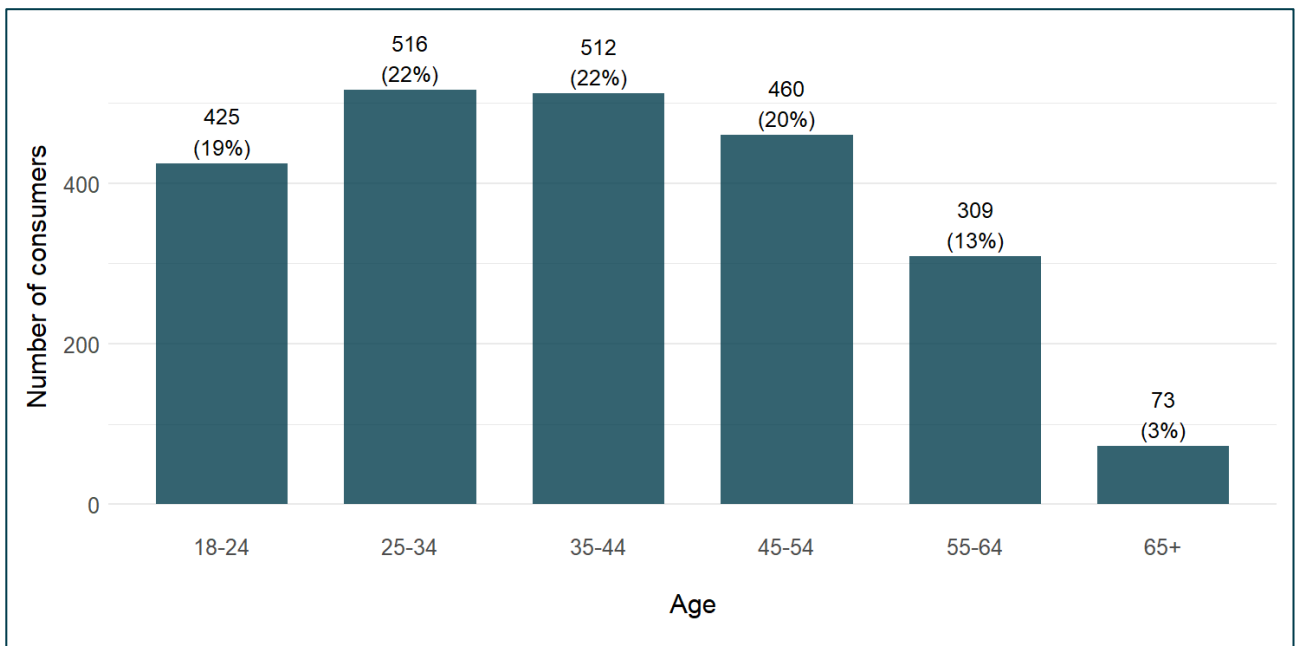
1. What are the demographic characteristics of SUSD consumers?
2. What are the details of consumers' presentation to SUSD?
3. Where are SUSD referrals coming from?
4. What factors impact the reach of the service?

## 4.1. Demographic characteristics of SUSD consumers

### 4.1.1. Age and sex

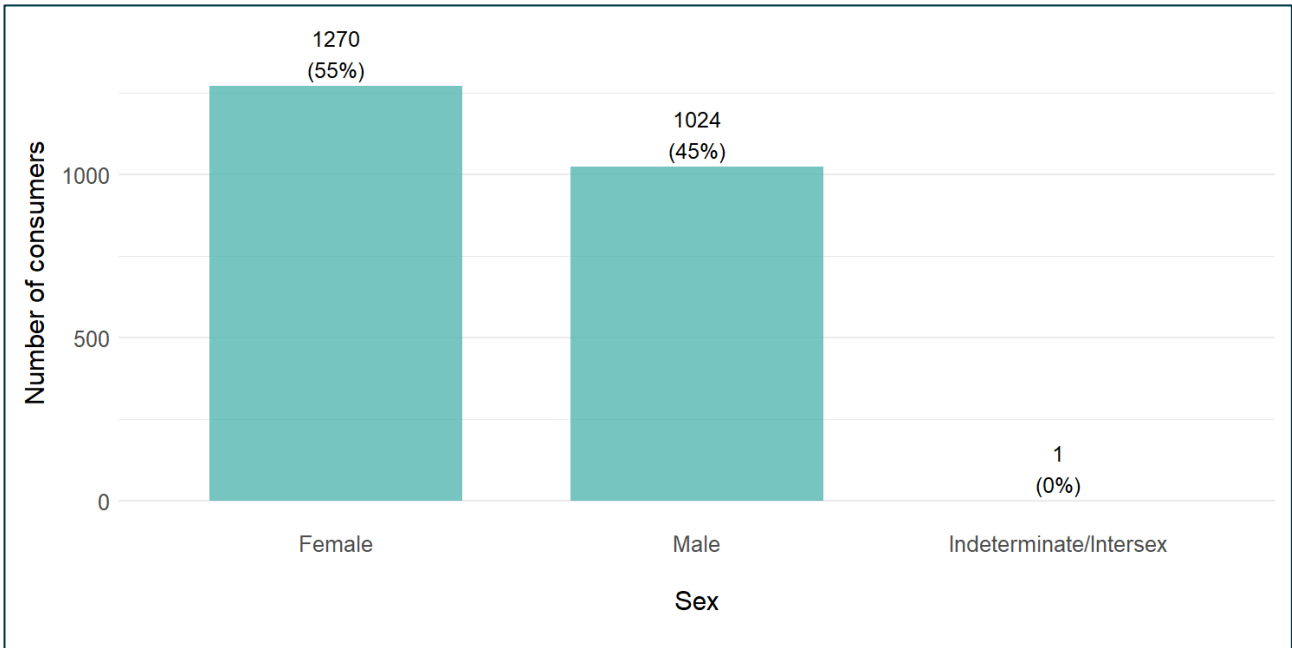
The age distribution of unique SUSD consumers is presented in Figure 2; and the sex distribution of consumers is provided in Figure 3. These data show that slightly more than half of consumers are female (55%), with two-thirds younger than age 45 years (64%).

Figure 2 | Age of SUSD consumers who attended SUSD between 2020-2023 (n = 2,295)



Note. Data sourced from RMHCDC

**Figure 3 | Sex of SUSD consumers who attended SUSD between 2020-2023 (n = 2,295)**

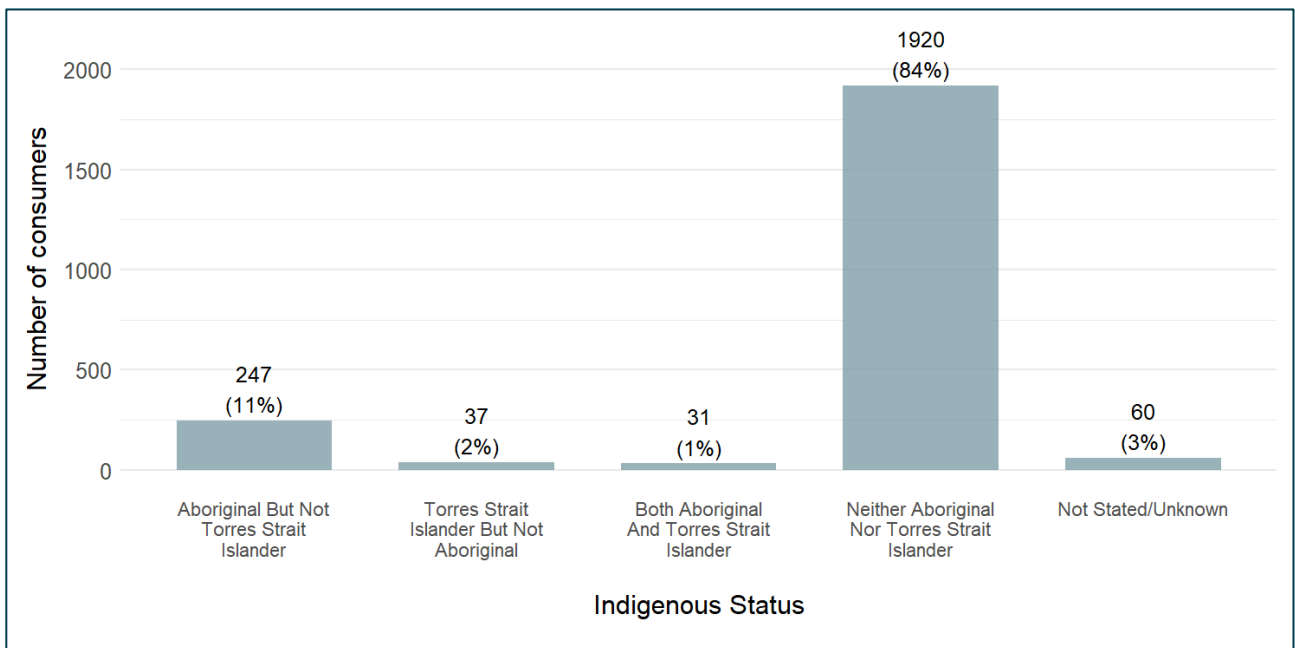


Note. Data sourced from RMHCDC

### 4.1.2. Cultural background

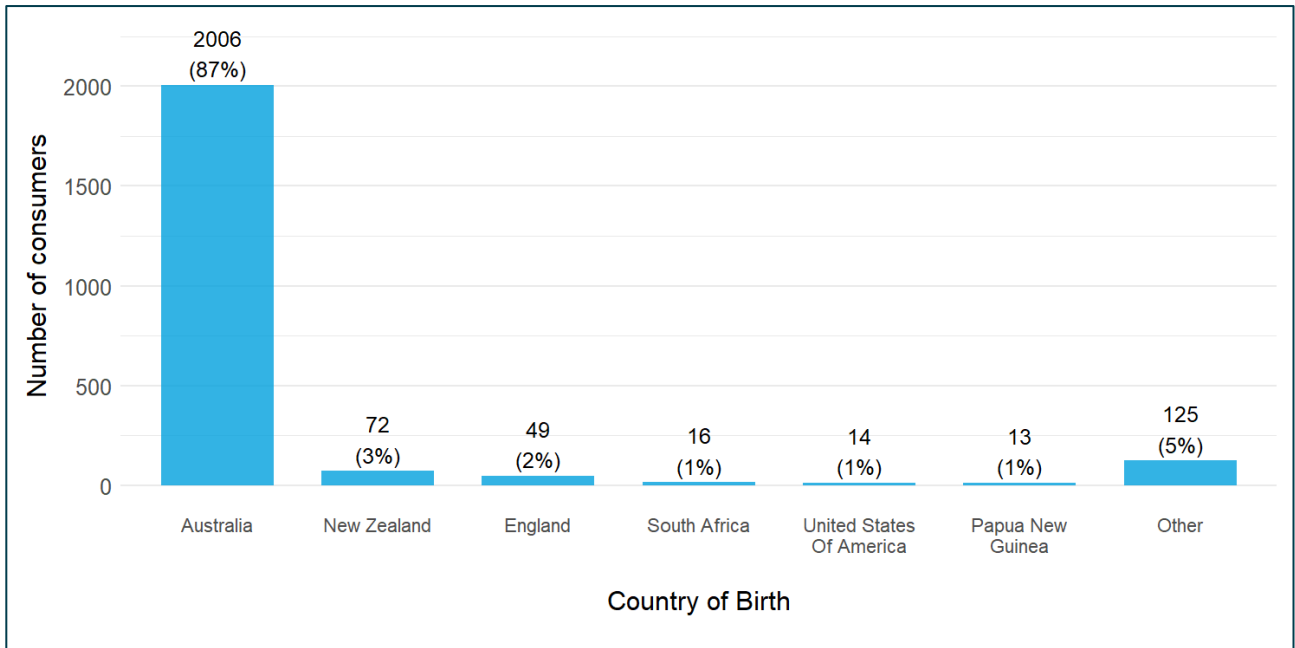
As shown in Figure 4, 14% of SUSD consumers are Aboriginal and/or Torres Strait Islander people. Furthermore, the data presented in Figure 5 shows that 13% of consumers are from a Culturally and Linguistically Diverse (CALD) background, in that they identified as having been born in a country overseas. Ninety nine percent of consumers nominated English as their preferred language.

**Figure 4 | Indigenous status of SUSD consumers 2020-2023 (n = 2,295)**



Note. Data sourced from CIMHA

Figure 5 | Birth country of SUSD consumers 2020-2023 (n = 2,295)

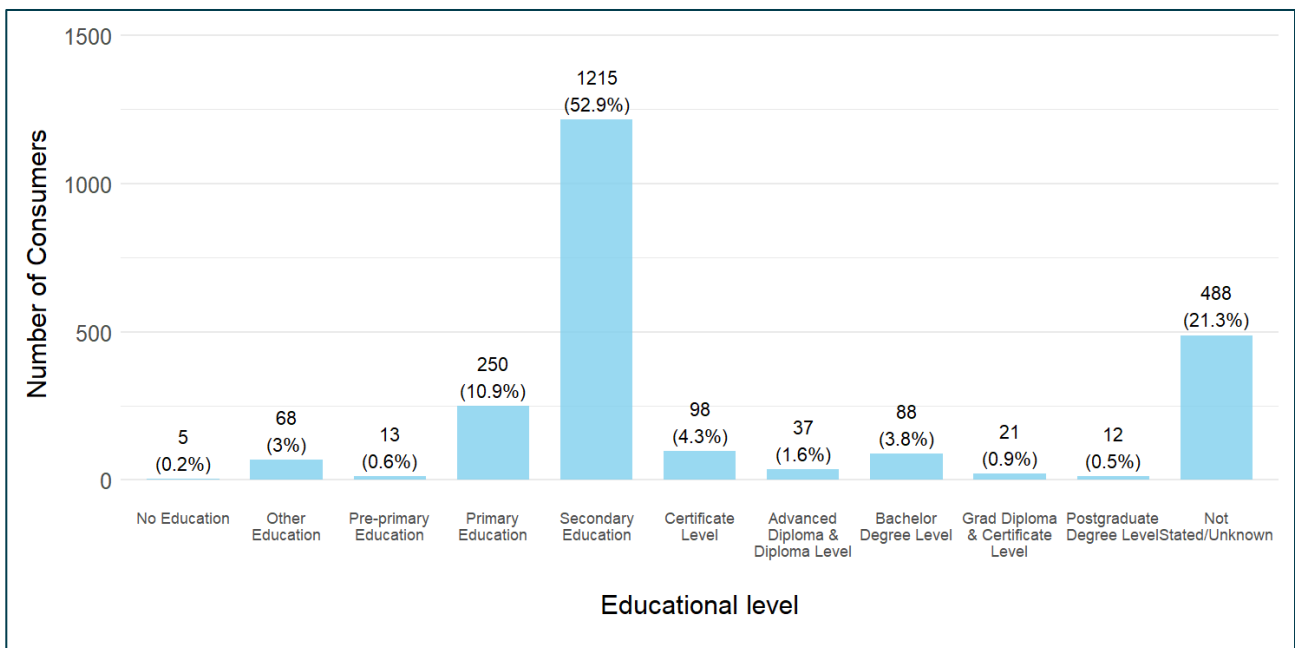


Note. Data sourced from CIMHA

### 4.1.3. Educational attainment

The highest level of education attained by SUSD consumers is shown in Figure 6. These data indicate that two thirds of SUSD consumers (64%) had completed a level of education equivalent to secondary school or higher.

Figure 6 | Educational attainment of SUSD consumers 2020-2023 (n = 2,295)

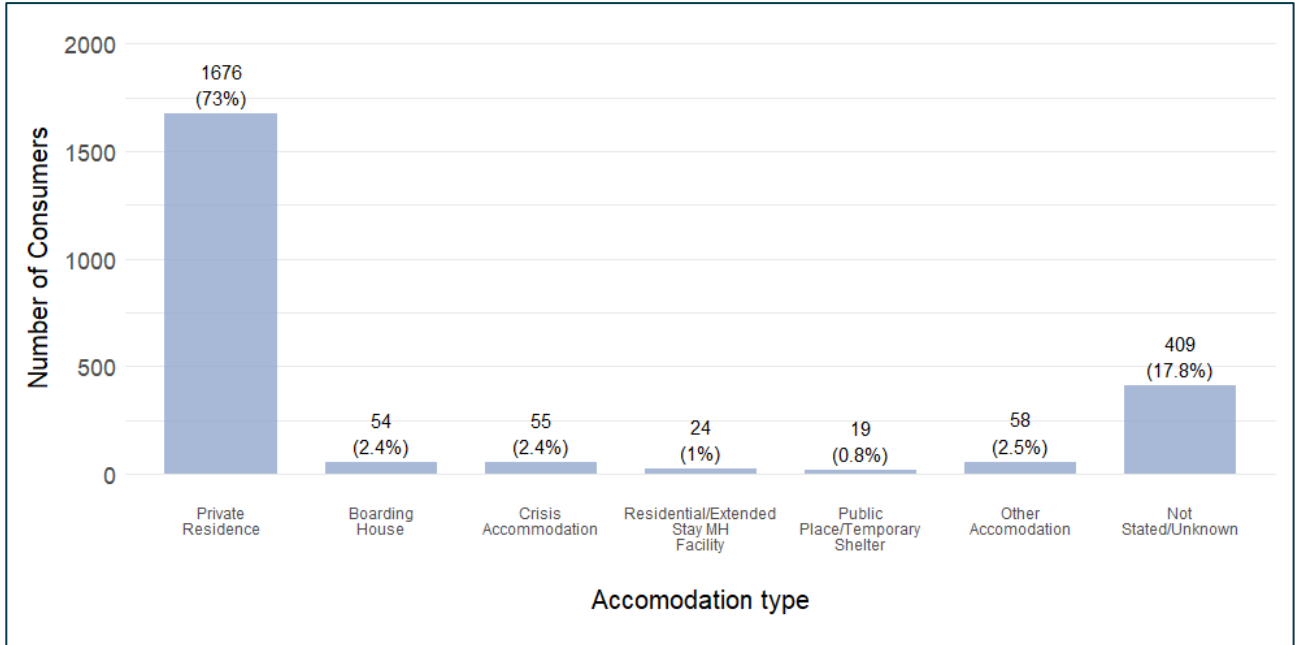


Note. Data sourced from CIMHA

#### 4.1.4. Accommodation type

The type of accommodation setting in which the consumer currently resides is shown in Figure 7, with most SUSD consumers (73%) living in private residences.

Figure 7 | Accommodation type of SUSD consumers 2020-2023 (n = 2,295)

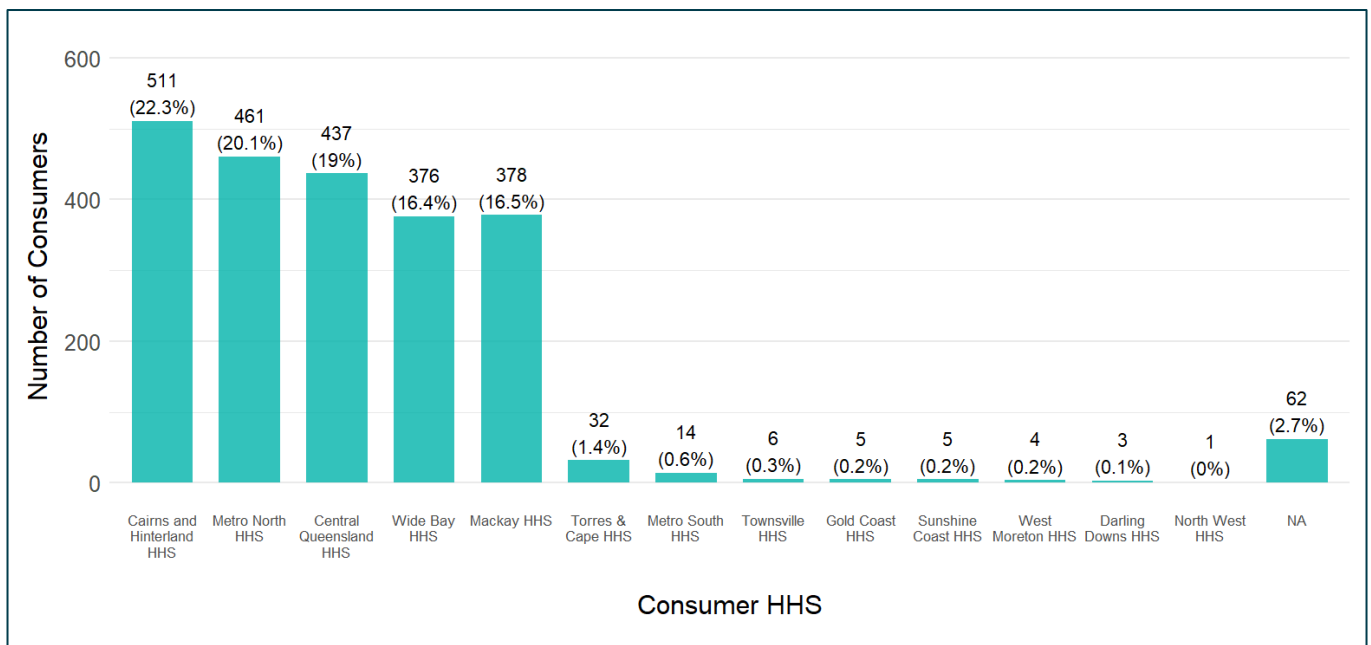


Note. Data sourced from CIMHA. 'Other accommodation' includes: Alcohol and Other Drug Residential Facility, Correctional Facility, Residential Aged Care Facility, Domestic-scale Supported Living Facility and not elsewhere classified.

#### 4.1.5. Geographic coverage of services

The residential data shown in Figure 8 indicate that most consumers (94.4%) who are accessing a SUSD service reside in the same HHS region in which a service is situated. A very small portion of consumers (3%) travelled from their area of residence to access the service at another HHS within Queensland.

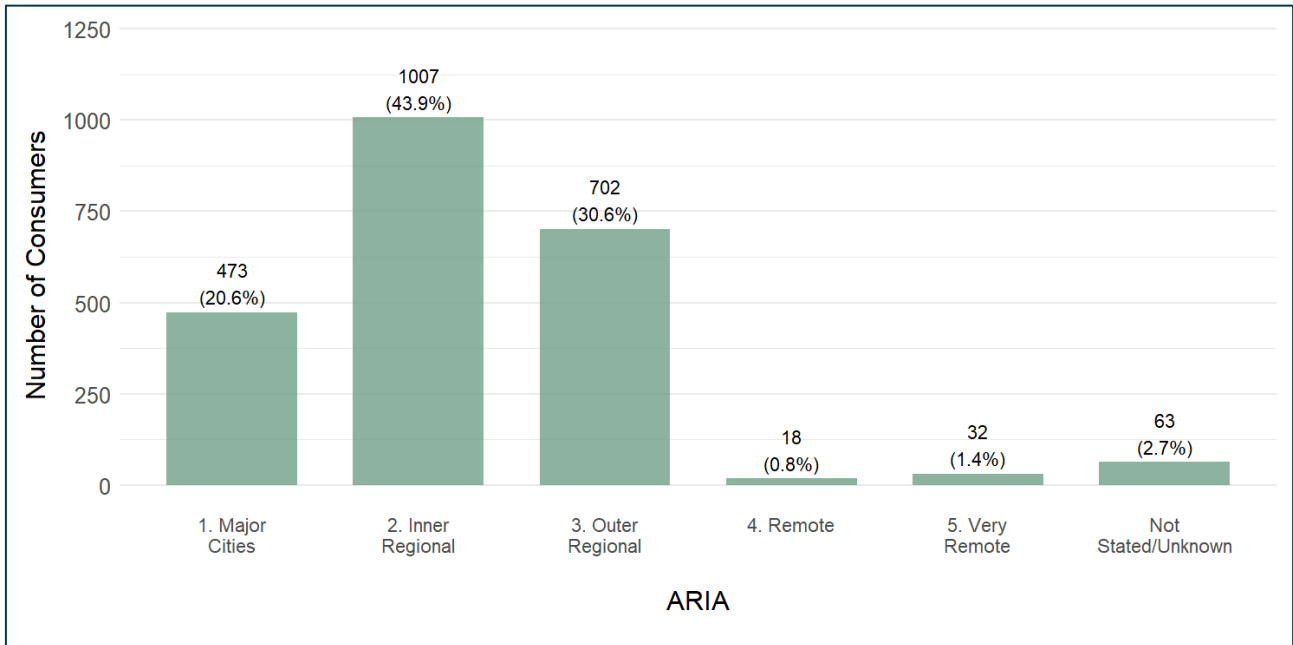
Figure 8 | SUSD services coverage by consumer HHS between 2020-2023 (n = 2,295)



Note. Data sourced from RMHCDC

Additionally, data on the remoteness area of SUSD service coverage (see Figure 9) shows that the service is largely being delivered in regions classified as *Major Cities* (21%), *Inner Regional* (44%) and *Outer Regional* (31%), as per the Accessibility / Remoteness Index of Australia (ARIA).

**Figure 9 | SUSD services coverage by consumer ARIA regions between 2020-2023 (n = 2,295)**

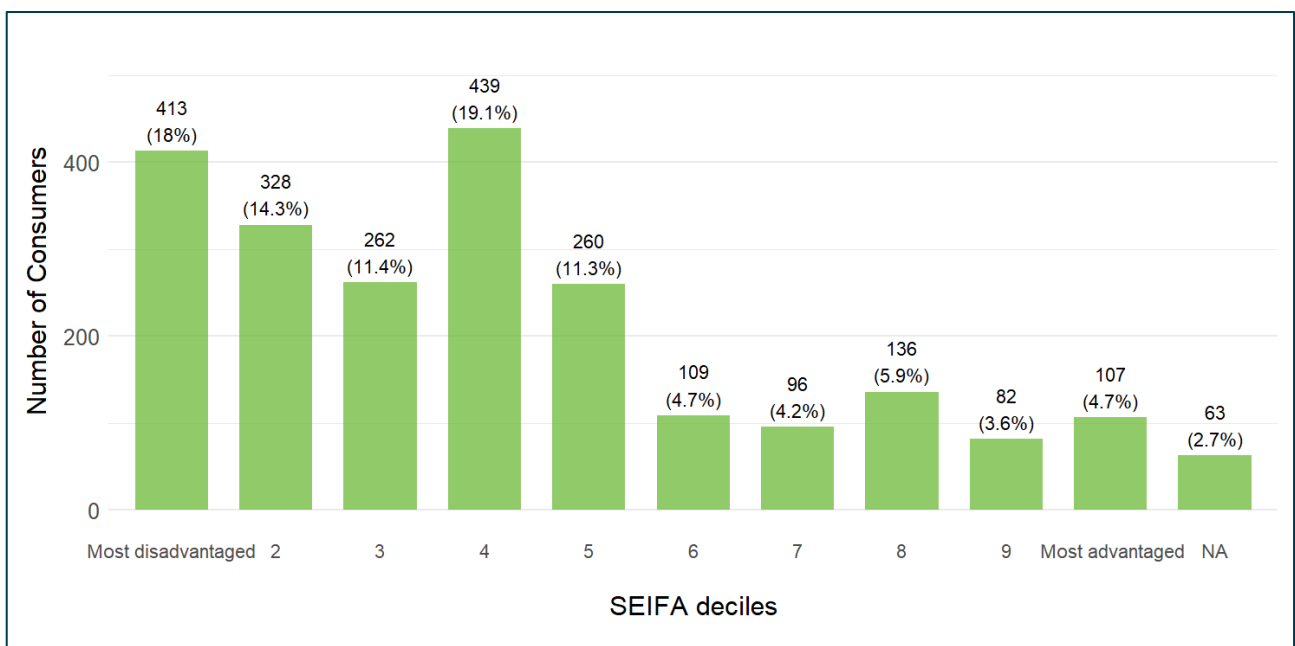


Note. Data sourced from RMHCDC

#### 4.1.6. Socio-economic coverage of service

As shown in Figure 10, the SUSD service is largely providing services in areas of Queensland that are ranked by the Socio-Economic Indexes for Areas (SEIFA) as disadvantaged in comparison to other areas of the state. Indeed, 74% of SUSD service coverage is occurring in regions of the state which have a SEIFA decile of 1 to 5 (meaning they have a generally greater extent of social disadvantage compared to areas with a SEIFA decile of 6 to 10).

**Figure 10 | SUSD services coverage by socioeconomic index areas (n = 2,295)**



Note. Data sourced from CIMHA

### 4.1.7. Demographic groups not being reached

The evaluation initially planned to undertake an assessment of the representativeness of SUSD consumers being reached through the service. In line with the RE-AIM framework, assessment of reach involves comparing the number and characteristics of SUSD consumers with the number and characteristics of the total consumer population who are potentially eligible to access the service. However, due to the lack of data and information available on the total eligible population, this analysis could not be performed. Interviews with SUSD staff were used as a proxy to explore whether there may be groups who are not being adequately reached by the service. The quality of the themes obtained through this method was limited but suggested the service may not be adequately reaching some groups of consumers including: consumers aged 50 years and above, Culturally and Linguistically Diverse populations, First Nations peoples and individuals with high physical health management needs.

*“Yeah, so you’d be getting referrals from a mental health perspective they’d be appropriate for a Step Up Step Down, but then on the referral it would have, diabetes on it, and requiring this level of care, and blood sugars taken every so often, and so you were turning good mental health referrals away because the people needed too much physical health management....So, not to say we wouldn’t accept them, but again, it depended on who you had in the house at any given week, or any given month, and if you said, yes to one consumer who was really time consuming for these sort of reasons, then if you had another referral two days later for a similar consumer you’d be going, we’re really sorry, we agreed to it from a mental health perspective they’re appropriate, but from a physical health perspective, we’re worried that they have sleep apnoea and they might pass away in their sleep, because we don’t have anyone doing night checks.” Previous SUSD Staff*

## 4.2. Presentation details of SUSD consumers

### 4.2.1. Mental health diagnoses

Analyses were conducted using RMHCDC data as it provided the most complete picture of diagnoses for Adult SUSD consumers. Table 8 shows the ICD-10 primary mental health diagnoses that were identified as most prevalent among SUSD consumers. Overall, there were 141 different ICD-10 codes recorded with 636 service episodes missing a diagnosis. The three most common first additional diagnoses were post-traumatic stress disorder, mental and behavioural disorders due to use of tobacco and emotionally unstable personality disorder, borderline type.

**Table 8 | The 10 most common primary ICD-10 mental health diagnoses of SUSD consumers 2020-2023 (n = 2,435)**

Diagnosis	n	%
F20.0: Paranoid schizophrenia	294	20
F60.31: Emotionally unstable personality disorder, borderline type	257	18
F43.2: Adjustment disorders	167	12
F43.1: Post-traumatic stress disorder	128	9
F20.9: Schizophrenia, unspecified	124	9
F32.2: Severe depressive episode without psychotic symptoms	115	8
F41.2: Mixed anxiety and depressive disorder	111	8
F25.9: Schizoaffective disorder, unspecified	101	7

F32.1: Moderate depressive episode	76	5
F32.9: Depressive episode, unspecified	69	5

Note. Data sourced from RMHCDC

Staff interviewed for the evaluation also reported that consumers most often have a schizophrenia, schizoaffective disorder, and borderline personality disorder diagnosis.

*“So, just the decompensation in wellness and becoming acutely unwell, and then either schizophrenia – there’s a lot of schizophrenia, and also people who have reasonable risk around suicide and stuff, supposedly once they’ve been stabilised. To be honest, I don’t think I’ve seen much in the way of depression, more borderline personality disorder and schizophrenia, I think, are the main ones.”* **HHS Team Leader, SUSD**

### 4.2.2. Reason for presentation

Data on the reason for presentation is not routinely collected. However, interviews with SUSD staff and consumers provided some insights into this. The qualitative data suggested that the most common reasons that consumers presented to the SUSD was exacerbation of psychological distress and suicidal ideation precipitated by situational crises (e.g., relationship breakdown, homelessness). A smaller number of presentations were for medication changes in a controlled environment. Problematic substance use prior to admission was also reported.

*“I had a mental breakdown due to a relationship falling apart, accommodation, job falling apart, stuff like that. Everything just fell apart at the same time.”* **Consumer, SUSD**

*“We have seen a lot more first presentations since COVID. I think COVID completely changed the cohort, so, a lot of situational crisis, a lot of relationship breakdowns.”* **NGO Service Manager, SUSD**

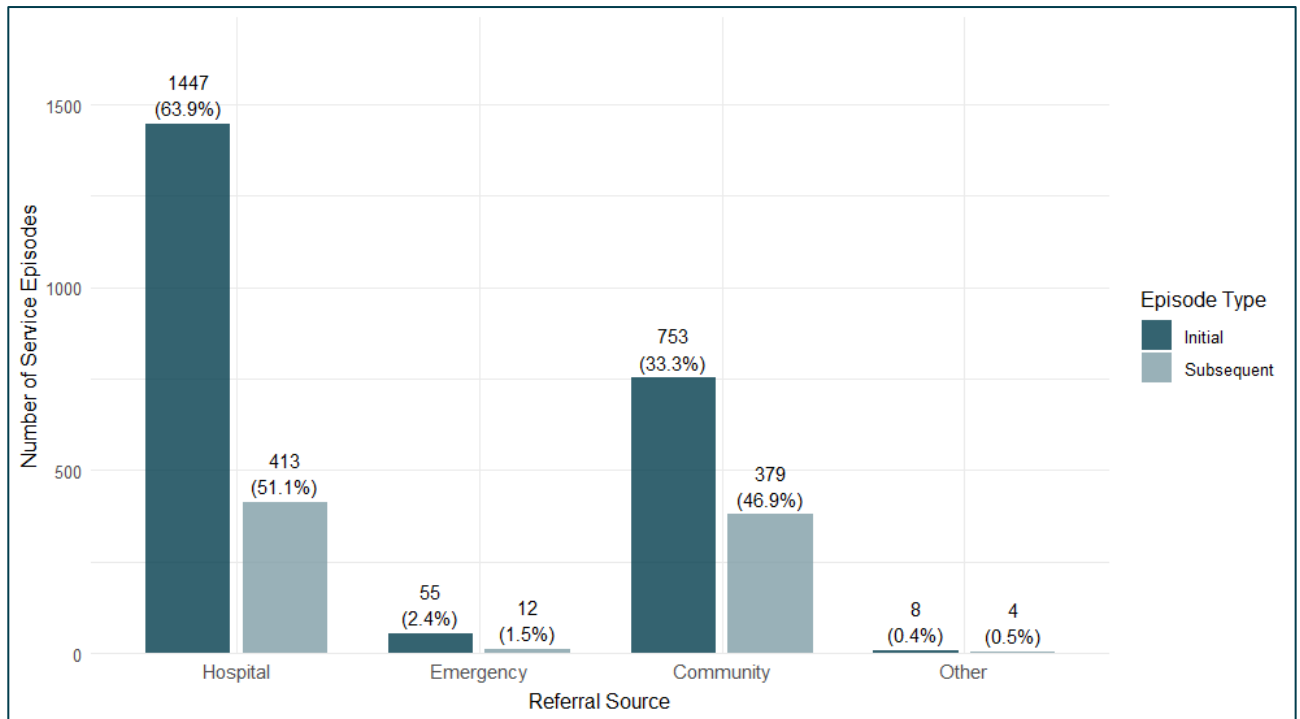
*“This time’s a bit more specific in terms of, the major reason I’m here is to get my meds changed in a controlled environment.”* **Consumer, SUSD**

*“What we are seeing is quite a substantial documented increase in clients who have co-existing drug and alcohol.... the vast majority of our clients who come into the service also have problematic substance use.”* **NGO Service Manager, SUSD**

### 4.2.3. Referral source

An overview of the referral sources for initial and subsequent service episodes at SUSD is presented below in Figure 11. The most common referral source for initial service episodes was the hospital (64% of total initial service episodes), followed by the community (33% of total number of initial service episodes). For subsequent service episodes, hospital and community pathways referred almost equal proportions of consumers (51% and 47% respectively).

Figure 11 | Referral source of initial and subsequent service episodes to SUSD (n = 3,071)



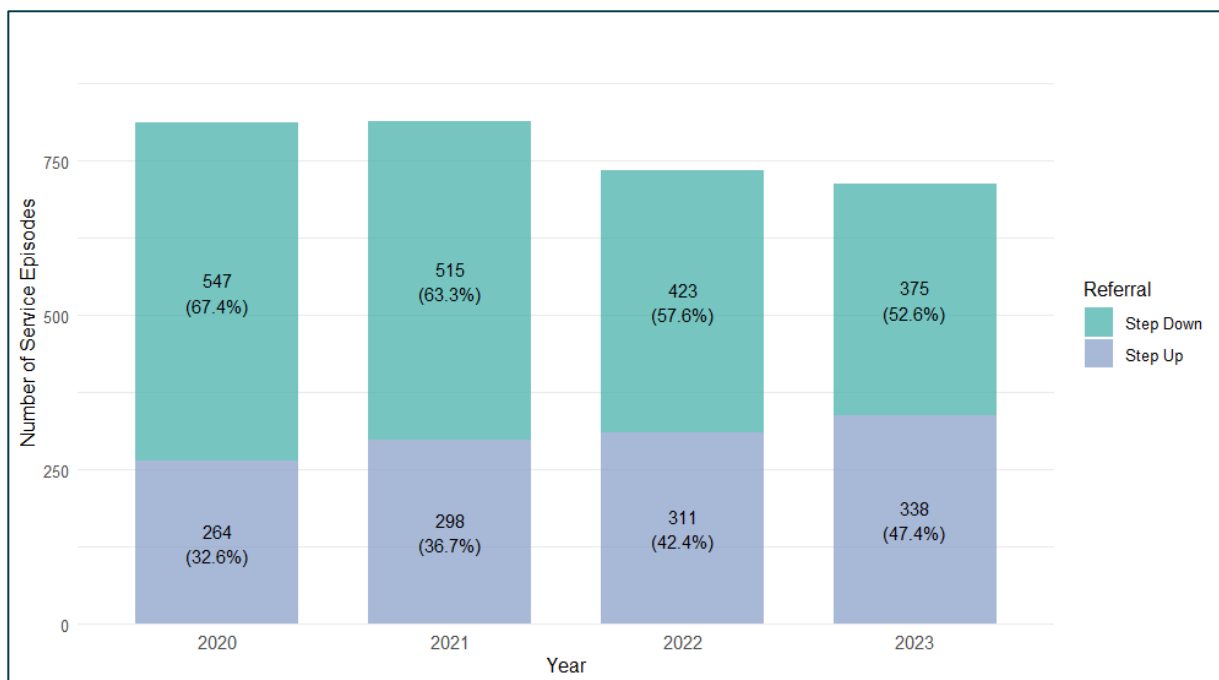
Note. Data sourced from RMHCDC

## 4.3. Factors impacting consumer reach

### 4.3.1. Referral pathways

Referral pathways into SUSD include “stepping up” from community mental health services or acute care triage or “stepping down” from acute mental health inpatient unit. Quantitative data (Figure 12) shows that from 2020-2023 there was an increase in step up referrals and a decrease in step down referrals.

Figure 12 | Number of service episodes from 2020 - 2023 grouped by referral type (n = 3,071)



Note. Data sourced from RMHCDC

Private psychiatrists, GPs and NGOs from the community can recommend SUSD to clients, however for a consumer to access the service, they must be assessed by Queensland Health Mental Health and assigned a treatment team prior to being considered for a referral. Staff reported that an advantage of this process is that the consumers details and history are available on CIMHA and this allows the SUSD intake coordinators to first screen for suitability on CIMHA prior to proceeding with an assessment.

*“We get a referral which is always through Queensland Health. So we take that referral, look on CIMHA, go back as far as needed through the history. Then sit down and think whether this person is suitable in general, but also, whether they suit the clients that we have currently as well.”* **NGO Staff, SUSD**

*“If we get a referral, we get an email here, look at their [referral] – then I normally go to their background and read about it in CIMHA or get their background, if the patient is suitable for us. Do the background check first.”* **HHS Staff, SUSD**

On the contrary, some staff reported that the requirement for consumers to be assigned a Queensland Health treatment team for a referral can act as a barrier to reaching people in the community that would benefit from being “stepped-up” into the service to prevent further deterioration which may lead to a hospital admission. This may be a missed opportunity to reduce pressure on front end services.

*“One of the hindrances is we only take referrals from mental health services. It’s good [in] some ways, but there’s a lot of GPs out there, there’s a lot of NGOs out there dealing with people who could benefit from what we do. With the focus of Queensland Health mental health services now being acute management of risk, you may have a major mental illness but be no danger to yourself or somebody else. You don’t get through the intake process, into mental health, you’re immediately pushed out to other services, therefore you don’t have access to here.”* **HHS Staff, SUSD**

*“They [consumers] have to present to community, Mental Health or ED to actually have that assessment done, so that they can get on Queensland Health’s operational books to get a referral to us. So, it actually – when you think of it that way, it’s actually kind of crazy, especially if you want to be eventually in that early intervention space, to actually then have to make somebody become part of your tertiary service to get a universal service... there’s also a danger with that, because you are putting an overload on the front-end services, as well, which they are already under intense pressure.....”* **NGO Staff, SUSD**

Several staff highlighted the missed opportunity in not accepting referrals from outside Queensland Health Mental Health, but other staff cautioned that the ability to take on referrals from organisations external to Queensland Health would overload the intake coordinators and require an adjustment to processes and staffing.

*“I didn’t know this place even existed before I went for my job interview, so I feel like the Step Up Step Down all over Queensland, needs to be better advertised, and maybe more so on the Step Up than the Step Down. We need to get into all those community GPs out there and let them know about what we’re doing, so that we can help people before they go to hospital. That’s what I think our focus should be, focussing on those ones stepping up from the community, but they don’t know about us. I didn’t know about us.”* **NGO Staff, SUSD**

*“But we have identified there’s a really big gap... around if there are alternative pathways to come into the Step Up Step Down that we should be considering. We do have a lot of community-based psychologists and psychiatrists and GPs who are actually starting to contact the clinical nurse here around how they can refer, and at this point in time, everything has to be triaged back through Mental Health.”* **NGO Service Manager, SUSD**

*"I'm actually glad that it only comes from Queensland Health themselves otherwise I think we'd get really inundated. So, it needs to be that process there where it is some clinical background and that we have access to people's referral information"*

**NGO Staff, SUSD**

*"I think you'd need to change the process of admission and referrals, because if we're getting GPs and – we love GPs, but they're GPs. They're not practicing mental health, so you might get 10 or 15 in one day for us, because someone might be having a bit of anxiety– so there might be a bit more of a process and things like that."*

**NGO Staff, SUSD**

### 4.3.2. Consumer awareness of SUSD

All groups of stakeholders reported a lack of awareness of SUSD among potential consumers in the community.

*"The general consensus that I get from a lot of clients when I do entries is that they had no idea that this place existed."*

**NGO Staff, SUSD**

Most consumers reported that they first found out about the SUSD during a hospital admission for mental health.

*"No, I never knew about it. They told me about it when I was in the mental health inpatient unit."*

**Consumer, SUSD**

*"I didn't even know they existed. But a few nurses in hospital told me it's good, if you can get it."*

**Consumer, SUSD**

### 4.3.3. Referrer awareness of SUSD

Referrers' awareness of the SUSD and its purpose was found to impact the number of referrals made and therefore service reach. However, maintaining referrer awareness of SUSD was reported to be challenging for sites to achieve in practice. During interviews, SUSD staff said that a key factor influencing awareness of the SUSD was the length of time the referrer had been in their role. High staff turnover in some referring teams contributed to reduced awareness of SUSD and increased inappropriate referrals.

*"Because we're a mobile workforce in mental health. You'd go back a year later to a Community Care Team and half the staff had changed. So, what we were noticing is that the people who had stayed for a while would be referring, but all these new staff members wouldn't refer because they just wouldn't know what we did, or where we were..... Yeah, turnover is even higher on the inpatient wards, and in retrospect, I probably should've done more frequent presentations to the inpatient wards."*

**Previous SUSD Staff**

*"But it does make it very difficult and a factor in our referrals, that affects our referrals significantly is the workforce in Queensland Health, high turnover, lots and lots of vacancies and using agency staff. So, whilst they might be able to do the clinical practice, they don't have that localised knowledge, and when you're working on a depleted workforce, you are only getting to the priority stuff."*

**NGO Service Manager, SUSD**

*"So we've had a huge change and transition of staff. We've got new staff all the time that don't know. So it's the staff that know what our function is and know the types of clients that do well here and know what we can contain and what we can't. They're very good."*

**HHS Staff, SUSD**

Given this mobile workforce, many staff emphasised the need for referring teams to receive regular promotion and education about SUSD. Some staff highlighted the value of referrers visiting the SUSD in person.

*“I mean, you do education but you’ve got your regs on the ward changing every six months. You’ve got a lot of locum consultants....So yeah. It’s just ongoing education...”* **HHS Staff, SUSD**

*“No. We do in-services, we try to go to the huddles and give education, but there’s nurses up on the ward that have never stepped foot in the Step Up Step Down, and they’ll tell you that somebody’s right for the service and you’re like, actually, no.”*

**NGO Service Manager, SUSD**

*“Look, I think it just needs to be a really regular thing where our clinicians from the hospital, the mental health unit through to the treating teams in community mental health, they should all – we should be talking about giving them a bit of an induction because otherwise, we start getting inappropriate referrals and so forth. So they really know the criteria, and that we are subacute but we don’t have clinicians here overnight, that sort of thing..... It needs to be constant..... All of a sudden, someone will say, this referral’s totally inappropriate. Oh, it’s come from someone who’s new...”* **NGO Service Manager, SUSD**

To increase awareness, sites use numerous strategies including delivering presentations to referring teams and senior leaders, inviting referrers to open days, developing brochures (for referrers and consumers), creating a video overview of the service, and attending referrer team meetings. Bundaberg SUSD is unique in that it has a complex care coordinator to help facilitate referrer awareness.

*“I work alongside the community care teams in Maryborough and Hervey Bay, and the acute care service down there, and the in-patient unit. I stick my nose in there, I’m asking the question is so-and-so – do you think they’re eligible for here? Appropriate for here?”* **HHS Staff, SUSD**

#### 4.3.4. Appropriateness of referrals to SUSD model

Staff and stakeholders provided mixed feedback on the appropriateness of the referrals received for the SUSD and their representativeness of the target group as stipulated by the state-wide SUSD MOS (i.e., people aged 18 – 64 years who have recently experienced, or who are at increased risk of experiencing, an acute mental health episode or further deterioration of mental health).

In general, long-term referrers who have a greater awareness of the purpose and scope of SUSD are more likely to send through appropriate referrals than newer staff (as described in section 4.3.3). However, SUSD staff in some HHSs reported that they were receiving increasing pressure to accept inappropriate referrals due to hospital bed pressure which has increased with the current housing crisis. The most common types of inappropriate referrals received included consumers who did not have a discharge address and those that were too acute for the service.

*“Most of them are [appropriate referrals]. I couldn’t give you a percentage, but there are a few that come through that are really, really not appropriate. It might be that their risk profile is way too high. It could be that they have - well really, we are actually finding that we’re getting referrals for more acutely unwell people. Just probably in the last nine to 12 months both the hospitals are experiencing very, very severe bed pressure. It’s usually coming from the community that we’re getting the more inappropriate referrals because the community case managers are trying to get their consumers into hospital because they know that they need a higher level of care but there’s a wait so then they will refer to us.”* **HHS Staff, SUSD**

*"I'm not so sure because now with the housing crisis we get a lot of referrals from people who don't have a discharge address. Basically, it's like the ward can't provide accommodation for them so they send the referral to us because at least they think, well, that's another 28 days that they've got to find accommodation. Obviously, that's not what we're here for and we do get stitched up a little bit. We take two people and then, very often, we get people here and then suddenly they're like, we've got nowhere to go?"* **HHS Staff, SUSD**

*"Well, I think often the priority is around bed pressures in the mental health units, so I think that takes precedence over the purpose of the facility, and also I think homelessness is a big driving factor as well."* **Broader HHS Staff**

Acceptance of referrals for consumers who do not have a fixed address differs across services (see Table 9) and in turn staff/stakeholder thoughts on accepting these types of referrals were mixed.

*"Some [services] will say, absolutely we will not accept anyone who's not got a permanent address. Whereas some do accept and we work with them to find them a – even if it's a temporary address right? Because what we're doing is actually helping their mental health needs for up to 28 days. If we can do anything else around their social needs, that's a good opportunity. But you know, it's the different nuances on the ground that are interesting."* **SUSD Stakeholder**

*"Look, the right people maybe; right circumstance, no. So, I think a lot of it is homelessness is what we're seeing, and until we resolve the homelessness, we're going to have these people presenting where we can't send them back out into changed circumstances. So, the work that we're doing is really futile, because we're not meeting those very immediate needs..... you'll ask somebody, what do you want to work on? I just want somewhere to stay for a few weeks. Do you know what? I get that. You don't want to work on anything else until you [meet those immediate needs] - it's Maslow's right?"* **NGO Staff, SUSD**

*"But there is a high percentage of people that are referred that are homeless, which I don't believe is a criteria for them to come in...but that becomes a revolving process where that person is not actually getting what they need while they're here because it's not our job to focus on homelessness. Then they end up back on the street or back in the hospital and then back in here and that's ruining our KPIs on successful stays – yeah."* **NGO Staff, SUSD**

In services that do accept consumers without a fixed address, staff reported an increased pressure to take on more consumers in these circumstances.

*"I think maybe the Step Up Step Down itself has put a rod in its own back a little bit because over the years they function so outside of [the service guidelines for referrals], it's almost like, well, you've done this up till now, why the sudden change? So, I think it's definitely a kind of double-edged sword. I think we've absorbed so much pressure that now it's kind of an expectation, and it's like anything, you can't change boundaries about halfway through and the other person is going to be like, sorry, what? No."* **SUSD Staff, SUSD**

*"But when it comes down to pressure to take on inappropriate referrals, for example, five people in the homeless category and blocking the whole service doesn't help. Then it's not come down to SUSD not being efficient. It's talking about you're using a service wrong."* **HHS Staff, SUSD**

Acceptance of inappropriate referrals has a flow on effect to consumer experience of the service and staff job satisfaction.

*“When you’ve got a cohort of people who are on a journey to recover, putting someone in here who doesn’t want to be here, or doesn’t understand how we do business here, affects everybody else. When we had major bed block we had four people in here who were acute, so almost half of our cohort were in a situation where we were struggling to deal with them, deal with the psychosocial stuff because they were all dealing with very prominent mental health symptoms. That does have a follow-on effect, and we do have - we had a few of the sub-acute people leave at that time...” HHS Staff, SUSD*

*“He did struggle with the people - individuals, and being on different journeys and different commitment. Some people just wouldn’t turn up, wouldn’t participate, all of that sort of stuff, which really impacted him initially. They have to be told, we’re here to do this journey together, and they just don’t show up, they don’t participate, they don’t help out with any of the group activities or sessions, or whatever. Chores. All those sorts of things. I think that was a struggle for him, because he went in with a really positive attitude.” Carer, SUSD*

## 4.4. Summary of findings

- It was difficult to determine the exact reach of the SUSD service due to a lack of available quantitative data needed to assess this domain of the RE-AIM framework. Analysis of qualitative data suggested some groups of consumers may be less likely to be reached by the SUSD, including consumers aged 50 years and above, CALD populations and First Nations peoples.
- Interviews revealed that consumers most commonly presented to the SUSD due to exacerbation of psychological distress and suicidal ideation, precipitated by situational crises. Additionally, analysis of RMHCDC data showed that paranoid schizophrenia and borderline personality disorder were the most common mental health diagnoses for consumers entering the SUSD.
- Referral from the hospital or “stepping down” was the most common pathway into SUSD on consumers’ first visit (64%). For subsequent visits, it was 50:50 whether the consumer came from the hospital (step down) or community (step up).
- From 2020 – 2023 there was an increase in “step up” (community) referrals (32.6% to 47.4%) and a decrease in “step down” (hospital) referrals (67.4% to 52.6%).
- The evaluation identified four key factors that impact the reach of the SUSD: referral pathways into the service, consumer awareness of SUSD, referrer awareness of SUSD, and the appropriateness of referrals to SUSD. Several opportunities for improvement were identified across each domain which may enhance the reach of the SUSD.

# 5. Adoption findings

## Defining and evaluating health service and consumer adoption

Adoption of the SUSD examines the extent to which broader HHS staff have adopted (i.e., buy-into and support) the SUSD model and the reasons why or why not. Adoption also covers the extent to which consumers are engaging with the SUSD when offered and the reasons why or why not.

This section of the report answers the following key evaluation questions:

- What are the key lessons learnt from setting up current SUSD sites?
- To what extent referring HHS staff buy-into and support the SUSD, and what are the reasons for the presence or absence of buy-in or support?
- Has there been an increase in referral numbers to the SUSD over time, and why or why not?
- Are eligible consumers engaging with the SUSD service when offered, and why do they, or do they not, decide to take up the offer?

## 5.1. Health service adoption

### 5.1.1. Setting up SUSD

There were limited staff and stakeholders interviewed through the present evaluation that were working at the SUSD when it was first established and/or were involved in the process of setting up the SUSD. This made it difficult for the evaluation to assess the process which sites undertook to set-up the SUSD at the local level and to identify key lessons learnt from this implementation process which future sites can draw upon.

However, it was evident from the few interviews undertaken with relevant staff that it takes time for services to establish their rhythm.

*"[the SUSD] had a rough start, it was probably ten months or so trying to get up and running... In terms of developing the partnership, taking management of the building, all that sort of stuff." HHS Staff, SUSD*

*"Basically, what I saw was a few people trying really hard to set up a service that in their mind they had this idea of what it should be, but they had literally no practical idea of what a Step Up Step Down was, or how it would run. It was all [based on] what they had read, rather than actually visiting any service." Previous SUSD Staff*

*"Because they couldn't staff it properly to start off with. They didn't have a clue about the program. The actual intranet stuff, the resources on the intranet, these people didn't even know about. I was working in the hospital at the time. We were referring here and kept getting told, no, no, we're not accepting, we're not accepting. So in the end, we just stopped referring."*

**HHS Staff, SUSD**

Two factors were identified as maximising the success of SUSD setup, including holding a partnership day soon after service opening, and involving experienced personnel who have previously worked in a SUSD service during the establishment period.

*“I think it was really useful to have a partnership day from the word go. Then looking at the model, looking at each other’s roles, understanding the roles each partner plays in the service provision as one team. I think that that’s still a difficulty.”*

**SUSD Stakeholder**

*“I’ll say that I think what worked really well for us starting this service.... we worked at Step Up Step Downs before and we knew what worked. We knew how to set it up, we knew the computer systems. It was just like smooth. I think that’s sort of really important...It makes some massive difference. Someone that already knows can go in and say you need this, this, this, and this, and here’s our staff manual, so forth.”* **NGO Service Manager, SUSD**

The support of referring services was also seen to be critical to the success of service set-up, which is consistent with findings reported in section 4.3.3, showing that referrer awareness of the service impacted its ability to reach eligible consumers.

Interviews with staff and stakeholders indicated that buy-in from HHS staff was mixed when the SUSD was first established at their sites. Staff had a lack of awareness and understanding of the purpose and value of the service and were hesitant to engage with the SUSD due to concerns about the service being voluntary for consumers.

*“It was challenging. I was doing these presentations to a whole bunch of staff members in mental health who I’d given this five minute introductory to what a Step Up Step Down was, and then at the end of that same presentation, 20 minutes later, I was going, this is how you refer, and just being welcomed with a bunch of people scratching their heads, and going, oh, this is interesting, we don’t really know what to make of it, just yet.”* **Previous SUSD Staff**

*“There were some that were quite positive. They were like, this sounds like a great option, particularly for those folks that might be in hospital that still need some support but don’t need as intense support as provided 24/7. But on the flipside, we would have feedback from some teams – well, this is a voluntary opportunity, what if somebody says no, what if somebody becomes unwell? There was a lot of sort of unknowns, and why can’t you take people with these particular risks, what if they’re safe at the moment – yeah.”* **Previous SUSD Staff**

### **5.1.2. Buy-in for SUSD from HHS staff**

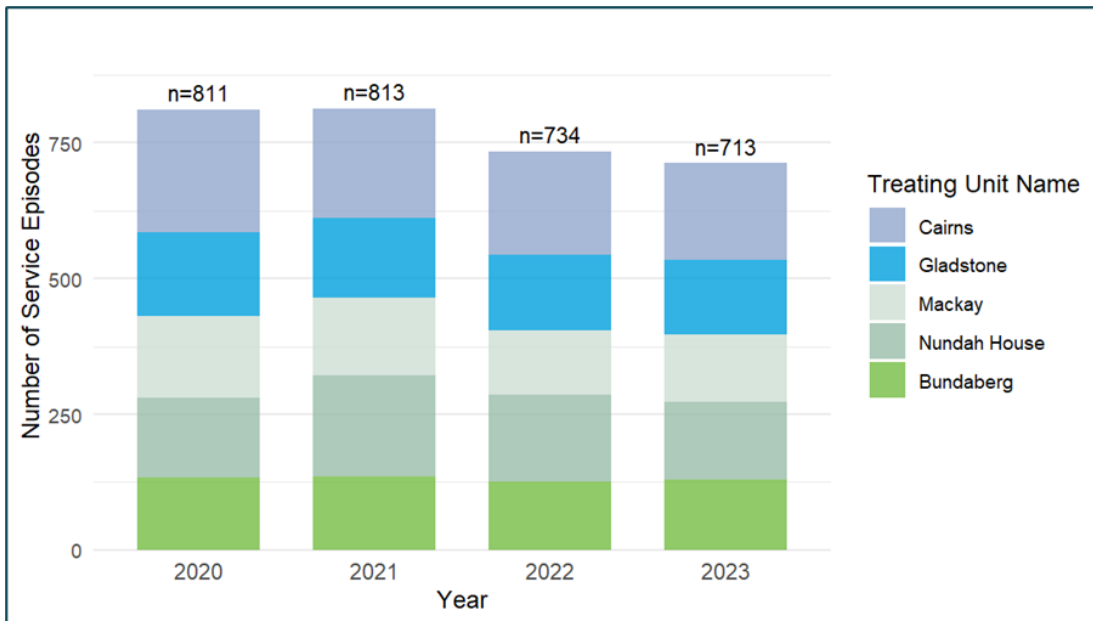
A large facilitator of buy in from HHS is the length of time referrers have been in their role and therefore the knowledge and feedback they have accumulated about the service (see section 4.3.3). Another facilitator is the strength of the partnership between the broader HHS and SUSD (see section 6.2.3). Below is an example provided by a service manager of a strong HHS buy-in and the factors facilitating this.

*“Some of it is that their mental health workforce has been stable for a very long time, so they have a very good knowledge base. Their community is a little bit smaller, so they have pretty effective relationships with their clients. They understand our service very, very well, so they’re able to talk with it openly, and I suppose, positively so they promote it. They have clients who have had really good experiences here so they’ve got testimonials so to speak from clients as well. They’re also engaged with the clients while they’re in the service here as well, so they have regular contact with us and with the client while they’re staying here. So, I think, and their transfers of care back to them have been incredibly successful, as well. In terms of that integration and seamless practice.”* **NGO Service Manager, SUSD**

### 5.1.3. SUSD Service episodes

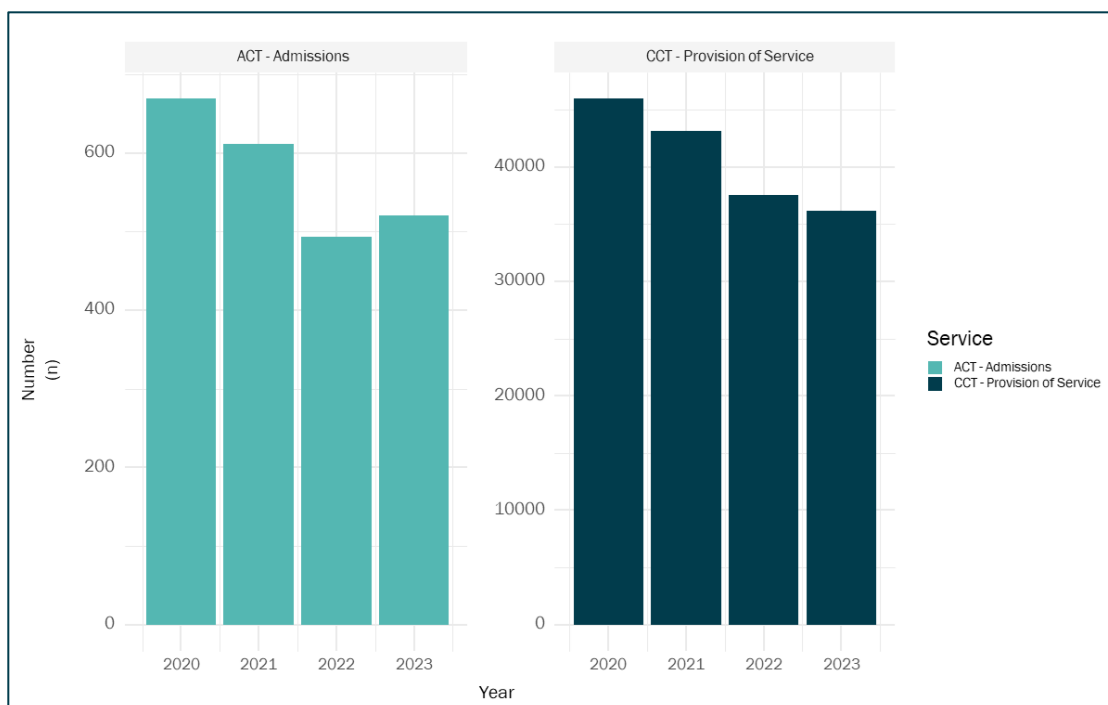
Between 2020 and 2023, a total of 2,295 unique individuals attended SUSD, making up a total of 3,071 service episodes across all five SUSD units. As shown in Figure 13, SUSD service episodes decreased between 2020 and 2023. The key referring services into Adult SUSD - Acute Care Teams (ACT) and Community/Continuing Care Teams (CCT) also experienced a decrease in service usage between 2020 and 2023 (see Figure 14). This suggests that the decrease in SUSD service episodes was due to a system wide decrease in service usage, not specific to SUSD services.

**Figure 13 | Number of SUSD service episodes per year split by Treating Unit (n = 3,071)**



Note. Data sourced from CIMHA

**Figure 14 | ACT admissions and CCT provision of service per year**

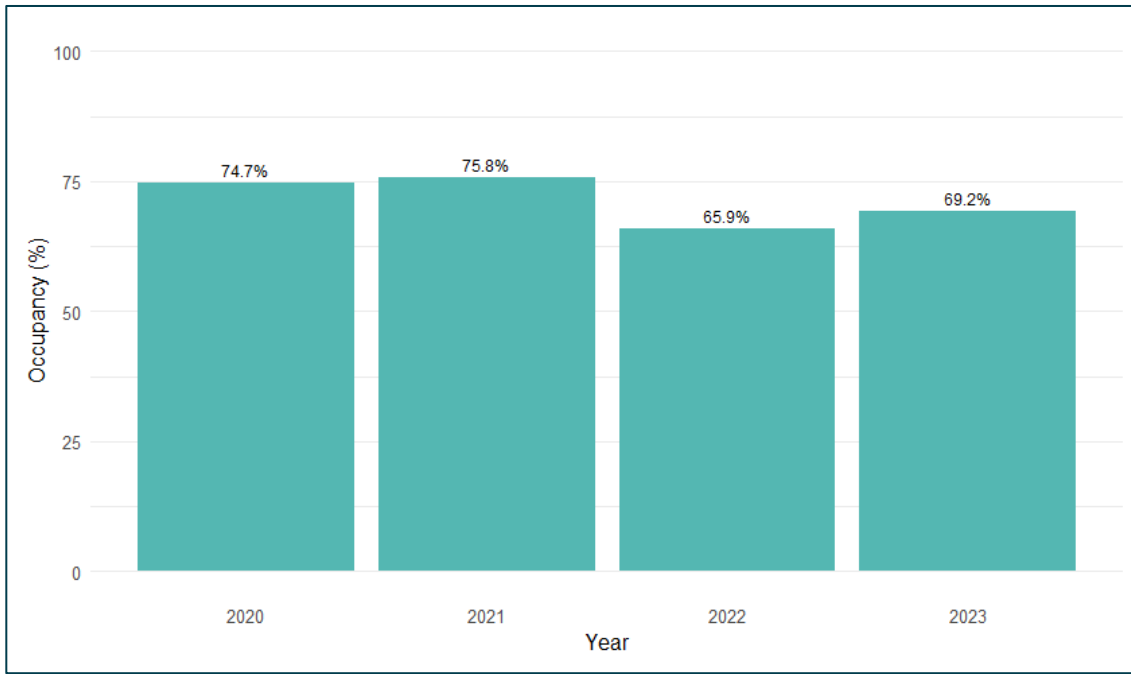


Note. Data sourced from CIMHA

## 5.1.4. SUSD Occupancy

Between 2020 and 2023 the statewide occupancy of SUSD services decreased from 74.7% to 69.2% (see Figure 15). The largest decrease in occupancy occurred between 2021 and 2022 where there was a 10% drop. This aligned with a decrease in service episodes between 2021 and 2022 as described in section 5.1.3.

*Figure 15 | Statewide occupancy of Adult SUSD services*



Note. Data sourced from MHE MNDS

## 5.2. Consumer adoption

Statewide data was not available to quantify how many consumers accepted the offer of a SUSD referral when it was suggested by their treating clinician. Interviews did however identify that consumers were less likely to accept a referral when referrers provided inadequate or inaccurate information.

*“I think, sometimes [a barrier is], the explanation from the person who refers. So maybe there’s a bit of inconsistency around the information. Misunderstandings.”* **NGO Team Leader, SUSD**

*“They [referring doctor] didn’t really say much about it. It was just like, they just mentioned Step Up Step Down, and - but they didn’t sell it to me, didn’t tell me what it was about. They didn’t say, when I said, no, well, these are the reasons we think you should go. These are the things we think could help you with. I would’ve appreciated that. So when I say the doctor offered it, I don’t know how much the doctor knew about it.”* **Consumer (declined SUSD referral)**

*“Yeah, one of the doctors recommended.....but I didn’t really know anything about it [after recommendation]. I went away and Googled [laughs]....nothing – nothing there.”* **Consumer, SUSD**

In circumstances where limited information was provided on referral, consumers and carers described fears and misconceptions about the SUSD prior to their stay. A commonly reported misconception was that the SUSD would be like an inpatient unit and restrict consumers’ ability to move freely or undertake activities, or by requiring them

to share rooms with acutely unwell consumers. Conversely, consumers who were acclimatised to the hospital environment expressed concerns that the SUSD would not provide enough support.

*“What he thought it was, was like being on the ward, so he wouldn't be able to leave and he wouldn't be able to do things that he might like to do. He wouldn't be able to come out with me. So that was a really big factor in whether he was going to go or not, because he didn't want to be stuck inside another building for another 28 days.”* **Carer, SUSD**

*“Particularly, community clients that were wanting that extra support. Some of them would be, well, no, I want to go to hospital, I know what to expect from hospital.....they would often be kind of like, well, I'm not going to get the same level of care as in hospital, or I'm comfortable with hospital, I'm not sure if I'm comfortable here – in here.”* **Broader HHS Staff**

That said, several strategies were used by services to provide the right amount of information about the SUSD to consumers and carers including brochures, in-person assessments, and walk-throughs of the facility both in person and via video. Both staff and consumers reported that meeting the SUSD staff and experiencing the environment firsthand could often change a hesitant consumer's mind.

*“So, they'll go, no, no, no, I don't trust it. So, we offer walk throughs where a referred consumer could do a walk-through of the Step Up Step Down with a Step Up Step Down staff member and try to build a bit of trust and then if they see the environment, then a walk through would be enough to change their, no, I don't want to go, because I want to stay at home, or because I've had this terrible experience on a locked in patient ward to, oh, actually, it's not too bad. Yeah, okay, put in that referral.”*

**Broader HHS Staff**

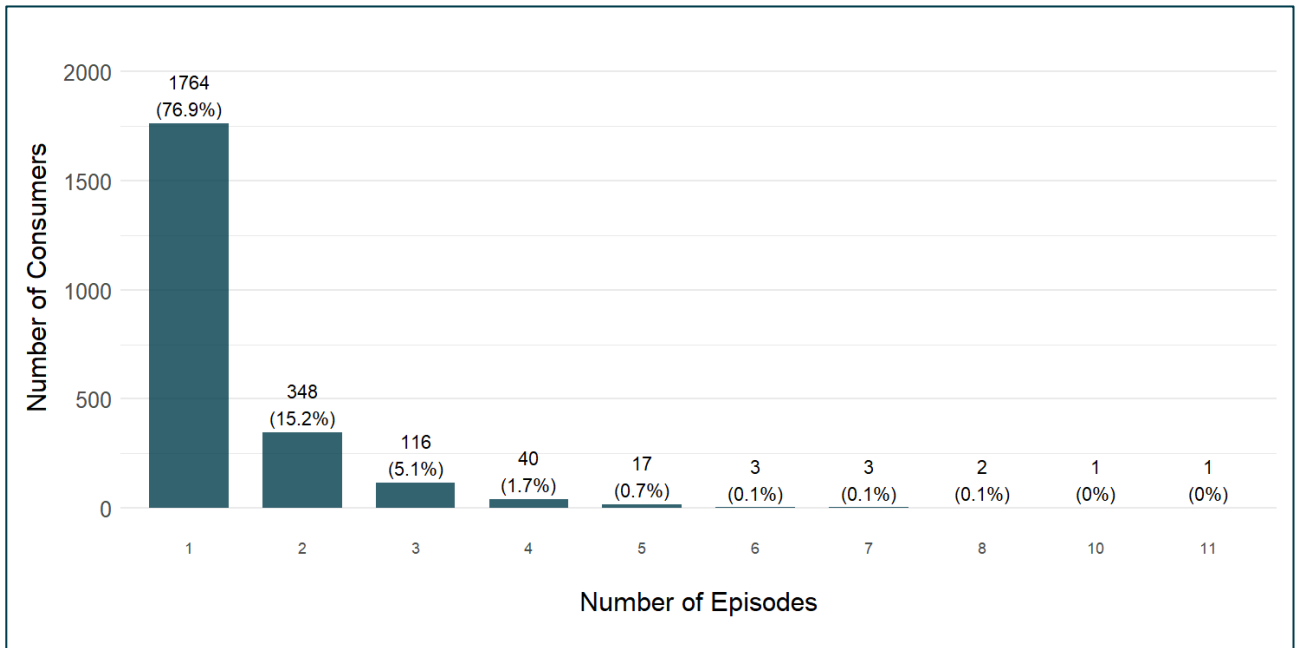
*“I was lucky again. I think they actually had a support worker personally come out to have a chat with me when I was still on the ward. Then I wasn't 100 per cent sold and I didn't really want to move in without having [seen it]. They were kind enough to actually pick me up and take me there to have a little bit of a look around. I felt comfortable because of that, and them letting me do all that, I suppose, actually getting admitted to it.”* **Consumer, SUSD**

Both staff and consumers reported that practical challenges prevented consumers from taking up a referral, including caring responsibilities for family or pets, work commitments and transportation barriers. Services provided additional support where possible to overcome these barriers.

### 5.3. Repeat presentations

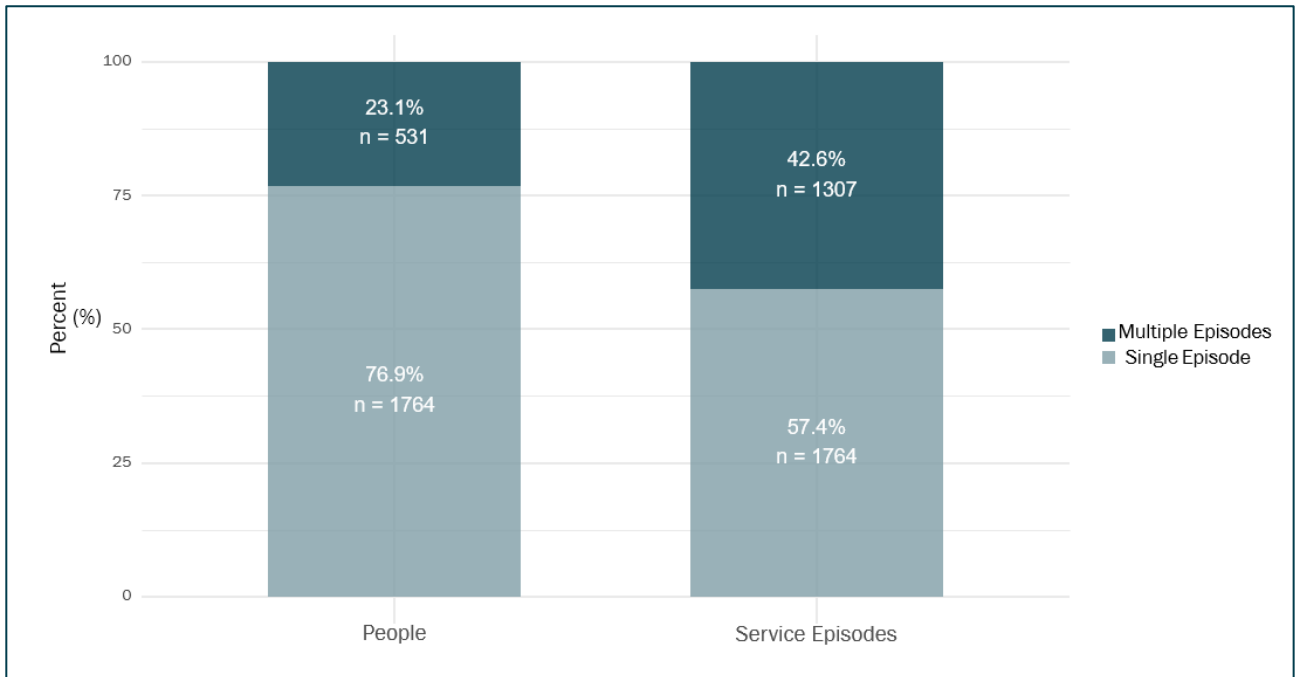
The data on the number of presentations to the SUSD services is shown in Figure 16. Most consumers (76.9%) visited the SUSD only once, while nearly a quarter (23.1%) used the service more than once. In terms of service delivery, 57.4% of all service episodes at SUSD were made by consumers who only attended once, compared to 42.6% of service episodes delivered to repeat presenters (see Figure 17). Among repeat presenters, most visited the SUSD twice, and only a small group visited more frequently. The highest number of visits by a single consumer was 11 occasions.

**Figure 16 | Number of presentations to the SUSD per consumer.**



Note. Data sourced from CIMHA

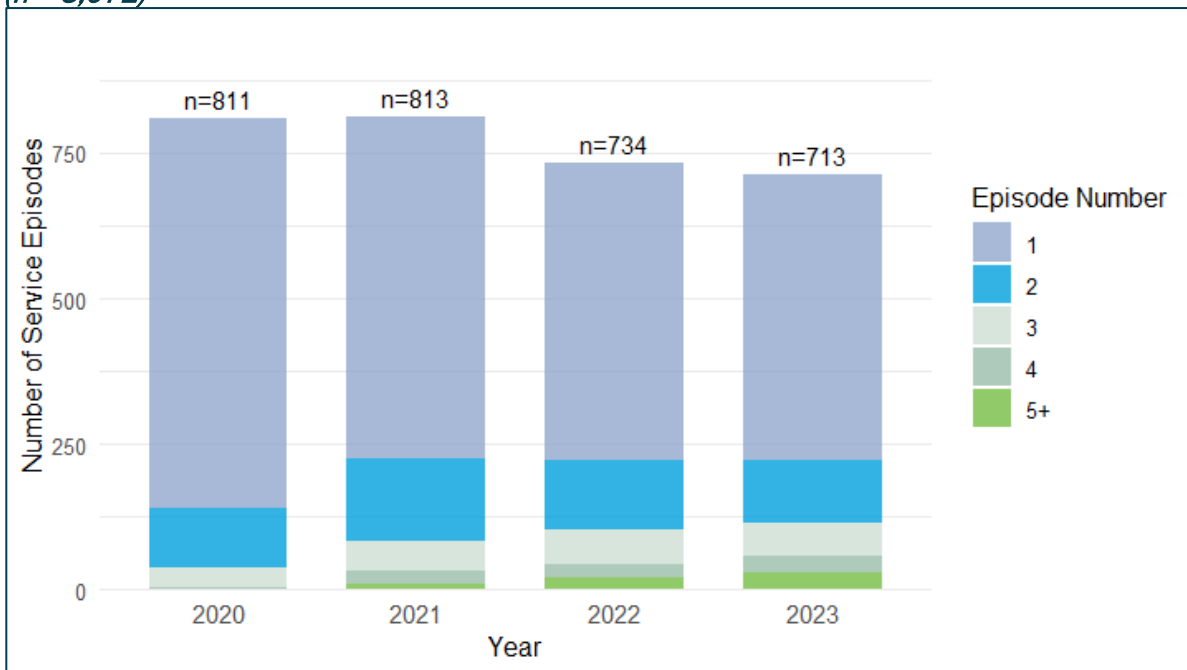
**Figure 17 | Proportion of services delivered to repeat presenters at SUSD.**



Note. Data sourced from CIMHA

Figure 18 depicts service episodes between 2020 – 2023, and for each year, breaks down how many consumers attended the SUSD for their 1<sup>st</sup> episode of treatment, 2<sup>nd</sup> episode of treatment, 3<sup>rd</sup> episode of treatment, etc. The figure demonstrates that consumers attending SUSD for multiple episodes increased over time. Consequently, new consumers to SUSD decreased.

**Figure 18 | Number of statewide SUSD service episodes per year split by consumer episode number (n = 3,071)**



Note. Data sourced from CIMHA

A very positive finding from the interviews was that most repeat presenters were coming back to the SUSD to receive support during subsequent mental health crises, thus preventing the need for hospital care. According to consumer interviews, they acknowledged that the service had helped them in the past and expressed willingness to utilise it again if they felt their mental health deteriorating, instead of going to a hospital.

*“If I felt that I had fallen after leaving here in say three months, six months’ time, yes, 100 percent I would come back to then relearn, regroup, and reassess my own life and then build myself back up here”. Consumer, SUSD*

*“They did mention that I could always be referred back, kind of thing, and to be honest, if I was referred back – not that I want to be – I don’t think I would be apprehensive about going. I’d be happy to be under their care instead of an acute hospital care, if that bridge came up”. Consumer, SUSD*

*“This time, I really was trying to avoid a hospitalisation. Because having had two this year, I really wanted to avoid it if at all possible, because it’s just not really an environment conducive to healing and wellness; it’s not a nice place to be. So, my case manager and the doctors who I was seeing referred me and worked really hard to get me a place this time so that I wouldn’t have to go to hospital”. Consumer, SUSD*

Overall, staff and stakeholders agreed that the service was appropriately utilised by repeat presenters. Most consumers returned long after their first visit, during crises and when in need of further help, which was critical for them in their recovery. Staff also observed that the service helped strengthen consumers' self-management skills, as they appeared more confident and seemed to learn more with each visit.

However, some staff felt that a few repeat presenters were becoming reliant on the service instead of accessing other community services more suitable for ongoing care. As a result, they emphasized the importance of linking these consumers to other community services when possible and encouraging them to apply the skills they learned in the program in the long term.

*“There are people who have come back, and we’ve done a bit more work, and they’ve been able to go back out. It’s almost like top-up for their recovery, let’s say. Then there’s some other people who rely on the service for their sense of safety and wellbeing. That can become quite problematic actually because they’re almost like institutionalised in a way”.* **NGO Staff, SUSD**

*“We also see people who come back to the service on several occasions, but on each time they leave, we can say they’ve made some kind of gain, and I think that’s really important. Yes, we might have a person come there four or five times, but each time they’re coming back, we’re seeing they’ve gained something from the last time”.* **NGO Staff, SUSD**

*“So, it’s not like a reoccurring same thing, same time, every time, it’s actually we’re strengthening them. The next time we may see them again, is that they seem more confident in being able to do something by themselves. So, I see that, okay, well, even though, I’m questioning what we do, is that at the same time I can see them becoming more independent over the time they come to us”.* **SUSD Stakeholder**

*“We want them to actually go home and really give it a try, and really put into practice what they’ve learned. Link in with the community networks, get some routine happening, give that a good sort of effort, and we also don’t want to create dependencies on the program”.* **NGO Staff, SUSD**

*“You’re not making forward progress, you need to solidify and show us that you are using the skills that you have learned there before we look at – yeah, and then having those conversations around what timeframe that might be. But yes, there have been people who have been through more than once, but it’s been a long time between admissions. I had somebody who hadn’t been here for three or four years, and they had been really quite well and then – you can’t put arbitrary rules around things. But yeah, we need to be mindful that the service is being used appropriately”.* **Broader HHS Staff**

## 5.4. Summary of findings

- Very few staff and stakeholders interviewed for the evaluation were working at the SUSD when it was first established, thus making it difficult to determine site-specific strategies that aided or inhibited service implementation. However, those interviewed reported that SUSD establishment was aided by hosting partnership days and involving staff who had previously worked in or established a SUSD service.
- Interviews revealed that buy-in from ED and HHS staff was initially limited across sites, but tended to improve in staff who had longer exposure to the service and understood its value.
- Service usage data showed that SUSD service episodes decreased across 2020 to 2023, consistent with decreases seen in service usage across the HHSs who were running SUSD services.
- Statewide data on acceptance of SUSD referrals were not available. However, interviews identified that consumers tend to have misconceptions and fears of the SUSD when referrers failed to provide accurate information to them about the service. This was a primary barrier to consumers accepting referrals. Strategies used by SUSD services to improve service uptake included brochures, assessments, and facility tours. Consumers were also inhibited from accepting SUSD referrals due to practical barriers such as family and work responsibilities that they did not feel able to delegate to others, and/or transportation issues. SUSD

services were found to be providing additional support to address these barriers.

- Most consumers visited the SUSD only once, but nearly a quarter of visitors used the service more than once. Most repeat presenters visited SUSD services twice, most commonly to receive support for a subsequent crisis and avoid going to hospital. Staff and stakeholders agreed that consumers may benefit from using the service on multiple occasions to support recovery but emphasised that repeat presenters demonstrating a reliance on the service should be linked to other appropriate community services for long-term care.

## 6. Implementation of SUSD

### Defining and evaluating health service implementation and sustainability

This section explores how the SUSD services were implemented by sites, including local adaptations put in place to enhance the SUSD model. It also examines factors that impacted the successful implementation and ongoing sustainability of the SUSD from a service delivery (i.e., process) perspective.

This section of the report answers the following key evaluation questions:

- How does the SUSD function in practice, and what are the variations in service delivery across the five sites?
- What are the factors impacting the implementation of the SUSD for health services?

### 6.1. Variability in service delivery across sites

SUSD services vary widely in the way they are delivered across the state, with local sites adapting the state-wide MOS to meet the needs of the communities they serve. The key elements of service delivery for each of the five SUSD sites (see Table 9) were therefore mapped by reviewing site-specific Service Guidelines, in addition to interviews with SUSD staff.

The evaluation found that SUSD services varied most with respect to staff profile, program planning and delivery, length of stay, and medication. These variations are discussed in more detail below.

**Table 9 | Overview of local site's implementation of the SUSD model.**

Service Element	HHS Site				
	Cairns and Hinterland	Central Queensland	Mackay	Metro North	Wide Bay
Name	Adult Step Up Step Down – Cairns	Step Up Step Down - Gladstone	Step Up Step Down - Mackay	Nundah House	Step Up Step Down - Bundaberg
NGO	MIND Australia	MIND Australia	MIND Australia	Neami National	MIND Australia
Facility	<ul style="list-style-type: none"> <li>• Re-purposed building</li> <li>• Two levels</li> <li>• Single bedrooms and one three-bedroom unit</li> </ul>	<ul style="list-style-type: none"> <li>• Purpose built</li> <li>• One level</li> <li>• Single bedrooms</li> </ul>	<ul style="list-style-type: none"> <li>• Purpose built</li> <li>• One level</li> <li>• Single bedrooms</li> </ul>	<ul style="list-style-type: none"> <li>• Purpose built</li> <li>• Three levels</li> <li>• Single bedrooms</li> </ul>	<ul style="list-style-type: none"> <li>• Purpose built</li> <li>• One level</li> <li>• Single bedrooms</li> </ul>
NGO staff profile 2024 <i>(24/7 coverage at all sites)</i>	<ul style="list-style-type: none"> <li>• Service Manager</li> <li>• Team Leader</li> <li>• Community Mental Health Practitioners</li> <li>• Peer Worker</li> <li>• Family Engagement Worker</li> <li>• Aboriginal &amp; Torres Strait Islander CMHP</li> <li>• Casual CMHP (as needed -2 available)</li> </ul>	<ul style="list-style-type: none"> <li>• Service Manager</li> <li>• Team Leader</li> <li>• Community Mental Health Practitioners</li> <li>• Peer Worker</li> <li>• Family Engagement Worker</li> </ul>	<ul style="list-style-type: none"> <li>• Service Manager</li> <li>• <i>Team Leader (on secondment, being backfilled by FEW)</i></li> <li>• Community Mental Health Practitioners</li> <li>• Peer Practitioner</li> <li>• <i>Family Engagement Worker (Not filled currently as in TL role)</i></li> <li>• Casual CMHP (as needed -5 available)</li> </ul>	<ul style="list-style-type: none"> <li>• Service Manager</li> <li>• Senior Practice Leaders</li> <li>• Community Recovery Support Workers</li> <li>• Peer Support Workers</li> <li>• Family and Carer Peer Worker</li> <li>• Casual CRSW (as needed -7 available)</li> </ul>	<ul style="list-style-type: none"> <li>• Service Manager</li> <li>• Team Leader</li> <li>• Community Mental Health Practitioners</li> <li>• Peer Support Worker</li> <li>• Family Engagement Worker</li> <li>• Casual CMHP (as needed -1 available)</li> </ul>
HHS staff profile 2024 <i>(in house)</i>	<ul style="list-style-type: none"> <li>• Clinical Nurse Consultant</li> <li>• Clinical Nurse</li> <li>• Administration Officer</li> <li>• <i>Team Leader (Access services - based at Cairns MH)</i></li> </ul>	<ul style="list-style-type: none"> <li>• Clinical Nurse Consultant</li> <li>• Psychiatric Registrar</li> <li>• Senior Psychologist</li> <li>• Occupational Therapist</li> <li>• Administration Officer</li> <li>• <i>Team Leader (SUSD and GIS combined role based at Gladstone CMH)</i></li> </ul>	<ul style="list-style-type: none"> <li>• Team Leader/Clinical Nurse Consultant</li> <li>• Registered Nurse</li> <li>• Occupational Therapist</li> <li>• Psychologist <i>(on leave - currently filled by Social Worker)</i></li> <li>• Allied Health Assistant</li> <li>• Administration Officer</li> </ul>	<ul style="list-style-type: none"> <li>• Team Leader/Nurse Unit Manager</li> <li>• Clinical Nurse</li> <li>• Consultant Psychiatrist</li> <li>• Psychiatric Registrar</li> <li>• Social Worker</li> <li>• Administration Officer</li> </ul>	<ul style="list-style-type: none"> <li>• Clinical Nurse Consultant/Lead</li> <li>• CNC - Complex Care Coordinator</li> <li>• Clinical Nurse</li> <li>• Social Worker</li> <li>• Administration Officer</li> <li>• <i>Team Leader (SUSD/ACT combined role based at</i></li> </ul>

	Clinical roster M-F 7:30am to 9:00pm, Weekend 8:00am to 4:30pm	Clinical roster M-F 8:30am to 4:30pm	Clinical roster M-F 7:30am to 4:30pm	Clinical roster M-F 08:00 am to 4:30pm	<i>Bundaberg CMH)</i> Clinical roster 7 days 8:00am to 4:30pm
Medical Team	Clinical in-reach provided by the ACT/CCT or by community-based Case Manager	Internal medical treatment team <i>(Consultant Psychiatrist for escalations and oversight based at Gladstone integrated services)</i>	Clinical in-reach provided by the ACT/CCT or by community-based Case Manager	Internal medical treatment team	Clinical in-reach provided by the ACT/CCT or by community-based Case Manager
Not eligible/ Service is not suitable for: <i>(From Service Guidelines)</i>	<ul style="list-style-type: none"> <li>• &lt;18 years</li> <li>• Requires a withdrawal/detox program.</li> </ul>	<ul style="list-style-type: none"> <li>• &lt;18 years</li> <li>• Requires a withdrawal/detox program.</li> <li>• Acutely unwell</li> <li>• Requires admission to a MH inpatient unit.</li> <li>• High acute risk of self-harm, aggression, or harm to others.</li> <li>• Homelessness is the primary issue.</li> <li>• Unwilling to engage in the SUSD program.</li> </ul>	<ul style="list-style-type: none"> <li>• &lt;18 years</li> <li>• Requires a withdrawal/detox program.</li> <li>• Acutely unwell</li> <li>• Requires admission to a MH inpatient unit.</li> <li>• High acute risk of self-harm, aggression, or harm to others.</li> <li>• Experiencing homelessness.</li> <li>• Unwilling to engage in the SUSD program.</li> </ul>	<ul style="list-style-type: none"> <li>• &lt;18 years</li> </ul>	<ul style="list-style-type: none"> <li>• &lt;18 years</li> <li>• Requires a withdrawal/detox program.</li> <li>• Acutely unwell</li> <li>• Requires admission to a MH inpatient unit.</li> <li>• High acute risk of self-harm, aggression, or harm to others.</li> <li>• Homelessness is the primary issue</li> <li>• Unwilling to engage in the SUSD program</li> </ul>
Length of Stay <i>(From Service Guidelines)</i>	<ul style="list-style-type: none"> <li>• 28 days maximum</li> <li>• Negotiated during referral and intake process and subject to change.</li> </ul>	<ul style="list-style-type: none"> <li>• 14-day average</li> <li>• 28 days maximum</li> <li>• Negotiated at the assessment phase and subject to change.</li> </ul>	<ul style="list-style-type: none"> <li>• 14-day average</li> <li>• 28 days maximum</li> <li>• Negotiated at the assessment phase and subject to change.</li> </ul>	<ul style="list-style-type: none"> <li>• 10 to 14 days average</li> <li>• 28 days maximum</li> </ul>	<ul style="list-style-type: none"> <li>• 28 days maximum</li> <li>• Negotiated at the assessment phase</li> <li>• Extensions beyond 28 days upon approval.</li> </ul>
Group Programs <i>(From interviews)</i>	<ul style="list-style-type: none"> <li>• Attendance encouraged</li> <li>• Approx. 3 groups daily inc. house meeting</li> <li>• Psychosocial groups adapted from Mind Recovery College</li> </ul>	<ul style="list-style-type: none"> <li>• Attendance compulsory</li> <li>• 5 groups daily inc. house meeting</li> <li>• Psychosocial groups adapted from Mind Recovery College Programs and in</li> </ul>	<ul style="list-style-type: none"> <li>• Attendance compulsory</li> <li>• 4 groups daily inc. house meeting</li> <li>• Psychosocial groups adapted from Mind Recovery College</li> </ul>	<ul style="list-style-type: none"> <li>• Attendance encouraged</li> <li>• Approx. 3 groups daily inc. house meeting</li> <li>• Psychosocial groups adapted from Neami Programs</li> </ul>	<ul style="list-style-type: none"> <li>• Attendance compulsory</li> <li>• 3 groups daily inc. house meeting</li> <li>• Psychosocial group program developed by the service manager in</li> </ul>

	<p>Programs</p> <ul style="list-style-type: none"> <li>No clinical groups</li> <li>Other group activities include: social activities, outings, mindfulness and relaxation</li> </ul>	<p>collaboration with HHS clinical practice guidelines and feedback from client groups</p> <ul style="list-style-type: none"> <li>Clinical group by HHS</li> <li>Other group activities include: physical movement, social activities, outings, mindfulness and relaxation, cooking and meal planning</li> </ul>	<p>Programs</p> <ul style="list-style-type: none"> <li>Clinical groups by SW and OT.</li> <li>Other groups activities include: physical movement, social activities, outings, mindfulness and relaxation, cooking and meal planning</li> </ul>	<ul style="list-style-type: none"> <li>No clinical groups</li> <li>Other groups activities include: physical movement, social activities, mindfulness and relaxation</li> </ul>	<p>conjunction with consumer feedback</p> <ul style="list-style-type: none"> <li>Clinical groups by CN and SW</li> <li>Other groups activities include: physical movement, social activities, mindfulness</li> </ul> <p>and relaxation, art therapy, cooking and meal planning</p>
Individual Interventions and supports	<ul style="list-style-type: none"> <li>Entry and exit assessments</li> <li>Recovery plan development (My Better Life Plan)</li> <li>Psychosocial support and intervention</li> <li>Community linkages and in reach</li> <li>Clinical support and treatment (Nursing)</li> <li>Exit planning</li> </ul>	<ul style="list-style-type: none"> <li>Entry and exit assessments</li> <li>Recovery plan development (My Better Life Plan)</li> <li>Psychosocial support and intervention</li> <li>Community linkages and in reach</li> <li>Daily living and practical assistance.</li> <li>Clinical intervention and treatment (Medical and Allied Health)</li> <li>Budgeting and financial resilience</li> <li>Accommodation support</li> <li>Exit planning</li> </ul>	<ul style="list-style-type: none"> <li>Entry and exit assessments</li> <li>Recovery plan development (My Better Life Plan)</li> <li>Psychosocial support and intervention</li> <li>Community linkages and in reach</li> <li>Daily living and practical assistance.</li> <li>Clinical intervention and treatment (Nursing and Allied Health)</li> <li>Budgeting support</li> <li>Exit planning</li> </ul>	<ul style="list-style-type: none"> <li>Entry and exit assessments</li> <li>Recovery plan development (Focus-of-Stay document)</li> <li>Psychosocial support and intervention</li> <li>Community linkages</li> <li>Daily living and practical assistance.</li> <li>Clinical intervention and treatment (Medical and Nursing)</li> <li>Exit planning</li> </ul>	<ul style="list-style-type: none"> <li>Entry and exit assessments</li> <li>Recovery plan development (My Better Life Plan)</li> <li>Psychosocial support and intervention</li> <li>Community linkages and in reach</li> <li>Daily living and practical assistance.</li> <li>Clinical intervention and treatment (Nursing and Allied Health)</li> <li>Vocational support</li> <li>Accommodation support</li> <li>Exit planning</li> </ul>

<p>In-reach support services</p>	<ul style="list-style-type: none"> <li>• The Junction Clubhouse</li> <li>• Independent Patient Rights Advisors (IPRA)</li> <li>• Centrelink</li> </ul>	<ul style="list-style-type: none"> <li>• In-service groups provided by Community organizations</li> <li>• Anglicare Finance/Budgeting Support (weekly group &amp; 1-on-1)</li> <li>• Anglicare Way Back support service</li> <li>• Anglicare Healthy Minds</li> <li>• Gladstone Women's Health - Healthy relationships group (focus on DV)</li> <li>• Yoga</li> <li>• Aboriginal and TSI MH Liaison Officer</li> </ul>	<ul style="list-style-type: none"> <li>• Employment Services</li> </ul>		<ul style="list-style-type: none"> <li>• Various external organizations present to residents (weekly group).</li> <li>• Community navigators</li> <li>• The Way Back support service</li> <li>• Bridges Health and Community Care</li> </ul>
<p>Other activities and amenities provided</p>	<ul style="list-style-type: none"> <li>• TV</li> <li>• Arts &amp; crafts</li> <li>• Outdoor space and facilities inc. pool</li> <li>• Karaoke</li> <li>• Table tennis</li> </ul>	<ul style="list-style-type: none"> <li>• TV</li> <li>• Arts &amp; crafts</li> <li>• Outdoor space and facilities</li> <li>• Gardening</li> <li>• Music</li> <li>• Board games</li> <li>• Pool table</li> <li>• Art therapy</li> <li>• Physical activity equipment</li> <li>• Computer</li> <li>• Journaling</li> <li>• Therapy dog (in-house)</li> <li>• Supported access to local services during stay</li> </ul>	<ul style="list-style-type: none"> <li>• TV</li> <li>• Arts &amp; crafts</li> <li>• Outdoor space and facilities</li> <li>• Gardening</li> <li>• Music and instruments</li> <li>• Games/puzzles</li> <li>• Journaling</li> <li>• Massage chair</li> <li>• Computers</li> <li>• Supported access to local services during stay.</li> </ul>	<ul style="list-style-type: none"> <li>• TV</li> <li>• Arts &amp; crafts</li> <li>• Outdoor space and facilities</li> <li>• Gardening</li> <li>• Music &amp; instruments</li> <li>• Physical activity equipment (inc. exercise bike)</li> <li>• Karaoke</li> <li>• Creative writing</li> </ul>	<ul style="list-style-type: none"> <li>• TV</li> <li>• Arts &amp; crafts</li> <li>• Outdoor space and facilities</li> <li>• Gardening</li> <li>• Music &amp; instruments</li> <li>• Board games</li> <li>• Pool table</li> <li>• Massage chair</li> <li>• Karaoke</li> <li>• Supported access to local services during stay.</li> <li>• Full Cityfit gym and Bundaberg Aquatic Centre Pool membership for 28 days.</li> </ul>

Family and Carer engagement	<ul style="list-style-type: none"> <li>Family Engagement Worker support available</li> </ul>	<ul style="list-style-type: none"> <li>Family Engagement Worker support available</li> <li>Family/Carer BBQ (every second weekend)</li> <li>Family Engagement Worker provides carer psychoeducational recovery and support group fortnightly.</li> </ul>	<ul style="list-style-type: none"> <li>Family Engagement Worker support available</li> <li>Family/Carer BBQ (on pause due to budget constraints)</li> </ul>	Family Engagement Worker support available (started October 2023)	<ul style="list-style-type: none"> <li>Family Engagement Worker support available</li> <li>Family/carer BBQ (every second weekend)</li> </ul>
Medication management approach	<ul style="list-style-type: none"> <li>Webster-pak or standard packaging</li> <li>Medication plan written by CNC/RN in conjunction with consumer. This plan identifies level of medication support required including: <ol style="list-style-type: none"> <li>Clinically administered by CNC/RN or by ACT team after hours</li> <li>Monitored (by Mind staff)</li> <li>Remind and Encourage (by Mind staff)</li> <li>Self-administer (no prompting)</li> </ol> </li> </ul>	<ul style="list-style-type: none"> <li>Webster-pak mandatory</li> <li>Medication plan written by CNC/RN in conjunction with consumer. This plan identifies level of medication support required including: <ol style="list-style-type: none"> <li>Monitored (by Mind staff)</li> <li>Remind and Encourage (by Mind staff)</li> <li>Self-administer (no prompting)</li> </ol> </li> </ul>	<ul style="list-style-type: none"> <li>Webster-pak or standard packaging</li> <li>Medication plan written by CNC/RN in conjunction with consumer. This plan identifies level of medication support required including: <ol style="list-style-type: none"> <li>Clinically administered by CNC/RN or by ACT team after hours</li> <li>Monitored (by Mind staff)</li> <li>Remind and Encourage (by Mind staff)</li> <li>Self-administer (no prompting)</li> </ol> </li> </ul>	<ul style="list-style-type: none"> <li>Webster-pak or standard packaging</li> <li>Medication plan written by CN in conjunction with consumer. This plan identifies level of medication support required including: <ol style="list-style-type: none"> <li>Independent with medications</li> <li>Requiring supervision</li> </ol> <p>For consumers requiring supervision, medication observation and support is provided by MNMH (clinical) staff or 2x Neami (non-clinical) staff</p> </li></ul>	<ul style="list-style-type: none"> <li>Webster-pak mandatory</li> <li>Medication plan written by CNC/RN in conjunction with consumer. This plan identifies level of medication support required including: <ol style="list-style-type: none"> <li>Monitored (by Mind staff)</li> <li>Remind and Encourage (by Mind staff)</li> <li>Self-administer (no prompting)</li> </ol> <ul style="list-style-type: none"> <li>Medication taking is monitored in the first 72hrs of a stay</li> </ul> </li> </ul>
Contact from SUSD after exit	<ul style="list-style-type: none"> <li>Consumers Leading Into Community (Mind Australia) 4-week intensive support program available after exit</li> </ul>	<ul style="list-style-type: none"> <li>Family engagement worker will make a follow-up call to family.</li> <li>Family Engagement Worker offers psychoeducational recovery and support groups- accessible by former clients family</li> </ul>		<ul style="list-style-type: none"> <li>Warm line (follow up) phone call by Neami National staff in the 1-7 days after exit (28 days at most).</li> </ul>	<ul style="list-style-type: none"> <li>Open house Friday morning for morning tea and karaoke</li> </ul>

## 6.1.1. Staffing profile of SUSD / staff capacity

NGO and HHS staffing profiles for each SUSD service are outlined in Table 9.

SUSD services are staffed by employees of the NGO and the hosting HHS. Across sites, NGO staffing was found to be consistent with the MOS, except for Nundah SUSD, which had fewer NGO mental health workers than the other sites. Several interviewed staff felt this impacted Nundah's capacity to deliver individual and group interventions (see section 6.1.7). Additionally, Cairns SUSD added an Aboriginal and Torres Strait Islander Community Mental Health Practitioner to their staffing profile in 2024, following this being identified as a gap during interviews for this evaluation process in 2023.

*"In regard to Indigenous clients, I don't feel like we are meeting the needs of those. We don't have a – I believe we have put in an ad for it, we may be getting an identified position, but I feel like there's definitely a barrier for people that come from Thursday Island and Kowanyama and stuff like that, they're usually the ones that aren't attending groups, that we aren't able to get paperwork done and I think it's definitely they're missing a link there."* **NGO Staff, Cairns SUSD**

In contrast, HHS staffing across the services was found to vary widely, in terms of how consistent the staffing mix was with the MOS and across sites. The MOS articulates that clinical staffing should include a consultant psychiatrist, a designated Clinical Lead and a multi-disciplinary team of nurses and allied health staff to provide clinical coverage between 8am and 10pm, 7 days a week. Table 9 shows that many SUSD were not able to achieve clinical staffing levels articulated in the MOS. At the time interviews took place for this evaluation (mid/end 2023) all sites other than Cairns had clinical coverage during business hours only. Staff and stakeholder interviews highlighted that the reduced clinical coverage created several challenges when it came to medication changes (see section 6.1.8), incident management, and the services' ability to take on more acute consumers. In 2024, Bundaberg expanded clinical coverage to include weekends.

*"Clinical hours over weekends would facilitate some people who are probably a bit more acute than what can be handled here [SUSD] now but aren't really unwell enough for the ward. It would open up the ability to provide care to a slightly more higher acuity."* **Broader HHS Staff**

*"Yeah. The other challenge that's also with the service model, is given that we don't have a clinician on-site, like 24/7, we've had to rely upon the after-hours nurse unit managers, so clinicians up at the hospital, that provide incident-based and clinical advice. There's varying degrees of understanding of SUSD, and varying degrees of - well how do I frame this - maybe appropriate collegial communication."* **SUSD Stakeholder**

It was found that two of the five sites had an internal medical team (as outlined in the MOS), while the remaining three sites had medical in-reach provided by ACT/CCT or by a community-based case manager. While this in-reach is thought to provide greater continuity of care for consumers, interviewees highlighted numerous practical challenges with this arrangement including the need to liaise with multiple teams, some of whom were very disengaged, as well as delays with reviews and medication changes. These challenges were magnified in SUSD servicing large catchment areas.

*"Normally the case manager from the community will in-reach. Right? Which is lovely for that model, because it gives the consumer that continuity of care. Get the same psychiatrists. They don't have to change treating teams. Lots of positives. But your trouble with having this is, so we take from virtually Papua New Guinea, right down to past Innisfail and out the other*

*side of the gulf is our catchment area. If you look at our footprint it's huge... So it's impractical for the PSPs to do much [more] than a phone call.... The team do try to catch up with each of their clients they've got in here weekly. But sometimes we can have six different teams which actually puts a little bit of stress on us when you've sort of got six different doctors sort of changing meds, doing everything like that.”* **HHS Staff, SUSD**

*“Chasing scripts and that sort of stuff is just a pain in my rear end. It never gets any easier.. We need to go and chase the doctors and then argue with the doctors if they don't want to do anything. So lots of different - you deal with lots of different medical staff. They're all different and they all practice differently. It can be very frustrating at times when they don't do the same thing as you know another doctor would do to get things done more quickly.”* **HHS Staff, SUSD**

*[In response to never putting treating team in SUSD] “Huge, I think it's huge. You're constantly trying to reteach teams what our role is, what the service is, what the function is. Then you're trying to constantly develop new relationships with new psychiatrists. So, I think it's a really big impact. I mean, it's massive. I think the time and energy that we spend trying to re-educate, rebuild relationships, or re-establish ourselves, all those things, that could be time that's far better spent elsewhere.”*  
**NGO Staff, SUSD**

Challenges with the internal medical team were found to arise when the consultants assigned to the SUSD were not practicing from a recovery-based framework. Staff and consumer interviews emphasized the adverse impact this had on the service.

*“At the moment we've got someone [a consultant] who is very much like my way or the highway kind of person and their way really has been causing actual problems. I worry that they're actually causing harm to consumers rather than being...a genuine benefit. Yeah and how to, you know, we have to try and deal with that in a way that's respectful. I mean that - my view is that consultants should never have been hired and I know I'm not the only one who feels that way. How did that happen? How can that be prevented from happening in the future?”* **Staff, SUSD**

*“But that first day I think, yeah, just settling in. Because there wasn't – one thing, I feel like the doctor that is in charge of everyone, I don't think he'll be there much longer because of the amount of complaints that got put in. But how come a doctor that only sees us for five minutes a week is in charge of our care?... But every other staff member – and the psych reg, she was amazing. But the doctor himself – and I don't just – it doesn't make sense as well, I think. They spend no time with us, but they are in charge of everything”* **Consumer, SUSD**

Nursing capacity and hours differed across the sites, with Gladstone only having one nurse, Cairns, Mackay, Nundah having two nurses, and Bundaberg staffed with three nurses (although one of these was the complex care coordinator across the region). Unsurprisingly, Gladstone SUSD staff expressed an additional nurse would be beneficial to better manage the demands of the role. Two of the sites experienced a high turnover in their nursing staff, and described the challenge of backfilling these roles and servicing leave due to the uniqueness of the SUSD model compared to the HHS services where casuals were sourced.

*“I think one CNC is not enough staffing to facilitate that. It is quite a process. That's because people just aren't aware of what the guidelines are – that the CNC does cover and have a lot of communication with a lot of people [potential consumers] that aren't actually – it's not the right service for them or they're not ready yet.”* **Broader HHS / Previous SUSD Staff**

*“The NGO team generally has fairly consistent staffing and they tend to have – when they do have casual staffing, it's people that have had some exposure to the model. Whereas the clinical side, I think that there are times – again, I think about leave*

*cover. When somebody takes leave – when one of the nurses takes leave, they get someone into backfill, but often that becomes quite a tense situation because they've never worked in that model and there's a few misconceptions and misunderstandings around how things operate.” Broader HHS / Previous SUSD Staff*

*“We've had changes of CNCs as well. We've had quite frequent changes in the last probably 12 to 18 months, and so then you're trying to re-educate a CNC on those [recovery model] kinds of things, and that's been destabilising as well. It is the most exhausting part of the role is trying to re-educate people over and over and it gets like Groundhog Day, and once you finally got people on board with them, then they go. You're like, oh. Yeah.” NGO Staff, SUSD*

*“We only have one CNC that works from 7am-4pm 5 days and one CN from 1-9pm every day however if either of them are sick or have holidays their shift is not always covered which is a concern for Mind staff, especially when assessing someone that may be high risk and based on having clinical staff on site we accept them.” NGO Staff, SUSD*

There was large variation in Allied Health staffing, and their role, across the five sites (see Table 9). At the time of interviews (middle/late 2023) Mackay had two Allied Health staff, Bundaberg, Gladstone, and Nundah had one and Cairns had none. In 2024 Gladstone onboarded an additional Allied Health staff member. Interviewees reported that the role of Allied Health staff at the SUSD services were underdeveloped and were often indistinct with other roles in the service.

*“I do a bit of referrals or linkages, if I need to, but it's really difficult with my role, because a lot of CMHPs, the community mental health practitioners, for Mind, that's part of their role too. You know?...It's really difficult, the knowing who's doing what and they also have a family engagement worker, which really is bread and butter social work. But because they've already got someone in that role - that's why it's been a bit...A little bit tricky, yeah, as such, but I guess if there's - and probably the more complex sort of things that would come up for social work, then, yes, I'd get involved.” HHS Staff, SUSD*

*“I've really said to the CMHP when I sat in and observed them here with Mind, that I didn't feel the – I didn't actually quite understand why they needed [Allied Health] groups when the NGO staff are really doing fabulous work. I can't really hold an edge on that... Yes, and the clinical nurse does most of the assessments. I'm more back-up for assessments. If needed, or a clinical nurse is sick, or something has happened....” HHS Staff, SUSD*

This lack of clarity over the role of the Allied Health staff led to some staff/stakeholders raising questions regarding Allied Health's use of time in the service.

*“I feel as though if the model were being seriously being looked at and properly assessed, the sensible thing would be to only have a full-time CNC and a CN/RN and the remainder of the clinical team [Allied Health] should inreach where needed... It's such a waste of money the amount of time the clinicians spend with nothing to do, there should be a better, more financially viable way to run a SUSD service.” Staff, SUSD*

However, some consumers spoke of their appreciation of having Allied Health as part of the SUSD multidisciplinary team and staff spoke of the missed opportunity of utilising the Allied Health staff available.

*“I think it should be a social worker, to be really honest with you, working with families, because that's core...enough to give the family psychoeducation too, whereas, I guess, Mind do not have that clinical knowledge to be able to say, this is your loved one's early warning signs. This is normal for this – and to normalise some of what they might be seeing.” HHS Staff, SUSD*

“The social worker there are in a position that is a generic allied health, so it could be the occupational therapist, it could be a psychologist, again, their position. People think, well there’s a social worker there, they can deal with Centrelink, they can deal with running housing and everything. The social worker will just come to me and say, no, I can’t because 80 per cent of the work is doing intake, doing assessment arranging everything. The remaining 20 per cent, maybe 30 per cent is in-house service, which still comes down to basic maybe Centrelink form, maybe do this.” **NGO Staff, SUSD**

“Such as, again, I think that there would be real benefit to actually having regular clinical groups and more clinical input. Because I feel like it’s a safe environment, you get a lot of connection to the community and support from the non-clinical team, but in terms of the therapy that could occur in that space, we just don’t have capacity to do that.” **HHS Staff, SUSD**

## 6.1.2. Length of stay

As indicated in the SUSD MOS, the length of stay for each admission is intended to be short-term, with a maximum of 28 days. Our analysis of quantitative data showed that the median length of stay was consistent at around 15-18 days across all SUSD units between 2020 and 2023. Table 10 presents the median length of stay at each SUSD service (and overall state-wide) from 2020 to 2023.

**Table 10 | Median length of stay across SUSD units from 2020 - 2023**

Treating unit	Length of stay in days (Median [Q1, Q3])			
	Year			
	2020	2021	2022	2023
Bundaberg	20 [10, 27]	22 [10, 28]	21 [12, 26]	18 [8, 26]
Cairns	13 [7, 20]	16 [8, 28]	19 [11, 25]	18 [10, 27]
Gladstone	14 [10, 21]	15 [11, 21]	14 [10, 20]	14 [11, 18]
Mackay	20 [11, 27]	21 [12, 27]	14 [9, 24]	14 [9, 21]
Nundah House	18 [13, 26]	17 [13, 24]	20 [14, 28]	23 [15, 28]
State-wide	15 [9, 24]	18 [11, 26]	17 [12, 24]	17 [12, 26]

Note. Median has been used as it is a more reliable measure of central tendency in this data set due to the presence of extreme outliers which distort the mean value.

Despite quantitative data showing consumers had comparable median lengths of stay across services, qualitative data indicated some variation in how the length of stay is determined and communicated. For most services, consumers entering SUSD were told that it is a two week stay initially, and this was communicated during the initial intake phase. At the care review stage, extensions were offered depending on the consumer’s readiness to leave and whether they were engaging in the program. Longer length of stay was reported to be necessary for clinical reasons such as medication changes that require monitoring. Nundah House automatically offers consumers experiencing homelessness a stay of 28 days and Cairns SUSD was found to extend a stay for consumers without a discharge address. Less frequently, services extended stays beyond 28 days if a consumer was awaiting admission at another mental health service (e.g. CCU). Bundaberg SUSD was found to be unique in encouraging consumers to stay for a standard 28-days, assuming their engagement in the program.

“...so we bring people in for a 14 day stay. Then reason [is needed] to stay after that [14 days], there usually has to be some reasoning, some sort of plan in place.... up to a maximum of 28 days.” **NGO Staff, SUSD**

*“No, generally a person will stay up to four weeks, but it all depends on how you’re going out there [in SUSD], whether you like it, whether you’re participating in the programs. We try to make it clear that if you’re not engaging in the program, you’ll be out.”* **Broader HHS Staff**

Staff and stakeholders’ opinions regarding the appropriate length of stay varied. Some felt that two weeks plus a review for extension was ideal. Rationales for this included that it allowed flexibility for consumers to be exited early if they were ready, or if they were not engaging in the program. In doing so, it also created bed availability for another consumer.

*“Yeah, so as far as I’m aware, so the service is licensed to have someone - or accredited to have someone stay up to 28 days. There’s generally a two-week target for that and that’s how the service is marketed or framed. But it allows the flexibility in that model. So not everyone needs to stay for two weeks, and then also, for some cases, and I suppose we’ve had increased presentation of homelessness or housing instability, then that’s led to consumers requiring a longer length of stay, yeah.”*

**SUSD Stakeholder**

*“There’s some of them [consumers] that are okay in two weeks, that opens a bed for somebody else.”* **HHS Staff, SUSD**

Conversely, several staff and stakeholders felt that three to four weeks was ideal. This was viewed as being enough time for consumers to benefit from a period of stability and sufficient time to establish new habits. Furthermore, it was noted that consumers generally required more than two weeks to settle into the SUSD environment before they could properly engage in recovery work.

*“But two weeks is not a long time for someone who’s going through all those sorts of changes, and new environment, new people, all that. By the time he started feeling comfortable it would’ve been probably day 10 or 12 [in SUSD]. I think that sort of first week definitely is a write-off...to sharing and experiencing and all those sorts of things...at least with our situation anyway, he wasn’t open to any of that initially.”* **Carer, SUSD**

*“I mean it’s two to three weeks before you can put in any changes anyway...so, I think 28 days is pretty good. Any longer than that it gets a little bit monotonous I think, and I had people settle in here [SUSD] a little bit too quickly and not want to leave.”*

**NGO Staff, SUSD**

Data obtained from the consumer interviews indicates that most consumers clearly understood what the length of stay was and the process and conditions for extension. There was one exception, where a consumer shared that their exit date was given to them with short notice and no consultation, and that other consumers in the service had a similar experience. Overall, most consumers felt that their length of stay (ranging from 2 to 4 weeks) was sufficient.

*“But sometimes the more you engage with the services, the more likely they could – normally you’re in there for two weeks but if you – the more you engage, sometimes they could extend it to the 28 days for your stay, which helped a lot of people out.”*

**Consumer, SUSD**

### 6.1.3. Program planning and delivery

SUSD services deliver a recovery-focused program consisting of clinical and non-clinical treatment and support. According to the SUSD MOS, the treatment and care provided should be inclusive, accessible, high quality and culturally appropriate. SUSD clinical and psychosocial interventions can be generic, individual or group based.

### 6.1.4. Individual recovery planning

SUSD staff reported that within the first 2-3 days of a stay, an individual recovery plan is developed with the consumer and family/carer, and this informs the supports and interventions offered to the consumer. The recovery plan is reviewed at different timeframes (e.g. weekly or after two weeks) depending on the service. In the interviews, consumers demonstrated various degrees of understanding or recollection of the recovery planning process. Several consumers reported that recovery planning was beneficial for them.

### 6.1.5. Individual interventions

Across SUSD services, there was some variation in the individual interventions that were available. Staff interviewees outlined that at most sites, consumers were paired with an NGO keyworker who worked one-on-one with them to guide and co-ordinate their supports and interventions. At Mackay SUSD, consumers were also assigned a Queensland Health keyworker. The interventions available at each SUSD were found to be influenced by the HHS and NGO staffing profiles summarised in Table 9 and discussed in section 6.1.1. For example, individual sessions with a psychologist were only available in Gladstone because they have a full-time psychologist on staff; Mackay SUSD offered assessment and individual support for activities of daily living through their full-time Allied Health Assistant and Occupational Therapist; while one-on-one psychoeducation for medications and physical health was also routinely provided by Mackay's full-time Registered Nurse. Furthermore, there was found to be variability in the range of community services and resources to which consumers could be linked, either individually or through in-reach groups, depending on the capacity the services had available to build this connection (see section 6.1.1).

### 6.1.6. Group program development

All SUSD services were found to deliver group interventions and activities with some notable variation between sites (see Table 9 for a full breakdown). Group programs were led by NGOs with most sessions facilitated by NGO staff. Gladstone, Mackay and Bundaberg SUSDs also offered clinical groups facilitated by allied health staff on topics such as stress management, medications, sleep hygiene and healthy living. Staff at Cairns SUSD and Nundah House reported that whilst it would be beneficial to offer clinical groups at those services, staffing capacity was limited.

NGO staff reported that many of their recovery groups were based on existing programs developed by their National organisations' Learning and Development Teams (e.g. Mind Recovery College, Neami's Flourish). As these existing programs were typically developed for different settings or timeframes, staff noted that adaptations were required for these programs to be appropriate for use within a SUSD.

*"So yesterday they [NGO staff] did one [group session] in the afternoon called mood and food and that's quite a long Mind Recovery College thing that runs over many weeks, so we've just cherry-picked pieces from it and then condensed it down into a one-hour basic thing."* NGO Staff, SUSD

*"So Neami's got a core set of like groupwork offerings that we have.... so for example, there's a group program that runs for like eight weeks. Staff can just pick out a module or two, or content out of those modules, and they can customise it to the consumers at the House. Recognising that the type of groupwork we do often is a bit more brief and a bit more targeted."*

SUSD Stakeholder

Some services tailored these existing group programs around the day-to-day needs of the consumers. Others followed a program schedule.

*“The groups are pretty good, but we do try and tailor them according to the needs of the residents because we might have a little bit of a set weekly sort of a planner, just to give people an idea of what sort of groups there are. But that can be quite different because people say, I'd really like something on mindfulness or something, so we can do that too... this happens at morning meeting, so you're judging sort of who's going to be there and what they might feel like.”* **NGO Staff, SUSD**

Some services re-developed their whole group program specifically for the SUSD setting. For example, Bundaberg SUSD surveyed residents over a three-month period about the type of group content they thought would be beneficial. Based on this feedback an eight-week group program was developed, to reduce the likelihood that consumers would repeat groups. Workbooks were also created for consumers to complete and take home. Consumers from multiple services reported that being provided written materials was beneficial.

*“They also had, there was a booklet every week with activities from the group sessions which I found really good. Plus they had a pigeonhole with probably 10 or 15 different... Booklets Like How to Handle Stress and Healthy Living. A lot of self-reflection, and I did a couple of those, and I found that to be good as well.”* **Consumer, SUSD**

*“A lot of the tips - they give you lots of like paperwork and sometimes, in some of the groups, some staff have compiled it all together in one little thing. So that's really helpful instead of having like 50 million sheets of paper. I mean, we still got 50 million sheets of paper but it's good now that sometimes they've put it all together. They could probably do it a little bit more.”*

**Consumer, SUSD**

The planning and delivery of group content was found to be an important consideration for consumer engagement. Whilst most consumers reported that they found the groups to be engaging and beneficial, a small number shared that they disengaged from groups due to the content being either boring, repeated, or irrelevant to them. Furthermore, staff at Cairns SUSD reported that participation by Indigenous consumers was impacted when content was not culturally appropriate. Following completions of interviews for this evaluation, Cairns SUSD added an Aboriginal and Torres Strait Islander Community Mental Health Practitioner to their staffing profile.

*“Like we repeated recovery groups a couple of times and I just kind of sat there like there's not much point me even going because I've already done it.”* **Consumer, SUSD**

*“But there were some groups there where I left because I was bored.”* **Consumer, SUSD**

*“I think what helps, that's interesting, is making sure that we are actually being responsive to the needs of the client. So, for example, at the moment, we've thought over 50 percent of our clients identify as Indigenous, and we've got actually a very low attendance rate at the moment, and that's probably because there's an absence of culturally appropriate material being delivered.”* **NGO Staff, SUSD**

### 6.1.7. Group delivery and engagement

Delivery of the group program was found to differ across services with the Bundaberg, Gladstone and Mackay SUSDs delivering a set timetable with required attendance. The expectation to participate was discussed with consumers

during the initial intake phase and a participation agreement signed. As a result, group attendance at these sites was reported to be very high.

*“But to actually come to the group, that was one of the things in the agreement, that they need to come to the groups, and we give them the times. All it is, you need to come at 9:30, 10:00, 2:00, and everything else in between is, come and go as you please.”* **NGO Staff, SUSD**

*“Yeah, they [consumers] are very good at engaging, because when they come to a Step Up Step Down, we [SUSD staff] usually sit with them and do the entry paperwork... So the service agreement, mentions that the two groups you need to participate. Otherwise, if you are missing from groups, then you can't stay here. Like it's part of the recovery, so you need to participate. So they are very happy for that and usually most of them are very happy to attend.”* **NGO Staff, SUSD**

*“Yeah. You have to be present. Part of the thing of you being there[at SUSD] is you have to attend those three groups. Otherwise, why are you there?”* **Consumer, SUSD**

In comparison, group programs at Nundah House and Cairns SUSD were more flexible, with attendance being encouraged but not required. Whilst both services had a group timetable, the day-to-day running of groups was influenced by the needs and wants of the present cohort of consumers. If consumers did not show sufficient interest or if there were too few consumers on-site to attend, a group session did not go ahead. In this situation, group sessions could be offered to consumers on a one-on-one basis. Staff and consumers from Cairns SUSD and Nundah House reported that group attendance could be low, and several consumers expressed disappointment about limited group availability.

*“Yeah, that's right. We might make a decision based on what people are doing. So, we have a morning meeting at 10 o'clock where we ask what everyone's doing for the day. So, in that we might get a gauge, six people are going out, maybe it's not the best day for a group. Let's offer one-on-one's. Someone's saying, this is a real issue for me, or we get into a conversation over the morning meeting about something to do with recovery and then we'll go, would you like to do a group around that. It happens very organically.”* **NGO Staff, SUSD**

*“It's kind of an unsaid compulsory component, but it's obviously beneficial to them to attend. But we get a mixed bag of attendance so again with the fluctuations of clients, depending on who we have. Sometimes we have a really cohesive group of peers that are really connected with each other and that's really good, when we get really good attendance. But then sometimes we have really segregated people which don't want to have those groups, so it's really touch and go. But the maximum I would say I've ever had in a group is maybe five.”* **NGO Staff, SUSD**

*“Yeah, and like you see someone who's stressed about going back into homelessness, doesn't want to go to a mindfulness group. I get it. So, it's really being realistic.”* **NGO Staff, SUSD**

Cairns SUSD and Nundah House indicated that their staffing capacity was a barrier to delivery of a more regular group program.

*“Yeah, definitely staffing [impacts on availability of groups]...If we're short staffed we need to move the activity schedule all around. Yeah, that's a bit tricky... Something that I still try to do even when I'm by myself, but then I burn myself out because I have this consumer focus is, why should they miss out because we're not staffed, so it's a really tricky...”* **NGO Staff, SUSD**

*"I would say that staffing is an issue. ...So if we've got three entries in one day, we're not going to run a group either, for example, during the day. But on a day where we don't have entries, or we only have one, it's more likely that certain things can happen."* **NGO Staff, SUSD**

Whilst one consumer expressed appreciation that groups were not mandatory, staff reported that non-mandatory group attendance reduced participation by consumers, and meant fewer groups were run. Consequently, group sessions were reported to be less effective, with consumers missing out on the benefits that groups provide. This in turn impacted the morale of staff and the experience of consumers who were motivated to engage in groups.

*"The conversation came up the day that I was leaving between a few of us, the fact that they don't push us to be involved in the group activities and whatnot, like a lot of other facilities do. They just really push you to do it. But these guys are 100 per cent, if you're not feeling it, or if it's not for you, that's fine. With all of their groups, which was really nice..... I just wasn't comfortable joining them. But I know that a lot of other people benefited from the group activities, and always encouraged me to come join. I was like, maybe [laughs]. With like outside eyes to other peers – like some of the peers – I think they benefited a lot."* **Consumer, SUSD**

*"No, yeah, that's the thing. There weren't too many groups things going on..... The group was supposed to, but they never - no, they never really showed. It's hard to get people who are in recovery. There was supposed to be. They had a board. They were supposed to do things, but we didn't really ever get to - it was a bit ad hoc and it was really only one guy, who was doing all the group activities. He was like the captain on the ship.... So, it's - yeah, I don't know. But I think they could do more group."*

**Consumer, SUSD**

*"[consequence of unengaged consumer] No groups. They don't come down to morning meeting. They don't want to participate in groups. They don't want to meet with the support workers one-on-one. They don't want to do anything. They're just they're just here. It's a bed and food - three meals and a bed. It just it actually really brings the morale of the staff down because when you see the NGO staff come into the office after they have run a really good group, they are so pumped and they're thinking about what they're going to do the next day. Then when we've got a house where nobody wants to do anything, it just really brings the morale down."* **HHS Staff, SUSD**

While some consumers reported no apprehension with attending groups, others found themselves initially reluctant to participate due to experiencing anxiety and other mental health symptoms, a fear of groups, and/or a fear of talking in front of others. Staff also reported that acute symptoms or distress were often a barrier to participation especially for consumers experiencing homelessness or other situational crises.

Some services reported that they assist consumers to overcome their initial apprehension to engage in groups by providing additional support. For example, consumers who feared group settings were given the option to sit at a distance from the group, where they were more comfortable. If group content was potentially triggering, consumers had the option to leave a group and staff were available to support them. At some services, staff were also available to sit with a consumer during groups to provide one-on-one support. Supporting consumers by providing them with reminders about group sessions and talking one-on-one about their concerns was also found to be effective. Consumer feedback indicated that staff support and encouragement helped them overcome their initial fears and that over time they found enjoyment and benefit in attending groups. This consumer feedback was consistent with one staff member's lived experience and observation that *"participation alleviates symptoms"*.

*“They [consumers] just need extra support [to come to groups], but that just comes from the workers on the floor. They see that somebody’s got an avoidance thing happening, they’ll just go and ask, how can I better support you so that you can attend and get the most out of your time here, it’s very limited. Are there some adjustments we can make, what could we do. Often times they’ll have the solution themselves, which is really important so that we’re not telling them or doing to them.”*

**NGO Staff, SUSD**

*“By the end of it you just feel really good, because you have interacted with other people and you have taken yourself out of your comfort zone, and you have beaten the anxiety that’s always there, and the fear of joining in to these groups where you just – I just feel sick, sometimes, before any activity like that. That just makes me feel sick. But I just – and the staff really encourage you, too. Let’s just say at the morning you say, yeah, I’d like to attend today – for example, there’s a mindfulness group at 2:00. If you indicate that you’re interested in that, if 2:00 comes and you’re not there, they’ll come and knock on the door and just check on you that you’re okay, and just see if you still want to come, and talk you through any anxiety you might be having. So, all of the groups are useful in that regard to me.”* **Consumer, SUSD**

Gladstone SUSD employed the strategy of giving consumers some responsibility and ownership of the group program to increase engagement. Consumers could determine and plan the weekly meal menu and be given opportunities to facilitate morning meetings or lead creative groups. The daily program was also designed to provide variety with the morning recovery group being more psychoeducational and the afternoon group being activity based. Consumers at Gladstone reported enjoying the variety, the routine and sharing skills with each other.

Finally, facilitator confidence was found to be an important factor in group engagement and several SUSD services indicated that their staff were trained in facilitation of groups and provided with a guidebook and/or running sheet for each group. However, past staff members from one SUSD service reported that they did not receive training for their group program which left some staff feeling out of their depth and anxious.

## **6.1.8. Medication management**

Most SUSD consumers receive mental health medication as a clinical intervention during their stay at SUSD (Queensland Mental Health Benchmarking Unit, 2022). Medication management at SUSDs need to comply with the policies and guidelines of both the local Queensland Health HHS and the managing NGO. Therefore, SUSDs vary in the way they manage medication across the state. Furthermore, staff described that because SUSD are underpinned by a recovery-oriented framework, the goal is for medication to be provided in the least restrictive way, where the goals and preferences of the consumer and their family/carer are considered, and consumers are supported to self-manage their medication. Interviews with staff and stakeholders highlighted the complexities of managing medications in the SUSD context.

*“So, our medication process hasn’t been signed off because that’s all being looked at by Queensland Health hierarchy...Yeah, but we would prefer it to go down to a model where clients can use their [medication] – how they would use their medications at home. Which is what’s in the Mind policies and procedures. Yeah, and some of the other Step Up Step Downs do that.”* **NGO Staff, SUSD**

*“Clinical governance comes down to Queensland Health. However, if there’s monitoring or something to be done, Mind staff will do it because at times, Mind are the only service that are there. Is that an area that needs to be looked at and improved? A*

*hundred percent. I think from a PRN, it's a really difficult one because they can't administer the PRN, we can't administer any medication. So, Step Up Step Down do it differently a little bit everywhere, which is quite scary.” NGO Staff, SUSD*

Across SUSD services, it was found that a variety of strategies were developed to navigate the complexity of medication management, as summarised in Table 9. At all services, medication plans were initially developed by clinical staff (CNC or RN) in conjunction with the consumer, and the medication support options were stepped. However, the levels of support and independence given to consumers differed at each service, as did the medication packaging methods used and the staffing types required for medication management. Nundah House is unique in being the only SUSD to be classified as an inpatient unit and thus medication was provided by the hospital pharmacy. However, this arrangement presented its own challenges with medications not always provided to the service in a timely manner.

In some instances, clinical staff were required to administer medications. However, as clinical staffing of SUSD was restricted to weekday workhours in many services, it was necessary for NGO staff to assist with the day-to-day medication management. Because NGO staff are not legally able to administer medications, they reported providing consumers with access to their room safe to access stored medications. Occasionally, this arrangement created confusion around role clarity, and presented challenges for NGO staff when medication was required after hours.

*“We do all use the same [MESA] system, which is a stepped process; either you're on full supervision, you're monitored, or you're self-administering, and we do a medication risk assessment with the clinical team to justify what the person's on and why they're on it. But in terms of - there's a staff confusion, I think, and general kind of, well, what role do we play in this? I don't think the system's there; I don't think the structure is there.” NGO Staff, SUSD*

*“Probably one of the more difficult situations is in the evening when we only have one support worker overnight, and they need meds that are not available to us, that's a real difficult situation. But we don't have access – yes, we have access to their safe, and to the meds chart, if it's charted for. But if they're wanting something that's not charted, – or if the meds by accident, not being put in their safe, it can be difficult as a support worker being overnight, not having that nurse here. We have to ring the after-hour nurse at the hospital, and nine times out of 10, actually 99 times out of 100, because one time I had to have a nurse actually come in to assist with the medication. But it's not one in 10 – it's one in 100 that that would actually happen. The other person just had to go without and wait until morning. There was a time in the middle of the night, when someone was just so distressed I called an ambulance, hoping they would have the medication, but of course they didn't either. It was just hell. Because they were charted for it, but it wasn't in their safe.” NGO Staff, SUSD*

*“If there's anything comes up, they'll [NGO staff] contact ACT. If ACT can't come over here, then they'll just call the ambulance and get them sent over. They get a bit of pushback from the ambulance sometimes. They've got to explain why they need to go over.” HHS Staff, SUSD*

Several staff and stakeholders suggested that the capacity of NGO staff to engage in medication management could be bolstered through education. Furthermore, some NGO staff expressed an interest in further medication training.

*“No, and qualification-wise, of course you're going to go, yep, nurse is the most qualified person to be doing that. But in terms of the NGO services that are within services, there are qualifications that they could get that would probably better prepare them to be able to perform medication functions within a service.” NGO Staff, SUSD*

*“Those staff at that other [sub-acute] facility had more education around medication which seems to be a real issue with Mind staff here, locally, at this particular facility.”* **Broader HHS Staff**

While some SUSD services allowed medications to be dispensed in regular packaging, others required all consumers to have their medications packed in a Webster-pak. Some staff and stakeholders reported that using Webster-paks was cumbersome, inefficient, costly, and restrictive for consumers.

*“Taking away somebody’s autonomy, control and management of their mental health, and automatically knee-jerking to a blister pack, it goes against what mental health, recovery and treatment is – if it’s needed and it’s indicated, absolutely. But it shouldn’t just be a rubber stamp....Everyone, Webster-pak, yeah, which then makes it difficult if you’ve got somebody here and you’re trying to adjust treatment. They’ve got a Webster-pak that says they’ve 10 milligrams. You want to bump it to 20. You’ve got to go get the Webster-pak repacked. They’re on one medication. It makes no sense, and it complicates things.”* **Broader HHS Staff**

*“We have been wanting to review the whole process around webster packing, because it's incredibly cumbersome. It delays entries and exits, and it's costly, and it's not something clients would overly do in the community.”* **NGO Staff, SUSD**

*“I think the negatives would be that facilitating medications – Webster-paks – things like that – that’s difficult when the chemists are some distance away from where – yeah.”* **Broader HHS Staff**

Consumer psychoeducation around medication was found to be provided at some services to help enhance medication adherence, reduce risk, and increase consumer knowledge and independence. According to staff, SUSD services could provide this education to consumers either one-on-one or via group sessions. However, gaps were evident in education provision at some services where consumers expressed an interest in learning about medication. Furthermore, one carer’s negative perspective on the medication approach at SUSD, suggests that carer consultation and education around medication could also be strengthened.

*“So, we manage the risk quite differently now, and we provide a lot more education and support to clients so that they can understand, and we look at why our client might be on restrictive practices, is it about compliance? Is it about them forgetting to take their medication? So, once we know what that root cause is, it means we can work in a therapeutic manner to try and address that with them.”* **NGO Staff, SUSD**

*“I always make sure I give them information on medication when they come in. So they're more aware of what they're doing.”* **HHS Staff, SUSD**

*“Yeah, maybe an explanation about how the medications interact with your body and stuff and what they're actually doing. Something like that.”* **Consumer, SUSD**

*“We had to go and get Webster-paks made up, because we couldn't get them done [at the hospital] before we left in a day, and all that sort of stuff, which surprised me that we went through all of that only for them to say, but you control your medication, you take that. I was like, ooh my God. I don't think that's a good idea in a place like that, for someone who doesn't cope with taking medication at the best of times, and having accessible, large doses of medication. I was a bit - that was my first red flag, I must admit.”* **Carer, SUSD**

## 6.2. Factors impacting implementation of SUSD

### 6.2.1. Partnerships

#### 6.2.2. Clinical and NGO SUSD staff

Stakeholders reported that the SUSD model can function best when there are clear and strong HHS and NGO leadership roles which recognise the strengths of each partner, and where the relationship is equal and collaborative. Interviews identified that this partnership worked well when led by approachable HHS and NGO leaders who modelled open, regular communication, and who worked together as a united team.

*"We just all feel like part of one team, really. So we don't feel like it's us and them anymore. In the past it has very much been that way. But since [HHS lead] have been here, and since [NGO service manager] have been here, the whole thing has just gone completely 180."* **HHS Staff, SUSD**

*"If it's unsettled in the management, it just flows right down to us. Yeah, I think the way [service manager] runs it is just - yeah, it's spot on... very approachable. That's what I find. If you've got any dramas and all that kind of stuff, there's no - you go and speak to them and they're quite flexible in whatever you need."* **NGO Staff, SUSD**

*"I think that just having that really approachable approach, it really keeps the teams together because they don't feel that there's a divide between the management. [service manager] and I [clinical lead] I are really very much on the same page when it comes to how things are dealt with. We go to handovers together, so we're always present in the handovers so there's that, I guess, the representation from us together as well... I think the other thing that really helps us both, [service manager] and I are very quick to jump up and help out on the floor if necessary. Neither of us will say, we're managers, we won't do that and you just have to manage it on your own... The staff know that they can come to us and say, I'm having trouble with this person or I don't know how to deal with this....we're very willing to just jump in and help and I think both teams really appreciate that."* **HHS Team Leader, SUSD**

Leaders reported that co-located offices helped to facilitate communication and a united relationship.

*"I also shared an office with the service manager of the NGO, so we were literally stuck in an office together which means we were required to work closely together...Because you got a great idea quite quickly as to how the other person thought, and I think as long as there's basic respect and good communication.... it's hard for there not to be good communication when you're sitting next to someone"* **Previous SUSD Staff**

*"I think when you've got a relationship where you don't have to sit there and write an email and say I want to bring to your attention - and instead you can have the CNC come across and say hey, [de-identified], I'm like, yep, okay, what's going on, and we just sort it about then and there."* **NGO Service Manager, SUSD**

Leaders were found to work hard on cultivating an equal and positive staff culture in the partnership, by modelling and encouraging respectful open dialogue in the workplace and implementing relationship building activities such as team lunches and celebrating occasions together. Regular, joint handovers were seen as a useful tool to collaborate about consumer care and learn from each other.

*“We work very hard at maintaining a collegial relationship. Things like those handovers, they go a long way towards helping everyone be on the same page... If there’s any issues we talk around, sort them out. If Mind start to come to us with a concern, then we’ll listen to them and we’ll – more often than not we’ll take their side and we’ll argue the point. We do a lot of work in emphasising that we’re a joint partnership.”* **HHS Staff, SUSD**

*“Every morning, clinical team are only here Monday to Friday during normal business hours, so we do one big handover every morning. Then, across the rest of the day, the Mind handover between each other as the shift swaps happen. If we have a client that’s dynamic, when there’s changes or decision making happening or we’re noticing changes in their behaviour, we’ll actually call a mini consultation of the workforce that’s on site, and actually redevelop a new strategy....We’re united and consistent in our approach.”* **NGO Service Manager, SUSD**

Although most of the SUSD partnerships were described in interviews as functioning well, problems that were identified, either current or in the past, were a result of leadership issues, the partnership dynamics becoming unequal and staff feeling as though their colleagues were unsupportive and unwilling to lend a hand.

*“We’ve got conflict, we’ve got what they perceive as passive aggressive behaviour. Not sharing information because CMHPs can’t possibly have this information. Even though they’re there 24/7, they’re there on the weekend when there’s not clinical staff. It’s that perception that there’s only certain things that they can have access to. It’s that kind of devaluing the role in some instances. Mostly it’s [partnership] very good, but in some instances, you get that.”* **SUSD Stakeholder**

*“Lots of dobbing, lots of blaming. No real teamwork in terms of that cohesion of, yeah, I’ve got your back. It’s okay, it’s been a busy day, we can help”* **SUSD Staff, SUSD**

*“I have really noticed a disparity in the balance of labour here, between Mind staff and Queensland Health staff..... I know other services operate differently and as a whole united team approach but our team does not operate like that....Often times they [Queensland Health Staff] are not doing anything, but do not offer to help us and I think this is about them being told to keep within their scope of practice, which I don’t think is right at all for a community setting, I think all staff should help with whatever needs to be done.”* **NGO Staff, SUSD**

In circumstances where these problems have occurred, partnership days have been held to help re-establish the relationship, but often, a change in leadership has occurred.

### **6.2.3. SUSD and broader HHS**

The evaluation found that effective partnerships across the broader HHS, including with the ACT, CCT, and the Mental Health Inpatient Unit were critical for the SUSD, particularly given that these units are key referrers into the service. Additionally, the ACT provides clinical coverage after hours for SUSD, and CCT case managers interact with the SUSD when they have a client that is staying at the SUSD. Interviews with SUSD and broader HHS suggest the quality and equality of these partnerships are mixed and at times strained.

Similar to the SUSD staff partnership, staff and stakeholders emphasised the critical role of leaders in setting the tone of the SUSD and broader HHS partnership.

*“You have different health partners, different relationships get along better, some don’t, some do. But it all just depends on who’s running the show or the teams that are managing. The clinical and non-clinical managers, how they actually manage it all.”* **NGO Staff, SUSD**

*“Again, we’ve reported that to the nursing director. He has now said to us, if that happens, you need to give me their name and when it happened and so forth, and I’ll deal with it. He’s very supportive of us, so that’s really good.”* **NGO Staff, SUSD**

*“It was a very tense conversation, but I have had the conversation with somebody in the executive team who literally said, you have a bed, we will be using it, and that was the conversation. No acknowledgement of me saying that this person is not appropriate, their risk profile is too high. They’re not going to engage in a program, they’ve got drug and alcohol issues, they’re homeless or they’re waiting for rehab. Whatever the thing is that we’ve identified that they’re not appropriate, you have bed, we will be using it - because the bed pressures are so significant.”* **HHS Team Leader, SUSD**

Partnership governance meetings were found to be held either bimonthly, or quarterly (depending on the site) with membership including NGO State Directors/General Managers, HHS Executive Directors of Mental Health, Program Coordinators, Consultant Psychiatrists for the service, SUSD Service Managers and SUSD HHS Team Leaders. In these meetings KPIs and outcome measures were reviewed and discussed. SUSD leaders described that at times a power imbalance can be felt within these meetings, with the NGO partners feeling like they were reporting to the HHS rather than both parties sharing their data and outcomes.

*“I note relationships where it’s completely unequal and we sit in governance, and we [NGO] provide all the reporting and it’s like we’re reporting to the HHS..... we don’t see the clinical data... we just present and they present nothing back..... this thinking that because we’re giving subcontractors service, therefore we need to be doing all the reporting from our side. But actually, there is that lack of understanding that we need to look at this is a whole. What difference are we making as a team? If you’ve got indicators about what difference you’re making clinically, let’s share it.”* **SUSD Stakeholder**

Another barrier to an effective partnership was that staff and stakeholders felt that there was limited understanding of the scope and purpose of SUSD in the broader HHS. This caused tension in the partnership due to mismatched expectations from both parties. For example, several sites described frustration about the lack of communication and input received from CCT case managers. However, an interviewee from the broader HHS reported that CCT case managers can feel confused about the role they play in supporting consumers while in the SUSD. Another example was that there were conflicting perceptions between ACT nurses and SUSD staff about the role that ACT clinical staff play with supporting SUSD after hours.

*“So, I’m not sure that the rest of the service has a good handle of the purpose and the aim of the Step Up Step Down at times. I think that other teams, at times, community teams feel a little confused about what their role should be with their clients being in that facility.”* **Broader HHS Staff**

*“There’s a struggle with collaboration between case managers and keyworkers and this kind of disconnect, I suppose in not knowing where they’re (case manager) at and what they’ve done with the client consumer, because they’ve obviously known the consumer longer than we have... It’s usually people that we’ve had pretty good relationships with that come here, that have a lot of their own clientele that come in and out of Step Up Step Down, so they know how it works. I think maybe it’s the newer case managers that don’t understand how it works or what we do here and think, okay, they’re there, they’re okay, we don’t need to worry about it [attending to their client while in SUSD].”* **NGO Staff, SUSD**

*“We have to push back and say, well, actually, accommodation isn’t our job. This isn’t our job. That still remains your job. We’re here for psychosocial interventions. So, we have varying amounts of success dependent on the individual case manager and the team as well. I know there’s been an improvement because we’ve been putting a lot of pressure on. But again, there’s this*

*healthy balance between putting pressure on and maintaining enough of a collegial relationship so that it's in the best interest of the client. That's not always easy." NGO Staff, SUSD*

*"I still think the – my general reflection is, I think a lot of people within Queensland Health, outside of the team here, don't really understand the way that it [SUSD] works. Sometimes I feel like the hospital just sees us as overflow. I think sometimes they see us as that, but we're not staffed like that. So, it's this ongoing, you know..." NGO Staff, SUSD*

*"Yeah, so we've had staff report back to me kind of like, yeah, at varying times, like a level of dismissiveness towards them. A level of, yeah, dismissiveness and irritability at points in time, yeah, and just not very supportive collegial conversations. Often, sometimes, like they don't quite have an understanding that some of our staff are not nurses, yeah." NGO Staff, SUSD*

*"I think it's when there isn't that context for how things operate, shared both ways - like we also need to understand the bed pressures, what their staff are confronted with daily too. So there's an opportunity for greater shared understanding about each other's roles and how we can support each other. So it's not just like one way, yeah." SUSD Stakeholder*

Services described implementing several strategies to strengthen partnerships between the SUSD and broader HHS teams, such as open days, walk throughs, information handouts and presenting at HHS team meetings. However, it was found that these partnerships are challenging to maintain given the large number of HHS teams that feed into SUSD, and the high turnover of staff in the broader HHS (see section 4.3.3 for more info).

#### **6.2.4. SUSD staff and consumers**

A key principle from the SUSD MOS is that consumers are considered equal partners in their relationships with mental health staff and in decision making about their own health care. This principle is considered essential to recovery. In interviews, consumers expressed that their interactions with SUSD staff made them feel empowered, safe and respected. Examples of this successful partnership were reported at all stages of the consumer journey, from the initial walkthrough, through to exiting the service, and post-exit where relevant.

*"I can't fault the staff. There's not one single person here that I wouldn't feel comfortable approaching or asking for help with something. They're just all very approachable, very professional. You can tell they've got the consumers in mind." Consumer, SUSD*

*"[in response to what elements work well at SUSD] The support, the workers, the belief they [SUSD staff] had in everyone as well to know that they [consumers] could achieve whatever they wanted to. Then the stepping stones to be able to do so." Consumer, SUSD*

*"No, well, I actually do love the staff. Yeah, they have been really, really helpful. They've all got their own individual ways and their individual styles and, yeah, I've grown accustomed to each and every single one of them. They've always been helpful and friendly and - you know, especially in the times of struggles as - they've always helped maintain - they've picked me back up again and maintained that self-belief in myself..." Consumer, SUSD*

*"[in response to what elements work well at SUSD] I do think it's the relationship between the Mind staff and the consumers. Some of the key workers are excellent. You can really – you get the right consumer and the right peer worker and you have a really good outcome for the consumer. You know, even people you take and you think, why did we take that person? But will still have a really, really good outcome. If you think wow, we didn't expect that." HHS Staff, SUSD*

Consumers appreciated when staff spent time with them as equals, by participating in day-to-day activities such as cooking and meals. Similarly, consumers highly valued staff being available to provide practical and emotional support at most times of the day, which starkly contrasted with their experiences in hospital where staff were viewed as being too busy or stressed. The lived experience of Peer Workers was particularly valued by both consumers and staff.

*“Even when you’re not doing classes or anything, you’re just sitting around, they’ll just come around having conversations with you. They talk to you about what’s going on, what’s been happening and how you’re feeling.”* **Consumer, SUSD**

*“[why are staff so amazing] I think it’s because some of them have gone through the same sort of health issues. So, that’s where they become very understanding of other people, because they know what they’re going through.”* **Consumer, SUSD**

*“The nurses were wonderful at the hospital – like they were really nice, but they were so understaffed and so busy, and they were just like, not much I can do – I’ve got to go and give medicine or stop violence or whatever.”* **Consumer, SUSD**

Although most staff interactions were overwhelmingly positive, there were a small number that were negative. These rather isolated incidents highlight the importance of all SUSD staff understanding and engaging in recovery-oriented practice.

*“So, his lack of empathy extended further than just being a clinical psychiatrist. It was just ego, power and really no insight into speaking to a woman in a domestic violence situation. It was quite derogatory, which put a lot of shame – put me under a lot of shame. Yeah, it wasn’t helpful”* **Consumer, SUSD**

*“I think a lot of psychiatrists do have impeccable social skills and they’re very personable, wonderful, loving people, but there are a few out there who.....they just don’t know how to relate to people. It’s a horrible catch 22 because I’m sure they’re fantastic in terms of knowing what medications do what, but when they actually have to deal with people, they can be really awful. I’m sorry, but they really can. That is, yeah, that - particularly for somewhere like [SUSD] we need to make sure those psychiatrists are not in charge because that would really undermine what we’re doing.”* **NGO Staff, SUSD**

### 6.2.5. SUSD staff and family/carers

As indicated in the SUSD MOS, the family and/or carers of consumers are an integral part of the partnership model and where possible, should be engaged and involved in all aspects of care planning and delivery. At the time of the evaluation, all SUSD services were found to either have appointed, or were recruiting, a Family Engagement Worker to facilitate engagement with families and/or carers. Staff reported that family and carers were encouraged to engage with the SUSD in a variety of ways including through attendance at assessments, meetings and care reviews, or at the regular family barbeque run by most services. Some staff spoke of offering support and information for the carer themselves either one-on-one or by referral to the Carer’s Gateway service.

Despite their centrality to the partnership model, qualitative data collected via interviews indicated that only a small proportion of family and/or carers were engaging with SUSD services. There were several reasons for this low engagement, with staff reporting that many consumers do not have a family member or designated carer supporting them. Furthermore, consent is required by the consumer to involve family members and/or carers in their care and at times this was not provided, thereby limiting the degree of family/carer involvement.

*“Most of them are happy [for their family] to be involved, but the other problem is some of them have no support system. So very few clients have a good family support system... so that time we can't do anything. Like if there is an involvement with family, we usually do the support coordination meeting, and we usually do the sessions with family.”* **NGO Staff, SUSD**

*“Some people give consent for their families to be included, and some people definitely don't give consent. We do have families that will phone up and ask for updates and we have to check in their [consumers] folder to see if we've got consent to share information with them, of course. That would be - most of that work is done by our family engagement worker, so she supports the families who are interested in their [consumers] care planning and she phones them up and sees what kind of support that they need.”* **NGO Staff, SUSD**

Other reported barriers to family and carers engaging with SUSD included the family/carer having other commitments, the distance of the SUSD to the family's homebase, and the stigma that can be associated with mental health services.

*“Then I'll gather the family because sometimes the family say, no, we don't have time, I don't want to. That's fine. I can just call them and say, hey, just want to give you a brief update as you want it. Or some will be wanting a bit more. So I will be very much guided by the family and what they want and what they need with the concerns for the consumer because some consumer just go, I do not want them to come here.”* **HHS Staff, SUSD**

*“Yeah. People are able to come in. My partner didn't really want to. He only did when he had to help me move in and move out... He just wasn't comfortable in the setting. But he wasn't in the hospital either and it's just the idea of it, and he just wanted to get me out.”* **Consumer, SUSD**

Several staff noted that more emphasis could be placed on carer engagement at their service. Furthermore, as some Family Engagement Workers were part-time and/or did not have their role back-filled during leave, staff noted opportunities to engage families were sometimes missed.

*“I definitely think we could improve on connecting with families better. I think we have started creating a letter to carers and helping them be a part of their recovery.....But yeah, I'd say it's maybe 20 per cent that we've got in here, it's not very much.”* **NGO Staff, SUSD**

*“If there was enough funding, I think it'd be good to have family engagement worker available more often. Because I've just had five days off and a lot happens in five days, and I come back...”* **NGO Staff, SUSD**

Obtaining family and/or carers' perspectives of their role in the partnership was challenging due to the limited number of family/carers that were recruited for the evaluation. However, of the three carers interviewed, all reported a preference to be well informed and felt they would have benefited from receiving additional information about the SUSD and/or updates on their family member. The degree to which carers felt informed by the SUSD varied widely, and the gaps in engagement were seen to have occurred at various stages of the consumer journey from the initial referral through to exit from the service.

*“So, yeah, and in your journey as a carer in this field, you've got to know when to step up and when to step back. Sometimes you can do that with information and sometimes you're really in the dark, and I think this time we were really in the dark,*

*because we'd heard nothing, until we got the phone call saying, come and get him.....So, I felt that that was where we were very much pushed to the outside, and I thought they could have - without necessarily breaching his privacy, they could have given us a little bit more information.” Carer, SUSD*

All three carers indicated they had been advised about a family barbeque held at the service. Only one of the carers was able to attend the barbeque and found it to be a good opportunity to check in with the staff and spend time with their family member. More information on carer satisfaction with SUSD is detailed in section 7.5.

*“So I was able to touch base with staff, I was able to spend some time with my brother in a setting that didn't seem so formal, so it was very nice. It was very casual, like going out to lunch.” Carer, SUSD*

From a consumer perspective, many indicated that their family/carer's involvement was limited to visiting them at the SUSD or supporting them over the phone. Those who had family that were more engaged found it to be beneficial and appreciated the support.

*“Then like even when they invited my parents to come for the barbecue, I had that - I felt like, oh, they're involved my family too, so it just - yeah, it was a really, really positive experience.” Consumer, SUSD*

*“My mum is very involved in my mental health journey. She doesn't call the place because I just tell her what's going on. But yeah, she's quite involved with that and if I'm nervous for an appointment she'll come in with me or something. Actually, the first time I came here, she came with me for the initial assessment because I was bit nervous. But other times I knew what to expect so I just came by myself.” Consumer, SUSD*

## 6.2.6. Cohort mix

Both staff and consumers spoke of the impact that the cohort mix had on the implementation of the SUSD program. When the cohort mix was balanced, consumers benefited from the opportunity to interact with, and learn from, others who had similar experiences to them. By living communally and engaging in group activities, consumers often developed a sense of belonging, and supported one another.

*“Yeah. It's like anything; it's what you put in is what you'll get out of it and I'm finding everyone here is putting effort into it .....we're all at different levels of our journey but we've all been through stuff... it's really shown that I'm not the only one dealing with crap and I'm not the only one that wants to face it and fix it, whereas before it was only - oh, only you got the problems, it's your issues...” Consumer, SUSD*

*“Obviously, I was very shy within the first initial process, but I've opened up quite quickly with the way that the people are here. They're very accepting and very kind, so it has helped me to come out of my shell very quickly.” Consumer, SUSD*

Staff reported that the implementation and effectiveness of the SUSD program was impacted when a cohort consisted of too many consumers who were not able or willing to engage, further highlighting the impact of referrals that were outside of the model (see also 4.3.4 *Appropriateness of referrals to SUSD* and 6.1.7. *Group delivery and engagement*). Furthermore, both staff and consumers felt that group size was important with larger groups being more conducive to generating connections and conversations.

*“You know you’re trying to create that environment you know? That people are supporting each other, work together et cetera. We just – sometimes it comes together, and you go, wow. You know, but it’s more by accident than design. Other times you’re just thinking what’s the point? ...It’s too diverse. You’ve got people that have got very chronic symptoms, you’ve got people that are emotionally deregulated. You’ve got people with addiction.” HHS Staff, SUSD*

*“I mean, it does make a big difference if the other residents are the kind of people who participate, as well, because the groups are certainly better when they’re bigger. Rather than three or four people, when you have the full 10 it just makes it better that way... Yeah, the more you get out of it, I think... and the less pressure on you, too. If there’s a group of three or four, sometimes there’s a little bit of pressure on you to input. Whereas you can spread that around a bit when there’s a bigger group.” Consumer, SUSD*

*“Because we’re group-based, we need that group to generate and when those conversations get going...that’s when people start to connect, or it’s when they feel more confident in sharing their story. They feel less alone, and a lot of people are just lacking connection when they come in, and they find that, it’s not even the work that we [the staff] do, it’s the work that they [consumers] do with themselves and amongst the group. We’re just supporting them to do it on their own, so yeah, it’s definitely more effective if there’s a few people here.” NGO Staff, SUSD*

Some consumers reported that cohorts biased towards a particular age-group or gender made them feel intimidated, uncomfortable, or alone within the group and consequently, they were less likely to engage with the program. Similarly, engaged or outgoing consumers reported a sense of frustration or disappointment when the cohort was predominately made up of disengaged or reserved consumers.

*“Well, the second time around, all of the other residents were so nice and even the staff – it was easy to get along with everyone. But the first time, I was the only girl there. It was just all older guys, and I didn’t really have anyone to get along with, but the second time was much better. It had more people – like more females and at different ages.” Consumer, SUSD*

*“The main reason why I felt uncomfortable is because the patients that were in here at the time, no one was interacting with each other. I found that really hard because all I wanted to do was talk to somebody.” Consumer, SUSD*

*“Then you’re sort of sharing that with 15 different individuals all on different journeys in their life. The first time I was in there, quite a few of us were friendly with each other and we used to talk and help each other, and that kind of thing. Then the second time I was in there, everyone just kept to themselves, no one really wanted to interact or talk. It was just, hey, how are you, hey, how are you – that’s it. It’s like, oh, okay. But the first time, everyone sort of was engaging with everyone else, which is a lot better because you’re all living together for X amount of time and sharing, having dinner with each other, and that kind of thing. But the second time, no one ate together. Everyone took their food straight to their room” Consumer, SUSD*

## **6.2.7. Staff training, supervision, and support**

HHS and NGO staff reported during interviews that there was variability in the type of training received by staff when onboarding to SUSD depending on whether they were employed by Queensland Health or an NGO. NGO staff said that they were provided a range of online and face-to-face training related to their role within the SUSD. Conversely, most HHS staff interviewed for the evaluation had transferred from other roles within Queensland Health and reported that they did not receive any formal training specific to the SUSD model when starting their position. Instead, many received in-person handovers as orientation with the length of these ranging from 30 minutes up to

one week. In some cases, this did not feel sufficient for the role and staff felt they would have benefited from SUSD specific training, especially given the uniqueness of the service model.

*"I've been an acting team leader for a community team, but that's not a 24-hour service. It's very different to working here. This place is so unique. It's like we sit in this, such a unique space. We're not community. We're not inpatient. We're not an acute ward. We're just this little island, so I just had to learn it all on the fly, basically."* **HHS Staff, SUSD**

*"So, yes, I'd say it's a moderate adaptation. We had one nurse, an experienced clinical nurse, she'd been out of Uni for about eight years, and she adjusted really, really well to the Step Up Step Down model of service from inpatient. But we had other staff who really struggled to transfer their skills. Overall, Step Up Step Down's probably it's a more therapeutic setting, than inpatient work, it's far less punitive. There are less people on TAs as well, and I suppose, there's a greater expectation that you work with people, rather than do things to people."* **Broader HHS/Previous SUSD Staff**

*"I think that maybe a little bit of the training about the treatment model and all that sort of stuff would be helpful. Especially for a clinically-based person that's come in, that's not...we don't sort of step your foot into therapeutic environments very often."* **HHS Staff, SUSD**

NGO staff across various sites reported undertaking training in recovery-oriented practice, peer work, groupwork and facilitation, borderline personality disorder, trauma informed practice and co-occurring substance use disorders and other mental health disorders. In some cases, the training was mandatory or part of the onboarding process, in other cases it had been sourced by the NGO Service Manager to address an identified gap. Several suggestions were made to support the professional practice of NGO staff including training in medications and critical incidents and providing training refreshers. To supplement formal training, some NGO staff reported that new team members were also given opportunities to shadow more experienced staff and sit in on groups and meetings as part of their orientation. Several NGO staff were also being supported to obtain specialised qualifications in mental health while working at the SUSD.

*"There's been gaps where we've implemented borderline personality training for staff so that we have a better understanding of that. I think that would be something that we would continue to do because yeah, that's probably an area that you just chucked in. Even medication, talking about different types of medication and the effects, you just you don't know that."* **NGO Staff, SUSD**

*"There's a whole suite of mandatory training that everyone's expected to, from students to volunteers, they all do it, so it's good. What they would normally do when they do start with us is their mandatory training, but in between they'd be going to the community meeting, sitting in on handover, attending morning and afternoon group, that sort of thing, so they get a bit of a sense of what we do and so forth."* **NGO Staff, SUSD**

The regularity of training beyond onboarding was not clear, with one NGO staff member reporting that they had not completed any refresher training since onboarding several years earlier.

*"We do [have training], but I think sometimes it would be helpful if it was revisited more often..... Maybe yearly. Because I did that when I started here, and that's coming up to several years ago....but yeah, maybe having refreshers."* **NGO Staff, SUSD**

Ongoing supervision of SUSD staff is necessary to ensure clinical competency, to provide an avenue to discuss challenges, and provide constructive feedback. Most of the interviewed HHS staff described the supervision they received as being informal, consisting predominately of conversations with colleagues and/or managers on an as needed basis. In some instances, allied health staff sourced their own supervision with external clinicians, and this was supported by their professional development allowance. In most cases, HHS staff indicated that they felt the support they had was sufficient.

*"We just have a catch up once a month with the team leader for the Youth Step Up Step Down, we meet once a month, and we just discuss things between ourselves. I find that extremely beneficial and probably for me that's probably the most beneficial."*

**HHS Team Leader, SUSD**

*"It's informal, but like if there are issues or something they might need to talk about, like with the changes I'm making for mental health, I'll just go and talk to him."* **HHS Staff, SUSD**

In comparison, NGO staff tended to have more structured supervision arrangements typically scheduled for once a month with a senior staff member or line manager. Many NGO staff also indicated that they felt comfortable to raise questions or concerns and seek guidance or support from both NGO and HHS staff when needed. It was suggested that Peer Workers could benefit from receiving peer supervision from other Peer Workers due to their lived experience being embedded into their work, however this was not always available. Additionally, while some NGO staff indicated that they had access to an online Community of Practice, others were not aware of any networks they could tap into to support their practice.

*"We do have regular supervision sessions, and they definitely help to explore, you know, am I feeling like I'm contributing, am I feeling enthusiastic about my work or feeling stagnant? What can I do to pick things up? I think those sessions have definitely helped to develop confidence in saying okay, we're going to do this this week, or I'm going to try and incorporate this into my*

*work."* **NGO Staff, SUSD**

*"I have monthly supervision with my team leader, but I have addressed the fact that I need peer supervision, so that's something in the pipes at the moment. Just from a lived experience lens it's a bit tricky, I don't have any issues with work, it's more of how I can manage my own personal stuff and then still be compassionate and hold the space for somebody else."*

**NGO Peer Worker, SUSD**

*"We have our team leader, all of our colleagues. Our clinical staff is absolutely fantastic. Our service manager is amazing. We're in a really lucky position in that our team is one that is incredibly supportive."* **NGO Staff, SUSD**

*"I think [NGO] is really good at offering support. We had a critical incident recently. I've been involved in a critical incident at SUSD in the past and the level of support that's there for you when something like that happens really impresses me."* **NGO**

**Staff, SUSD**

Some senior HHS and NGO staff participated in the Benchmarking Learning Network which is an opportunity to network with, and learn from, other Adult SUSD services.

## 6.2.8. Physical facilities and location

All SUSD sites were located in a standalone building in the community, independent of the hospital. Staff and consumers reported that the positioning of the service away from the hospital helped reduce stigma associated with hospital Mental Health, and support consumers' transition back into the community due to the availability of nearby facilities.

*"Yeah. I like that it's not attached to the hospital. There isn't a stigma. They're not an inpatient. They're voluntarily coming. It takes the medical side of things and makes it more therapeutic [in the combination] of both. I like that where it is. It's out in the suburbs where they don't feel like they're under a microscope. It's good to get them to feel familiar there and then that we can slowly transition them out to being in community settings and engagements"* **Broader HHS Staff**

*"The one in [suburb] is quite central to a lot of places. You are able to walk to the shopping centre. You're able to walk to a chemist. You know. Yet it's private. But the amount of times that I drove past it I didn't even know it existed. Yeah. It's not labelled so you don't feel like, you know – not that I care about being judged but for your own safety they are very cautious about everything."* **Consumer, SUSD**

*"The location, too; nice and close to [shopping centre], and nice and close to parks so that you can go to a walk to the park. Everything that you need is in walking distance from [the SUSD], as well, and next to the train station. I know a lot of people use the train."* **Consumer, SUSD**

Although most staff and consumers reported favourably about the location of the different SUSD sites, there were some safety concerns raised with the location of Cairns SUSD due to its location and the ability for anyone to access the premises.

*"It's not purpose built. It's in a socially - I'd say yeah, socially impacted suburb. The location is good within a sense that it's close to the city and the hospital but it's - there's a lot of social dysfunction within this community. So you often get people wandering in looking for cigarettes or looking for past residents."* **NGO Staff, SUSD**

Four out of the five SUSD facilities were purpose-built. For these facilities, consumer feedback was overwhelmingly positive with consumers often reporting their surprise at how nice and welcoming the facilities were, especially when compared to the hospital.

*"To be as nice as it was kind of surprising, I think, the first time I came here. Because you just didn't know what to expect. You think about different facilities; they might not be [as nice]. But it's 10 times nicer than the hospital."* **Consumer, SUSD**

*"Immediately after that, I went into the interview with my brother. Then they're like, okay, do you want to come and have a walkthrough? They showed me through the centre, and it was just really beautiful and a very welcoming place. There was no uneasy feelings about anything for either of us and I could leave comfortably knowing that he was safe."* **Carer, SUSD**

*"It's a very welcoming feeling and very relaxed. It's - yeah, I really do like how relaxed it is and the décor and everything."* **Consumer, SUSD**

Consumers valued having access to their own private and secure self-contained rooms. They reported that this increased their sense of autonomy and safety and contributed to making the SUSD more like a home and less like a hospital.

*“Coming from the hospital, that was a massive thing to have your own space – your own bathroom. Back at the hospital, people were smoking in the bathroom, and if you were in there for more than like 30 seconds, they’d be knocking on the door.....It’s full on. So that was amazing to come and be able to go in that room whenever you want. So if things are a bit busy, or you’ve been out and you’re tired, you can literally just go to your room. There’s no – it’s, you have your own privacy, I suppose.” Consumer, SUSD*

*“Just having that ability to be independent within a community. The fact that you have your own room with an ensuite and you can have that independence within that space, that really helps.” Consumer, SUSD*

*“Oh, the building’s beautiful and the facilities are amazing. It’s really, really good. Yeah. It’s better than what I expected it to be. I wasn’t really sure. I thought it would be just like a hospital, but no, it’s like individually - individual living and yeah, it’s amazing.” Consumer, SUSD*

Consumers and staff appreciated the range of indoor and outdoor spaces available for both personal and communal time, including outdoor gardens, yoga/meditation rooms, arts and craft spaces, lounge and TV areas, games and hobby spaces, and communal kitchens.

*“The big common area downstairs, the lounge room, the kitchen area, the outdoor seating, and also the breakout seating areas on each floor. It’s just – like, I can’t fault the facilities. It’s almost like a hotel in some ways. I’m sitting here looking out my window; I’ve got this big bay window and lots of light coming through. Yeah, really clean; never a worry about cleanliness or hygiene or anything like that.” Consumer, SUSD*

*“But everything is new and clean and nice, and there’s lots of different areas – you don’t have to sit with everybody. You can go out to the garden and sit there. You’ve got your own space.” Consumer, SUSD*

*“Yeah, it was great. I played pool, watched TV. So yeah, the communal room is great. It’s brilliant....Everyone was always there... Yeah, the way it’s built is just brilliant.” Consumer, SUSD*

Staff members felt that it was beneficial for office spaces to be designed in such a way to facilitate collaboration between staff members and the HHS and NGO teams. Being co-located on site and working in shared spaces was reported to support the partnership and create workflow efficiencies (see section 6.2.2).

It was clear that the Cairns SUSD facility was not seen to be fit for purpose by interviewees. Adapted from an older style two-storey motel, the Cairns facility was reported to be run-down, visually unappealing, lacking functionality, and in need of frequent maintenance. Furthermore, as mentioned previously, the safety and security of residents was seen to be compromised due to the facility’s location and layout. This sub-optimal physical environment was seen to be impacting both the implementation of the SUSD model and consumer adoption and engagement.

## 6.2.9. Funding

Feedback from staff combined with the positive service experiences reported by consumers, would indicate that the majority of SUSD are adequately resourced. However, insufficient ongoing funding was seen as a potential risk to the sustainability of the SUSD by some interviewees. Furthermore, some services reported that it was challenging to meet the increased expenses incurred due to rises in award wages and the rising costs of goods. To supplement funding received by Queensland Health, some services were accessing community grants to enhance service provision. Staff interviewees had a variety of suggestions for where any additional funding could be best allocated, including through additional staffing and training, equipment and activities for consumers and carers, and the provision of some follow-up and support to consumers' post-exit.

*“Once upon a time, we could promote ourselves and get adequate training and all that sort of thing. Now, I'll do things like I'll write grants and so forth for our community engagement stuff that we like to do. I think that's important”* **NGO Service Manager, SUSD**

*“So it's always about making sure that any award changes are covered and indexation's covered and so on and so - and the cost of goods keeps going up for everybody.”* **SUSD Stakeholder**

## 6.3. Summary of findings

- Several variations were identified in the implementation of the SUSD model across services including HHS nursing and allied health profiles, hours of clinical coverage; location of medical teams (internal vs in reach); standard length of stay; availability of individual and group interventions; expectations of attendance at group sessions and medication management. The impact of these variations are discussed.
- The evaluation identified several factors which underpin the successful implementation of the SUSD including sufficient staffing capacity; strong HHS and NGO leadership; strong partnerships with referring teams and broader HHS; appropriate cohort mix; adequate staff training, supervision and support; appropriate facilities; and sustainable funding source. Gaps and areas for improvement were identified across several of these factors.

# 7. Effectiveness findings

## Defining and evaluating effectiveness of the SUSD

The effectiveness of the SUSD explores the extent to which the SUSD has achieved its intended outcomes for consumers, carers and the healthcare system. It also looks at the mechanisms and factors underpinning these outcomes to understand how and why the SUSD works.

This section of the report answers the following key evaluation questions:

- Has the SUSD improved the mental health outcomes of consumers, and why/ why not?
- Has the SUSD improved consumers' experience of mental health care, and why/ why not?
- What impact has the SUSD had for carers, how and why?
- Has the SUSD led to a reduction in ED presentations, and why/ why not?
- Has the SUSD led to a reduction in mental health admissions, and why/ why not?

## 7.1. Service level measures of effectiveness

SUSD services collect a range of quantitative data on entry and exit to help determine the effectiveness of the service. According to staff interviews, the HHS were collecting clinical measures required by the National Outcome and Casemix Collection (e.g. HoNOS, Life Skills Profile) and the NGO were undertaking entry/exit surveys to measure recovery, psychological distress and service satisfaction (e.g. Kessler Psychological Distress Scale, Recovery Assessment Scale). Consumers were also encouraged to provide feedback to the NGO either confidentially via written feedback cards or verbally during meetings and groups. HHS data is utilised for benchmarking activities undertaken by the Queensland Mental Health Benchmarking Unit and the Clinical Improvement Team MHAODB (see section 8.2.2).

Throughout the interviews, staff highlighted potential opportunities to improve how effectiveness is measured within SUSD services, including by capturing consumers' progress towards goals set during recovery planning, and by collecting longitudinal data to determine long-term effectiveness and outcomes. Interviewees also expressed that findings from data collection and analysis could be better communicated between the HHS and NGO teams and/or to staff and stakeholders more broadly. Doing so would inform staff understanding about the effectiveness of the service and its impact. Staff interviewees reported that they were currently relying on anecdotal evidence and consumer feedback to draw conclusions regarding service effectiveness.

*"I think that if we are collecting decent data – so your HoNOS scores – I think that potentially could be a way to capture the change that people are having. Again, it's really inconsistent with how the data is captured. I also think that potentially you could look at the consumer's goals in entering the unit, or progression in those goals – so even looking at, okay, well, we've got a care plan, and we've identified that these things are part of your care plan and being able to tick those off."* **Broader HHS**

*"So it's very difficult then to see our clients getting readmitted to an acute facility for example. What happens to them afterwards? Are we following up clients to see the longitudinal benefit that we've made to a client's welfare? We see the short term benefits, but we don't see then the ongoing."* **SUSD Stakeholder**

*"I don't know if we can really tell [if the service is effective], because I don't know that there's a lot of research or data available about re-presentations after that, how often they have to be seen by mental health services after that, if they actually do engage in whatever their recovery stuff is. So, I actually don't know, and I...I think anecdotally, maybe some, but I don't know, because I think it really has to be based on data, and yeah, you do often see the same faces going through, yeah. So, yeah, kind of have to question if they're doing a rehab, like a recovery-type program, how effective that is. I don't know about data, about avoiding hospital admissions. So, I'm not sure if that's successful or not. I don't know that data, yeah."* **Broader**

**HHS Staff**

*"I just go on feedback that we get from the residents. I mean, you're getting people that come in quite shaky and they're leaving - it doesn't happen all the time, and it's not 100 per cent effective, but majority of the people that come through here thank us and we get lovely letters like we got today and - yeah. We get things written on our whiteboard that we had on our whiteboard from another resident who just left yesterday."* **NGO Staff, SUSD**

## 7.2. Impact on mental health outcomes

### 7.2.1. The Health of the Nation Outcome Scales (HoNOS)

The HoNOS is a clinician rated tool which aims to measure the health status and social functioning of an individual (18 years and older) diagnosed with a mental disorder and receiving clinical care from specialised mental health services in the public sector (Wing et al., 1998).

The HoNOS consists of 12 scales which measures behaviour, impairment, symptoms, and social functioning that individuals with significant mental disorder may experience on a scale of 0-4 with a total score calculated by summing the ratings on each scale, resulting in a total score from 0 to 48 (Australian Institute of Health and Welfare, 2021; Burgess, Pirkis, & Coombs, 2015). For the purpose of the Australian National Outcomes Case Mix Collection (NOCC), significant improvement is seen as a reduction of 4 points or more (Department of Health, 2021). Research by Rees et al., (2004) suggested that a change of 3 to 4 points on the HoNOS may be a useful cut off for clinical improvement in patients with anxiety and depression, and the clinical stability of those with psychosis.

Analysis of CIMHA data was undertaken to explore whether SUSD services were impacting the total HoNOS scores for SUSD consumers. This involved comparing the median total HoNOS score at the start and end of a consumer's first and second SUSD service episode. As seen in Table 11, for both first ( $n = 1879$ ) and second service episode consumers ( $n = 393$ ), a Wilcoxon signed-rank test showed that the median total HoNOS score decreased by 3 points from the start and end of SUSD service episode. This reduction was statistically significant for both groups, and approached clinical significance.

**Table 11 | Non-parametric test of change in HoNOS total score from start to finish of SUSD service episode.**

Timepoint	Median	IQR	p-value
<b>1st service episode (<math>n = 1879</math> paired observations)</b>			
Start SUSD	10	[7, 14]	<.000
End SUSD	6	[4, 10]	
Difference	-3	[-7, 0]	

2nd service episode ( <i>n</i> = 393 paired observations)			
Start SUSD	11	[7, 15]	<.000
End SUSD	7	[4, 11]	
Difference	-3	[-7, 0]	

Table 12 shows that the older adults who attended SUSD (*n* = 73) experienced a significant reduction in their median HoNOS 65+ total score of 4 points, which suggests that this group of consumers had both a statistical and clinically significant improvement in their social functioning and wellbeing from the start to the end of SUSD.

**Table 12 | Non-parametric test of change in HoNOS 65+ total score from start to finish of SUSD service episode.**

Timepoint	Median	IQR	p-value
All service episodes ( <i>n</i> = 73 paired observations)			
Start SUSD	11	[8, 15]	<.000
End SUSD	7	[4, 10]	
Difference	-4	[-7, -1]	

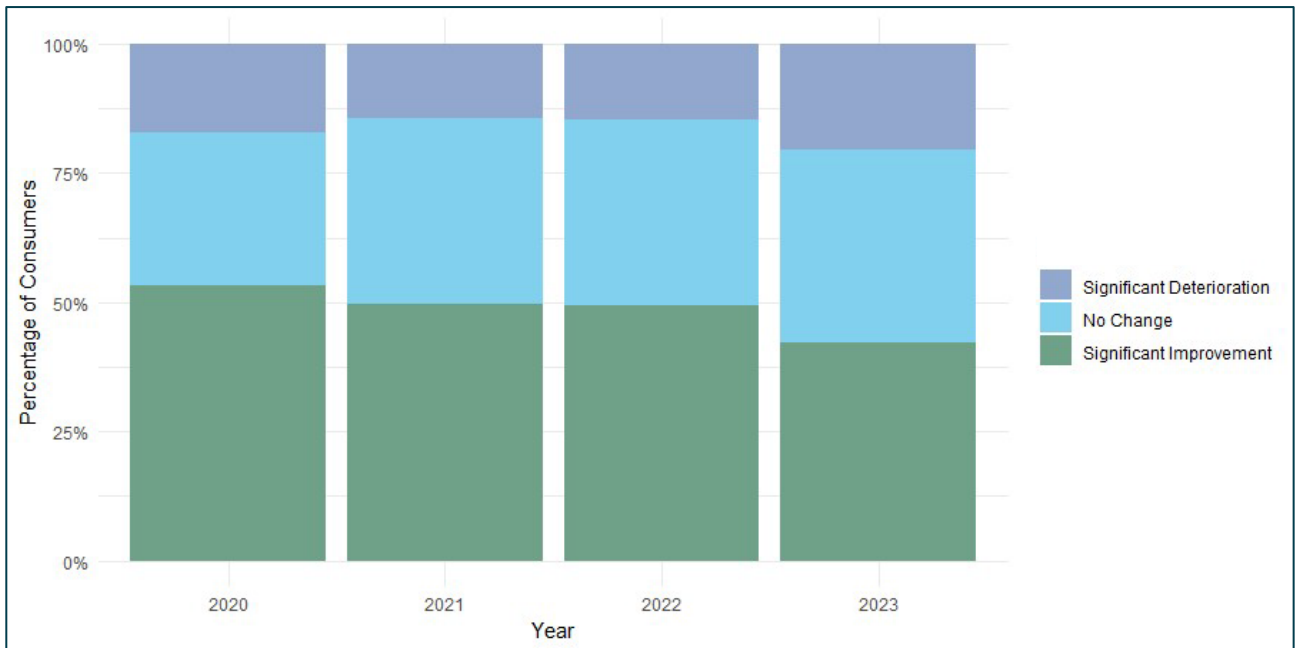
To examine if there was a difference in the change in HoNOS scores between consumers who step up and those who step down, a non-parametric test was conducted as seen in Table 13. Consumers who stepped up (*n* = 1067) and consumers who stepped down (*n* = 1484) both experienced a statistically significant reduction in total HoNOS score of 3 points pre- and post- SUSD. Whilst the median difference HoNOS score was the same for both the step up and step down groups, the change in the distribution was statistically significant (*p* = .001), with those who stepped up experiencing a mean reduction of -3.96, versus those who stepped down having a mean change of -3.12. These results suggest that those stepping up had a marginally greater improvement, however this difference was not clinically meaningful.

**Table 13 | Non-parametric test of differences in HoNOS change between consumers who have stepped up versus consumers who have stepped down.**

Step up or Step down	Median			Mean change	IQR change	p-value
	Pre	Post	Change			
Step up ( <i>n</i> = 1067)	11	7	-3	-3.96	7	.001
Step down ( <i>n</i> = 1484)	10	6	-3	-3.12	6	

Further analysis was undertaken to compare the clinical outcomes across the SUSD units statewide from 2020 to 2023 (see Figure 19). For this analysis, change in total HoNOS scores were categorised into: no change, significant improvement or significant deterioration using NOCC guidelines (Department of Health, 2021). A Pearson's Chi-squared test found no significant differences in the clinical outcomes between 2020 and 2023 ( $\chi^2 = 6.98$ , *df* = 6, *p* = 0.32) which indicates the effectiveness of SUSD services on clinical outcomes has remained consistent across the four years.

Figure 19 | Statewide HoNOS total outcomes by year of service delivery.



### 7.2.2. Consumer reported mental health outcomes

Interview data complements the quantitative findings with consumers reporting a range of positive mental health outcomes because of their stay at the SUSD. Some consumers gained coping skills that helped them to alleviate anxiety and panic attacks, prevent self-harm, and/or reduce suicidal ideation. Others reported significant improvements in their mood and hope for the future. Several consumers shared that they received a change in diagnosis and/or medication/s that resulted in significant improvements to their mental health symptoms and understanding of their mental health and behaviour. In some cases, consumers had sought help for their mental health previously but did not feel they got the help they needed until their stay at SUSD.

*“It is a journey, and I’ve struggled with what I thought was anxiety– having anxiety really badly after the breakdown. I saw psychologists and psychiatrists and found it really hard to gel with them. I became really insular as a result of the breakdown, so found it really difficult to communicate. It’s really only been since being in the Step Up Step Down program that I actually feel I’m back to where I was before I had my breakdown. It’s been 15 years of not being well.” Consumer, SUSD*

*“I was just surviving, and I didn’t really have any growth. But since coming to Step Up Step Down, I’ve really been able to make progress. Just to stop and reflect, like how I’ve got to process things – because I don’t have that time to stop and reflect and think about things and learn new things – it’s been excellent. I’m looking forward to the future now.” Consumer, SUSD*

*“I think it’s been positive. I think it’s been pretty life-changing, actually. If I didn’t come here from hospital, I don’t think I would have been prepared – and that’s all the honest truth. I think this place is gold for mental illness. It’s being around like-minded people.” Consumer, SUSD*

*“I think the medication helped me the most, getting me off the medication. Because they reckon it was reacting with each other and sending me loopy...That’s what they told me and I was like, well that would probably make sense.... I’m doing a lot*

*better now though. Less stressed, sleeping well. I get tired at 7:00, I can go to bed at 7:00. Before it was like 11:30 at night and I'd go to sleep and then I'd be waking up at 3:00 in the morning."* Consumer, SUSD

## 7.3. Impact on recovery and life skills

### 7.3.1. Life Skills Profile (LSP-16)

The LSP-16 is a 16-item measure used to provide insight into the general functioning of individuals with mental illness, including how they function in social relationships and ability to do day-to-day tasks (Buckingham et al., 1998; Department of Health, 2021). Each of the 16 items are scored on a 4-point scale from 0 to 3, with lower scores suggesting a higher level of functioning. The total score is calculated by adding the individual scores together and can range from 0-48, however, it is important to note that some questions may not be relevant, therefore, items with missing data are excluded from this total score calculation (Department of Health, 2021). Research examining clinically significant change in LSP-16 has primarily looked at change over a 3-month period so we were unable to determine clinically significant change for the SUSD length of stay.

Analysis of CIMHA data was undertaken to explore whether the SUSD service has impacted the total LSP-16 scores for SUSD consumers. This involved comparing the median total LSP-16 scores at the start and end of consumers' service episodes (n = 2110) and this showed a statistically significant reduction of 1 point in LSP-16 median score (see Table 14). This suggests that consumers experienced an improvement in ability to complete daily tasks at the end of SUSD. Table 15 shows a comparison in change of LSP-16 scores (pre- to post- SUSD) between those consumers who stepped up versus those who stepped down. No significant differences were seen between these two groups.

**Table 14 | Non-parametric test of differences in LSP-16 scores from start to finish of SUSD service episodes.**

Timepoint	Median	IQR	p-value
All service episodes (n = 2,110 paired observations)			
Start SUSD	9	[5, 13]	<.000
End SUSD	7	[3, 12]	
Difference	-1	[-5, 2]	

**Table 15 | Non-parametric test of differences in LSP-16 score change between consumers who have stepped up versus consumers who have stepped down**

Step up or Step down	Median			Mean change	IQR change	p-value
	Pre	Post	Change			
Step up (n = 798)	9	7	0	-1.14	6	.151
Step down (n = 1,312)	8	7	-1	-1.25	7	

## 7.3.2. Consumer reported recovery and life skills

In addition to mental health improvements, consumers developed or improved various life skills during their time at the SUSD. These included cooking, cleaning, keeping a routine, self-care, going out in public, and attending appointments. Consumers also reported finding housing, returning to work and general improvements in their life or recovery overall. Many of these improvements were retained after exiting the SUSD and this is discussed further in section 8.1.

*“I learnt how to cook....I learned how to do my washing.....And make the bed...It's made me a bit more independent.....more confident.” Consumer, SUSD*

*“I was helped on a number of occasions very much by being redirected from a bad thought process to being redirected and ending up doing some mindfulness or some music or some gardening, or going for a walk. I even re-exposed myself to going out in public to the local market with [name] and then, the following week, with [name], and that was a big thing for me. So, I took some big steps while I was in there.” Consumer, SUSD*

*“I really like the idea of having to take responsibility for – everyone had a turn at cooking. Then whoever cooked didn’t have to clean up and everyone else cleaned up. You looked after your own room, you made sure that it was clean. You did your own laundry, et cetera. I suppose that sense of actually having to take responsibility for my life again.” Consumer, SUSD*

*“I didn't quite know what to expect. But, definitely, I feel normal again. I feel like I've recovered....I've secured a place to stay. I'll be going back to work in a couple of weeks' time.” Consumer, SUSD*

## 7.4. Consumer satisfaction with SUSD

### 7.4.1. Your Experience of Service (YES) survey

A quantitative assessment of consumer satisfaction with their experiences at SUSD was undertaken using the Your Experience of Service (YES) survey data. The YES survey is offered to public mental health service consumers for a six-week period annually. Response rates for SUSD services from 2020 to 2023 are shown in Table 16 to give an indication of representativeness across services. This number of responses are 6% of the number of service episodes for this period and are not sufficient for conducting statistical tests. Therefore, the following results may not be representative of the total population and should be interpreted with caution.

**Table 16 | YES survey response rates 2020 to 2023**

SUSD	2020	2021	2022	2023	Total
Bundaberg	20	20	20	15	75
Gladstone	11	6	13	4	34
Cairns	11	17	0	4	32
Mackay	10	14	5	11	40
Nundah House	9	6	1	3	19
<b>Total</b>	<b>61</b>	<b>63</b>	<b>39</b>	<b>37</b>	<b>200</b>

Questions 1 to 22 of the YES survey are used to calculate an overall experience score out of 100. A score of 80 and above indicates a positive experience. The questions ask consumers about various aspects of their experience including if they were shown respect, felt safe, had their individual needs met, were supported to participate, and if they were provided information and support. Table 17 shows the average overall experience scores for SUSDs in comparison to scores received across Queensland Health services statewide. These data show that SUSDs consistently score higher than the statewide average. Table 18 shows that from 2020 to 2023, the majority of surveyed SUSD consumers had a positive experience.

**Table 17 | Overall YES experience scores 2020 to 2023**

	2020	2021	2022	2023
SUSD	92.1	92.3	91.9	93.7
QLD	85.8	85.5	85.7	86.0

**Table 18 | Proportion of YES responses with an overall score of 80 or above (indicating a positive experience)**

	2020	2021	2022	2023
SUSD	91.8%	90.5%	87.2%	89.2%
QLD	73.6%	73.3%	73.4%	74.2%

## 7.4.2. Consumer reported satisfaction

Consistent with the YES data, the majority of SUSD consumers interviewed indicated that they had a positive experience at the SUSD they visited. Most felt that the service met their expectations, with some adding that it was even better than they expected. With a few exceptions, consumers indicated that their time at SUSD was helpful for their recovery, and they attributed this to several aspects of the service. Of high value for many consumers was the sense of safety provided at the SUSD and the support and care provided by the staff. These themes are discussed in more detail in section 6.2.4.

*“Yeah. Oasis can be a whole different version for people, and that is the only way that I would describe my journey through it. It wasn’t a sanctuary. It was an oasis, yeah. Where they gave me – an oasis you can get water. They gave me knowledge to survive. They were supportive in a time of distress. The staff there – there is not one person who isn’t amazing. There is nothing that they could do to better that place.” Consumer, SUSD*

*“So, yeah, and it has been really, really good. It’s helped me tenfold. It’s.....I’ve got nothing but positive about this place, yeah...” Consumer, SUSD*

*“It was fantastic. I’d live there for the rest of my life if I could. It’s fantastic. Really it is. It’s really, really good.” Consumer, SUSD*

Some of the consumers interviewed had experienced multiple stays at the SUSD, while others indicated that they would visit the SUSD again if needed. Consumers also said they would recommend the SUSD to others who might benefit from it. In many cases the consumers interviewed couldn't think of ways that the service could be improved

due to the experience being so positive for them. However, some suggestions were made that included: more groups, physical activities led by a qualified instructor, a gym, more food, longer length of stay, and more staff. The most frequently made suggestion was that there should be more SUSD services available.

*“Maybe people from outside of the house to come in and do dedicated programs. Someone who is a specialist in the field or something, or even a psychiatrist. Just people in the field of mental health coming specifically from outside the house to do programs.”* **Consumer, SUSD**

*“I think more centres would be fantastic.... So more people can access it, and what works is the fact that it’s a small group of people, it’s a family.”* **Consumer, SUSD**

*“Imagine if there was one in every town... Like all the people – sick people that needed it, it would be so lovely.”* **Consumer, SUSD**

### 7.4.3. Comparison of SUSD experience to alternate/previous care

Most consumers who were interviewed had previous experience as an inpatient on a mental health ward. Many participants made comparisons between their experience at hospital with their time at the SUSD with one consumer summing it up succinctly as: *‘hospital and SUSD are like chalk and cheese’*. Interviewees described the hospital environment as being distressing, noisy, restrictive, and impersonal, and consumers felt that hospital staff were usually too busy and stressed to spend time with them outside of doing observations and medications. For some, the hospital environment was very challenging, and they welcomed the opportunity to step down to the SUSD.

*“Excited to be out of the hospital. One of the first times that I started to feel human again. I really didn’t like the hospital experience. It had some positives, but it was just the noise. It was so quiet to come to somewhere like this, from hospital.”*

**Consumer, SUSD**

Consumers described their transition into the SUSD as *‘a weight off and a sigh of relief’*, *‘being lifted up’*, and being able to *‘feel human again’*. Compared to the hospital, consumers particularly valued that at the SUSD they had freedom of movement, privacy, and access to their belongings at any time. Other positives included the calm, quiet and relaxing environment, having access to supportive staff and being treated like an individual. For some consumers, entering the SUSD environment reduced their distress and enabled them to engage in their recovery. Many consumers also reported that they would prefer to go to a SUSD instead of hospital in the future if necessary.

*“Yeah, it was heaps good. Like I said, I was - like, I was really uncomfortable in hospital, and I was - I was actually suffering a fair bit from panic attack, kind of just being really anxious and stuff. That was when I was in hospital, but when I got there [SUSD], yeah, I really relaxed... Yeah. I could really - like after about 48 hours of being there, I was completely relaxed and I was happy to do - like, do a group in the morning and then a group in the afternoon, and like, that wasn’t - it wasn’t too much.”*

**Consumer, SUSD**

## 7.5. Carer satisfaction with SUSD

### 7.5.1. Carer Experience Survey (CES)

The Carer Experience Survey (CES) collects data from carers who have supported someone that has been engaged with Queensland public mental health services. As shown in Table 19, the number of surveys completed at SUSDs during the evaluation period was low for all sites except Bundaberg. A potential barrier to CES data collection is the suitability of the measure for the SUSD service. During an evaluation site visit a SUSD staff member indicated that the CES was not considered to be fit for purpose. If sites do not perceive the CES survey as suitable or valuable, then this may impact the number of carers being invited to complete the survey. Furthermore, services also indicated that not many families/carers engage with the SUSD, and therefore are not present to be offered the survey. The limited availability of statewide data meant that a quantitative assessment of carer satisfaction was not possible for this evaluation.

*Table 19 | CES response rates 2020 to 2023*

SUSD	2020	2021	2022	2023	Total
Bundaberg	8	9	15	4	36
Gladstone	0	0	1	0	1
Cairns	1	0	0	0	1
Mackay	0	2	0	0	2
Nundah House	0	0	0	0	0
Total	9	11	16	4	40

### 7.5.2. Carer reported satisfaction

Three carers who had experience with supporting a family member staying at a SUSD were interviewed for the evaluation. All carers reported that they had the opportunity to attend the SUSD and found the facilities and staff to be warm and welcoming. One carer remarked that this helped them to feel comfortable that their family member was going to be safe at the SUSD and another carer appreciated that the physical facility was discreet in terms of not being identifiable as a mental health facility.

*“They showed me through the centre and it was just really beautiful and a very welcoming place. There was no uneasy feelings about anything for either of us and I could leave comfortably knowing that he was safe.” Carer, SUSD*

Two of the three carers indicated that they were offered support from a Family Engagement Worker. While one of these carers did not feel they needed support at the time, the other found the support provided to them was valuable. Furthermore, they shared that the support provided to their family member at the SUSD had a positive flow on effect to other members of the family.

*“I was actually offered support as a carer from her [Family Engagement Worker]. She sent a referral off to Carer’s Gateway, because my son was with us at the time and she’s like, ah, you have your hands full [laughs]. So she actually got me in contact with Carer’s Gateway as well to access some support services for myself, to help me with carer’s burnout and all of the rest of the things that come along with being a carer.” Carer, SUSD*

“Yeah, so it’s actually been helpful not only for him, but everybody around him as well and we can all see the big difference that it has made.” **Carer, SUSD**

All carers indicated that they thought the SUSD was a good service and would support their family member to attend again if needed. Several suggestions were made to improve the experience for carers including the provision of more information, improving consultation with carers, extending length of stay beyond two weeks, and providing family therapy sessions. Further information about family/carers engagement is detailed in sections 6.2.5 and 8.1.

## 7.6. Impact on inpatient admissions

Analysis of CIMHA data was undertaken to explore whether the SUSD service had impacted the number of acute inpatient admissions for the SUSD consumers who had a SUSD service episode in 2021 - 2022. This involved comparing the median number of acute inpatient service episodes that consumers had in the 12-month period prior to, and after, their first SUSD service episode (see Table 20). When considering all consumers with a history of at least one acute inpatient service episode in the 12-months prior to their first stay at a SUSD ( $n = 923$ ), a Wilcoxon signed rank test showed there was a statistically significant reduction in inpatient admissions (median difference = -1 admission) in the 12-month period following their stay at a SUSD. Further analysis was undertaken on the sample of consumers ( $n = 182$ ) who had at least two acute admissions in the 12-month period prior to their first SUSD service episode. We found that that this particular group experienced an even larger reduction in their inpatient admissions (median difference = -2 admissions) in the 12-month period following their encounter with the SUSD. Together, these findings support the conclusion that the SUSD service is helping to prevent inpatient admissions relating to mental health.

**Table 20 | Non-parametric test of inpatient admissions 12 months before and 12 months after SUSD service episodes.**

Timepoint	Median	IQR	p-value
<b>All consumers who had an acute admission before or after SUSD (count from 1<sup>st</sup> episode)</b> ( $n = 923$ paired observations)			
12 months pre	1	[0, 1]	<.000
12 months post	0	[0, 1]	
Difference	-1	[-1, 0]	
<b>Consumers who had at least 2 acute admissions 12-months prior to SUSD</b> ( $n = 182$ paired observations)			
12 months pre	2	[2, 3]	<.000
12 months post	0	[0, 1]	
Difference	-2	[-2, -1]	

Additionally, Table 21 shows the median number of inpatient admissions in the 12 months pre- and post- SUSD for consumers who stepped up ( $n = 299$ ), versus those who stepped down ( $n = 624$ ). Both groups experienced a significant reduction in inpatient admissions from 1 to 0 in the 12-months pre- and post-SUSD, and there was a significant difference in their change distribution ( $p < .000$ ), with consumers who stepped down experiencing a mean change in inpatient admissions of -0.623, compared to -0.221 for those who stepped up. These results may

suggest that consumers who stepped down had a slightly larger reduction in inpatient admissions (pre- and post-SUSD) compared to those who stepped up. However, these results collectively indicate that SUSD services are having a significant impact in reducing the number of inpatient admissions consumers have after SUSD.

**Table 21 | Non-parametric test of differences in 12-month pre/post inpatient admissions between consumers who have stepped up versus consumers who have stepped down (count from 1<sup>st</sup> episode).**

Step up or Step down	Median			Mean change	IQR change	p-value
	Pre	Post	Change			
Step up (n = 299)	1	0	0	-0.221	1	<.000
Step down (n = 624)	1	0	-1	-0.623	1	

## 7.7. Impact on ED presentations

An analysis of EDC data was undertaken to explore the potential impact of the SUSD service on mental health related ED presentations for SUSD consumers who had a SUSD service episode in 2021 - 2022. This analysis involved comparing the median number of ED presentations which consumers had in the 12-month period pre- and post- their initial (n = 979 observations) SUSD service episode (see Table 22). Wilcoxon signed rank tests were undertaken and showed a statistically significant reduction in mental health related ED presentations at 12-months post-SUSD, equivalent to one less ED presentation on average, following a consumers' first stay at a SUSD service. These findings support the conclusion that the SUSD is helping to prevent mental health related ED presentations. Further analysis was undertaken on the sample of consumers (n = 533) who had at least two mental health related ED presentations in the 12-month period prior to their first SUSD service episode. We found that this particular group experienced an even larger reduction in their ED presentations (median difference = -2 admissions) in the 12-month period following their encounter with the SUSD. Together, these findings support the conclusion that the SUSD service is helping to prevent inpatient admissions relating to mental health.

**Table 22 | Non-parametric test of the number of mental health related ED presentations 12-months before and 12-months after a SUSD service episode**

Timepoint	Median	IQR	p-value
<b>All consumers who had an ED presentation before or after SUSD (count from 1<sup>st</sup> SUSD episode) (n = 979 paired observations)</b>			
12-months Pre	2	[1, 3]	<.000
12-month Post	1	[0, 3]	
Difference	-1	[-2, 1]	
<b>Consumers who had at least 2 ED presentation 12-months prior to SUSD (n = 533 paired observations)</b>			
12-months Pre	3	[2, 4]	<.000
12-month Post	1	[0, 3]	
Difference	-2	[-3, 0]	

Further analysis (see Table 23) was undertaken to compare the change in ED presentations between consumers who stepped up ( $n = 523$ ) versus those who stepped down ( $n = 865$ ) to their first service episode. Both groups experienced a median reduction of 1 ED presentation in the 12-months following their SUSD service episode. Whilst this difference is the same between groups, the difference in their distributions were statistically significant ( $p < .000$ ), with those who stepped down experiencing a slightly larger reduction in the number of ED presentations in the 12-months post-SUSD (mean change = -0.721) compared to those who stepped up (mean change = -0.704). This may not reflect a meaningful difference between these two groups, however, overall, these results suggest that SUSD is having a significant positive impact on reducing the number of ED presentations for consumers, particularly for those who have had at least 2 ED presentations in the 12-months before SUSD, as they experience a reduction of 2 ED presentations post-SUSD.

**Table 23 | Non-parametric test of differences in 12-month pre/post ED presentations between consumers who have stepped up versus consumers who have stepped down (count from 1st episode)**

Step up or Step down	Median			Mean change	IQR change	p-value
	Pre	Post	Change			
Step up ( $n = 523$ )	2	1	-1	-0.704	3	<.000
Step down ( $n = 865$ )	2	1	-1	-0.721	3	

## 7.8. Summary of findings

- The SUSD is effective at improving consumers' health status and functioning, with consumers experiencing a statistically significant reduction on their Health of the Nation Outcome Scales (HoNOS) total score from pre- to post- their SUSD stay (Median change -3 for adults and -4 for older adults).
- The SUSD is effective at improving consumers' general day-to-day functioning for consumers as indicated by significant reductions in the total Life Skills Profile (LSP-16) scores from pre- to post- SUSD stay (median change = -1).
- The SUSD is equally effective for consumers' stepping up, and consumers' stepping down.
- Findings indicate that SUSD may be helping to prevent inpatient admissions; those consumers with a history of inpatient admissions had a statistically significant reduction in their number of inpatient admissions (median change = -1) in the 12-month period following their first visit to the SUSD in comparison to 12 months prior. Those who previously had two or more acute admissions experienced an even greater reduction (median change = -2).
- Findings suggest that SUSD service episodes may also be helping to prevent mental health related ED presentations. Consumers with a history of ED presentations had a statistically significant reduction in mental health related ED presentations in the 12-month period following their first visit to SUSD in comparison to 12 months prior. Those who previously had three or more acute admissions had an even greater reduction (median change = -2).
- Consumer satisfaction as measured by the YES survey indicate that approximately 90% of surveyed SUSD consumers report a positive experience.
- Interview data shows that most consumers find a SUSD stay beneficial for their recovery and report positive mental health outcomes. Consumers particularly value the care and support provided by staff and the warm and welcoming SUSD environment. Furthermore, the SUSD was the preferred option for mental health care, over a hospital inpatient admission.

# 8. Maintenance findings

## Defining and evaluating maintenance of the SUSD

At the consumer and carer level, maintenance of the SUSD explores the extent to which the SUSD has achieved a sustainable impact on individuals who have accessed the service. At the system level, maintenance looks at the sustainability of the SUSD as part of mental health support practices within the HHS.

This section of the report answers the following key evaluation questions:

- To what extent did consumers and carers develop knowledge and skills during their time at the SUSD, and have they used these knowledge and skills since?
- What are the factors impacting the ongoing sustainability of the SUSD for health services?

## 8.1. Impact on consumers' and carers' knowledge, skills and resources

Analysis of interview data indicates that during a stay at a SUSD consumers gained knowledge, skills and connections that were beneficial for their personal recovery. Consumers who exited the SUSD reported that some of these gains such as learning new coping skills and how to seek help were maintained longer term.

*"I don't really do meditation and stuff anymore, but I know that I still use my breathing techniques and stuff. If stuff is getting hard or stressed out, I take myself away and go to a calm space. I usually go down and sit down by the beach or by the water. I've been able to express myself a bit more now as well....Instead of just holding everything in, if I've got a problem, I'll voice it instead of just pushing it down." Consumer, SUSD*

*"I still draw on everything that was helpful.....so they would give you tools or experiences and things that you could use, i.e. mindfulness or various things, or their lived experience stories or this telling or the sharing of your space, so that you can put that in your toolkit, and I have used those things since. How to control, self-control, self-manage a situation when there isn't a peer worker, where I'm not near my house... Bringing myself back to the moment. Not getting panicky, escalating. Getting out, going for a walk, facing the fear. Feel Everything and Rise. The acronyms that they tell you. Feel Everything And Rise and all of those things, they come back into your head when you need them." Consumer, SUSD*

*"...because they've been committed and attended - and completed Step Up Step Down, they're more likely to engage as well. So they're actually help seeking, whereas a lot of people that are referred from the Community Mental Health or the unit, they're just ticking a box or oh, that sounds all right, but are not probably really in their right head space for that sometimes, so and it's a bit of process to go through Step Up Step Down prior to coming to us." SUSD Stakeholder (External Support Service)*

Consumers also spoke about developing a better understanding of themselves and their mental health problems at SUSD and were able to draw on these insights to help prevent escalation of symptoms or distress. In some cases, medication changes made at the SUSD were having a significant positive impact on consumers' symptoms and quality of life.

*“Yeah and understanding when I’m starting to get angry....or frustrated, and start breathing. Like I can notice when I start breathing rapidly, I know that something’s going on. I’m actually revving myself up, I got to slow down my breathing before it escalates.” Consumer, SUSD*

*“I was only diagnosed with the bi-polar while I was in there [at SUSD]...I’m now on a mood stabiliser. I think that that has got a lot to do with it, but also too for me, it’s that realisation and being able to look back and say, oh yeah that was a high. It was a high high. Also too, I can now understand why the anti-depressant medication really wasn’t working.” Consumer, SUSD*

For many consumers, the healthy habits, routine and daily living skills embedded in the day-to-day at SUSD were incorporated into their daily life post-SUSD with some reporting improvement in maintaining healthy sleeping patterns, eating habits, cessation of substances, taking medications and keeping appointments.

*“Because of my insomnia I didn’t sleep through the night. So, yeah, the sleep patterns are up to date and everything now. Yeah, sleeping through the night is pretty good. Back on my medications.” Consumer, SUSD*

*“One thing that I started there, which I still do to today, is I have breakfast every morning. I know that sounds strange for some people, but for 30 years I didn’t eat breakfast. I had a cup of coffee and a cigarette. So that was my breakfast. ...Some people might think, oh, that’s just - well, everyone does it daily, but I didn’t. I never used to eat breakfast ever. I was just cigarette and coffee and that was it. So I gave up coffee as well because I had - well, I gave up cigarettes. I used to have to have coffee and cigarettes. So I gave up the coffee as well. Yeah.” Consumer, SUSD*

Consumers also spoke of discovering or reigniting interests and hobbies at the SUSD that they planned to pursue further. Some had set vocational goals and developed a pathway to achieve them and gained skills such as resume writing.

*“It has inspired me to go back to what I used to do. I used to do crocheting before, as well... So, I’m going to try and get back into my crocheting again, when I get home as well. [name] has inspired me... Because she does a lot of crocheting, and she is fantastic, and watching her has inspired me to give it a go, and get back into it again. Whereas, if I hadn’t have come down here, I wouldn’t have been doing any of that. I wouldn’t have even thought about doing anything.” Consumer, SUSD*

*“I really struggled with the thought of having to write a resume, not ever having to write a resume. Well apart from when I applied for promotion. Because I wasn’t in the right headspace I found it hard to get started but [Staff] gave me some examples and I then - I smashed out a resume in no time. That was good and I’ve done some research into the courses, and there’s a massive demand, a massive demand for community support...I’m keen to pursue this.” Consumer, SUSD*

Family and/or carers also benefited from engaging with SUSD by gaining new knowledge, skills and resources that helped them in their role as a carer. Carers were provided with resources and information or connected to support services like The Carer’s Gateway. One carer shared that guidance received from the SUSD about how best to support her brother was invaluable, as was the support provided to him by a case worker to which he was referred after exiting the service.

*“I didn’t know anything about the support services that were available to us, so that was really helpful. She [Family Engagement Worker] was amazing in explaining all of that, and offering to send links to other things as well, if we needed it.*

*Even after he left, she was very clear, keep in touch, if there's ever anything you need, feel free to call. So that was really good. I did read the pamphlets and stuff, that she gave me, because I don't really have any outlet or support, I guess, from my end either."* **Carer, SUSD**

*"They were really open to answering any questions that I had about how to support him in the community when he came home .... they gave me some really helpful skills in encouraging him to leave the house, rather than just saying, hey, let's go, and how to prepare him for leaving the house. Getting him to appointments as well, because that's something he really struggled with. He wouldn't be able to sleep or anything leading up to the appointment, so they gave us some tips on what to do in those circumstances as well."* **Carer, SUSD**

Whilst many interviewees spoke of consumers experiencing moderate to profound long-term change instigated by a stay at SUSD, interview data indicates that some consumers struggled to maintain these gains after exiting the service, with some re-presenting to the SUSD and other mental health services. Although some consumers were connected or referred to support services following exit, the SUSD often did not follow-up to ensure consumers acted on these referrals. Several interviewees suggested that providing follow-up for consumers who have exited the SUSD may help them to further consolidate the skills and gains made whilst at the SUSD. This would also present an opportunity to support consumers to follow-up with referrals.

*"I definitely think that even I would right now benefit from more support but I already know I'm not going to get it so..."* **Exited Consumer, SUSD**

*"They did an absolutely fantastic job and he's [consumer] maintained a lot of things. However, a little bit more repetitiveness to help them once they come out if they don't have support like my brother has with me, might help."* **Carer, SUSD**

*"So, it would be really good if we could maintain – have funding for some ongoing support for maybe a month or a couple of weeks post exit to be checking and going, how are you going with applying the strategies that you learnt, because we know what they were. So, to be able to walk alongside them and having that check in a couple of times a week, how are you going with this? Okay, you had that stressful day, how did you manage that? Do you remember what you were doing here? Making sure that's embedded in because like I said, we've got some clients who were coming back six, seven times. So, we know that they're benefiting from the program, but it's that embedment and that habitual change. We know that habits take at least 28 days to change, and start embedding in. Lifestyle stresses coming in the middle of that, it easy to forget, or to not practice as much as what you did here. So, that would be one of the big things that I would like to see."* **NGO Service Manager, SUSD**

## 8.2. Sustainability of SUSD

### 8.2.1. Staff recruitment and retention

The optimal functioning and sustainability of SUSD services requires the recruitment and retention of an adequate number of skilled, qualified and experienced clinical and non-clinical staff. This was recognised by SUSD staff and stakeholders interviewed as part of the evaluation, with many reporting that staff recruitment and retention was a major risk to the sustainability of SUSD. Recruitment of someone who is the right fit was reported to be of particular importance to team functioning and staff retention. Resilience, emotional intelligence, openness to learn, life experience, collaborative, and good communication were sought after skills and qualities. Some regarded that it was particularly important to select clinical staff who work with a recovery-focused approach for therapeutic

relationships and team functioning to thrive. Furthermore, interviewees thought it was beneficial to backfill clinical staff with people who had previous SUSD experience due to their familiarity with the unique SUSD model.

*“We have also been deliberate in the recruitment process. We have sat in on each other’s interview panels [HHS & NGO], and what we are looking for is particular qualities in staff. We can teach them technical skills, we can teach them the way we work here, but we are looking for attitude, we are looking for teamwork, we are looking for professionalism, the core inner attributes of somebody that is part of their personality and their nature.”* **NGO Service Manager, SUSD**

*“Yeah. I think resilience is a big one for me, and emotional intelligence. So hard to capture that when you’re doing an interview, without – because you go off people’s references. No one’s going to put a dodgy reference....Look, sometimes it’s a hit and miss. I’ve had people who have been degreed up from Masters of social work, they got all the skills, been doing it for a while. We say, yeah, no, they’d be a good fit. A few months down the track, they’re burnt out, not robust or not being able to manage it. Then you get somebody who has come from, either a tradie or hairdressing, you know what I mean? Who’s got a passion, who has that resilience of them skills, the skillsets, especially if you work in hospitality. You’re getting abused all the time. Communication’s good for hairdressers and beauty therapists, tradies. They work hard and things like – so you look at that type of background and they have been outstanding workers.”* **NGO Team Leader, SUSD**

*“We try and have a bit of a pool of people who know this place. When it comes to the nursing staff, we have a bit of a selection of people who have worked here before, might have done a secondment, know what the service is. Just because it’s easier for them to come in and they can just step in and do it.”* **HHS Team Leader, SUSD**

Recruitment of sufficient NGO staff to operate the service 24/7 was reported to be particularly challenging for some services and required flexible solutions. Strategies being adopted by some services included developing partnerships with education providers, providing work placements for volunteers/students, and recruitment of tertiary students and people from other professions with transferrable skills. Having a pool of casual staff was viewed as important to cover staff on leave and operate the service 24/7. However, job insecurity and inconsistent or insufficient work hours was reported to make retention of casual staff challenging. Some services were able to provide more consistent work by employing casuals across related services (e.g. Crisis Support Space and CCUs). However, this created new challenges due to the different nature of these services and potential conflicts of interest.

*“The other challenge is like being a 24/7 roster, COVID and sickness, like at times we’ve been quite thin on staffing. So how I’ve managed that is to put on additional casuals, like surplus casuals for what we’ve needed. So some of the challenge of that is how you provide people enough hours to, a, retain them, and b, retain a level of skillset.”* **SUSD Stakeholder**

*“It’s hard to retain casuals to cover shifts. With sickness going around it’s a bit inevitable, but it’s hard on staffing. Often, we’ll just be training up a casual or we’ll just trained them up to know 50 per cent of the processes, and then they go and find another job, full-time job.”* **NGO Staff, SUSD**

Many of the staff interviewed had worked at the SUSD long term and expressed high satisfaction with their roles. HHS staff found it satisfying to work in a therapeutic framework with the NGO, being able to spend more time with clients, and the calm and positive working environment. NGO staff shared that they liked working within a multidisciplinary team and being able to use their lived experience, strengths and interests to help consumers.

*“So, it’s good. It really is the most satisfying job I’ve had since coming back to Queensland Health. For me, as I say, I came from a little bit of a toxic environment that had, in my opinion, once again only – a lot of burnout, and not cohesive working environment, and for me, it’s been heaven. That’s the honest answer.”* **HHS Staff, SUSD**

*“It’s so recovery focused and that’s what I like. Thirty years of nursing, emergency, rural remote, mental health, recovery care [can be] fabulously – that person that has a smile, that laughs and feels the laugh in your belly, that is showering more than once every two, three weeks, six months – those type of things – someone that’s outside of the house recovering can be so much. It’s an incredibly rewarding job over there [at SUSD].”* **Broader HHS / Previous SUSD Staff**

*“I really enjoy being able to just be open about my personal experiences and yeah, I feel really well suited to the role.”* **Peer Worker, SUSD**

*“The other positive thing is like working in a multidisciplinary team. That’s a very positive thing. Because we are not clinicians, sometimes like the - when they [consumers] are confused about medication.. I can’t say, because I’m not clinical. But here, because it’s in a multidisciplinary team and everybody is in a different field, it’s help for client. I think that’s another positive thing I feel.”* **NGO Staff, SUSD**

*“I’m into [hobby/activity], so I’m able to incorporate that into my role. So when we get certain clients come through, if they’re interested in that same [hobby/activity] often I’ll get paired up with them. But yeah, it’s very good – like people can use like their strengths and interests and stuff to help clients as well”.* **NGO Staff, SUSD**

Staff reported that services had experienced periods of high turnover of either HHS or NGO staff at various stages since being established. Staff turnover was attributed to a variety of factors including COVID-19, Queensland Health secondments, leadership challenges, inadequate training or support, and staff burnout. Staff burnout was seen as more likely to occur when a service experienced long-term short staffing, a disengaged external treating team, and/or consumers with high clinical acuity.

*“I think that when there is a high turnover of staff – both for the clinical team, but also for the NGO time – that that has had a huge impact. Again, it’s that, getting to know you, kind of stuff, and getting to know the model”* **Broader HHS / Previous SUSD Staff**

*“I think, clinical acuity is always the biggest risk to a SUSD....Yeah, because there’s no security on site. There’s not a lot of night staff. So, I think the risk is that if a service takes – there are multiple risks if a service takes too many acute consumers. One, is that you’re just going to have clinical incident after clinical incident which we had sometimes, and the follow-on risk is that staff become burnt out rapidly and leave when we also had periods of that as well. So, that’s probably the greatest issue. Too much clinical acuity which then leads to staff burn out, which then leads to a poor functioning service, and then people hear about a poor functioning service and refer less, the reputation is damaged.”* **Broader HHS / Previous SUSD Staff**

## 8.2.2. Benchmarking

Ongoing statewide improvement of SUSD services is supported by The Queensland Mental Health Benchmarking Unit (QMHBUS) at West Moreton HHS; The Clinical Improvement Team (CIT) at the Analytics, Improvement and Transformation Unit MHAODB; Mind Australia; and Neami National.

QMHBU facilitate benchmarking and networking activities of SUSD services in Queensland. Benchmarking for SUSDs commenced in 2020 and QMHBU undertake an annual process of planning, data collection and reporting with findings reviewed and shared with senior executives, services and staff through presentations, reports, brochures and/or posters. As part of this process, QMHBU hosts a SUSD Learning Network which facilitates SUSD service collaboration and provides an opportunity for shared learnings and knowledge across services. A focus area is determined for each benchmarking round by the QMBHU Learning Network. Additionally, services can nominate for an audit to be conducted on specific areas of interest such as physical health or drug, alcohol and tobacco smoking. Both SUSD HHS and NGO staff are members of the Learning Network with meetings scheduled biannually or annually at a minimum. SUSD services are supported to identify areas of strength and quality improvement initiatives through the Learning Network meetings.

The Clinical Improvement Team (CIT) at the Analytics, Improvement and Transformation Unit MHAODB also undertake benchmarking activities of Adult and Youth SUSD services (excluding Nundah House). CIT utilise CIMHA data to prepare Special Service Type Clinical Indicator Benchmarking Reports four times a year for distribution to Mental Health Information Managers and Service Executives. CIT also provide training opportunities through online workshops and information sessions covering outcome measures and clinical indicators.

Both Mind Australia and Neami National collect SUSD service data and outcomes and report on this internally and during partnership meetings to inform service improvements.

## 8.3. Summary of findings

- SUSD services assist consumers to develop skills, knowledge and resources that are beneficial for their personal recovery and ongoing mental health management. Whilst many consumers maintain gains made at the SUSD, others could benefit from additional follow-up after exiting the service.
- SUSD services connect family/carers to valuable information, resources and support, that are beneficial for themselves and their loved one.
- Ongoing sustainability of the SUSD is dependent on recruitment and retention of suitably experienced and qualified staff. Maintenance of the NGO staffing profile is of particular importance due to the NGO's responsibility for 24/7 operation of the service.
- Whilst many SUSD staff reported high levels of satisfaction in their role, services have experienced periods of high turnover at various stages since being established. Turnover has been attributed to COVID-19, Queensland Health secondments, leadership challenges, and staff burnout.
- Continuous improvement of SUSD services is supported by ongoing benchmarking, networking and trainings activities undertaken by QMHBU and CIT.

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# Appendix A: Steering Group

Member	Role	Position	Organisation
Dr Zoe Rutherford	Co-chair	Co-ordinating Principal Investigator	QCMHR
Genevieve Smith	Co-chair	Senior Research Officer	QCMHR
Angela Sunley	Member	Research Officer	QCMHR
Fleur Ward	Member	Manager - Mental Health Strategy	Mental Health Alcohol and Other Drugs Strategy and Planning Branch
Olivia Falvey	Member	Team Leader	Queensland Mental Health Benchmarking Unit
Camille Davey	Member	Team Leader	Queensland Mental Health Benchmarking Unit
Senthil Muthuswamy	Member	Operations Director	Metro North HHS
Ossi Beck	Member	Clinical Improvement Coordinator	Mental Health Clinical Improvement Team MHAOD
Gayle Clifford	Member	Service Manager	Mind Australia
Chris Deller	Member	Service Manager	Neami National
Kim Bradley	Member	Clinical Nurse Consultant	Mackay HHS
Jillian Vella	Member	Team Leader/Nurse Unit Manager	Metro North HHS
John Byrne	Member	Peer Support Worker	Neami National
Janet Wilson	Member	Lived Experience Representative	
May-Britt Mosshammer	Member	Lived Experience Representative	
Melissa Pietzner	Member	Lived Experience Representative	

# Appendix B: Program Logic Model

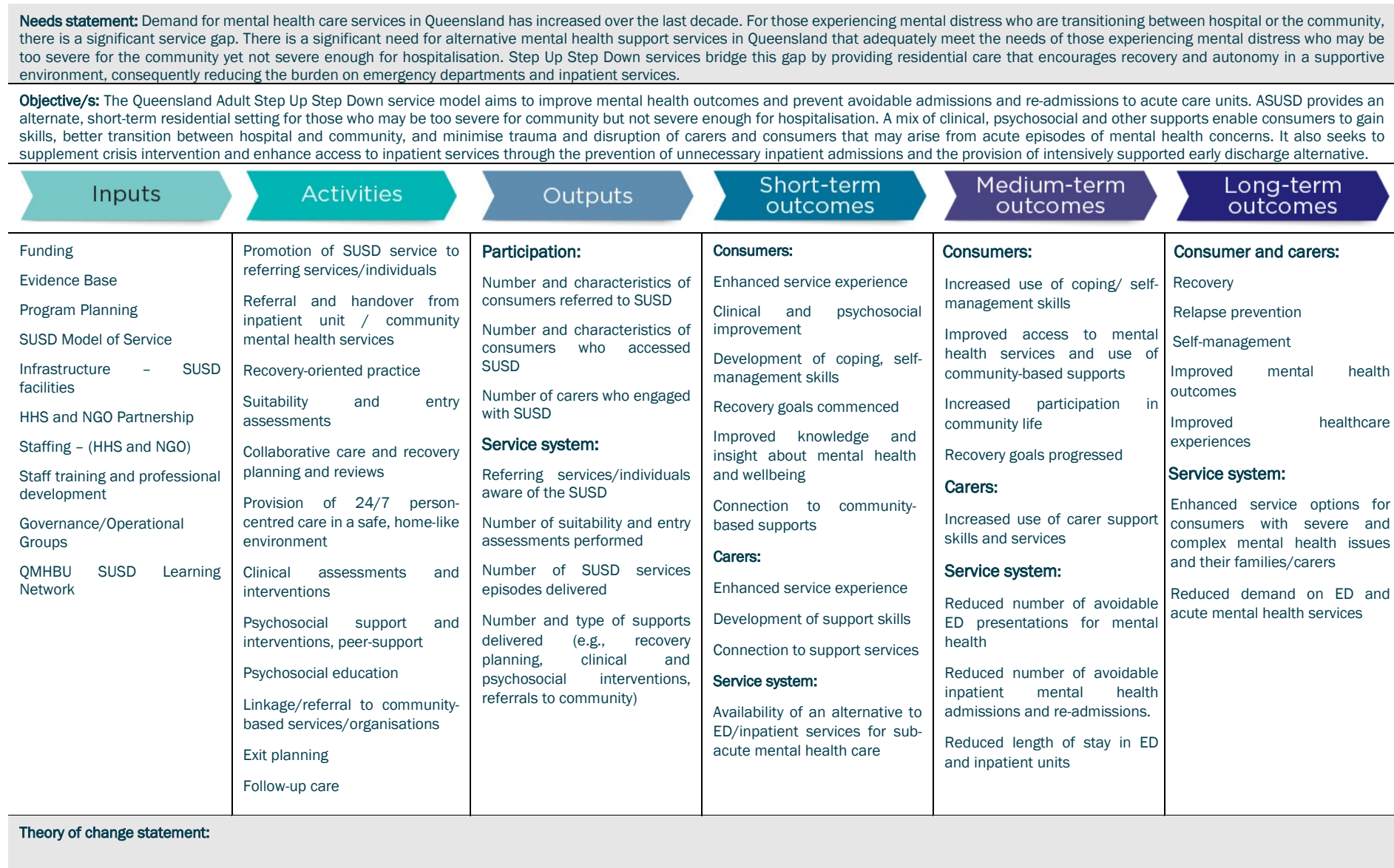
A program logic model was developed for the Adult Step Up Step Down, articulating how the Adult SUSD is intended to work. It provides a visual representation of the relationships between the program’s inputs, activities, outputs, and expected outcomes. An overview of the key components of program logic models are summarised in Table 24.

*Table 24 | Definitions of program logic model elements.*

Model Element	Definition
<b>Needs statement</b>	Provides information about why a service is needed, and the problem or need that the program will address.
<b>Objectives</b>	Identifies what you want to achieve through service delivery.
<b>Inputs</b>	The resources that have been deployed to establish and implement a service (e.g., staff, funding, spaces).
<b>Activities</b>	The specific actions, interventions and processes that are delivered through the service.
<b>Outputs</b>	Measures of who receives the services and what services and activities have been delivered. These outputs are needed to achieve the short-term outcomes.
<b>Short-term outcomes</b>	The changes that you would expect to see at the completion of the service.
<b>Medium-term outcomes</b>	The changes you would expect to follow on from the short-term outcomes.
<b>Long-term outcomes</b>	The long-term outcomes you would expect to follow on from the medium-term outcomes and which should resolve the issue identified in your needs statement.
<b>Theory of change</b>	Explains how and why the activities in the program logic model will lead to the intended service outcomes, drawing upon published research evidence about what works and how it is expected to contribute to intended outcomes.

The program logic model for Adult SUSD is provided in Figure 20. This program was developed using a modified version of the La Trobe program logic and was also guided by a literature review of previous evaluations of Step Up Step Down service models of care, a document review of the Adult SUSD service guidelines, and drawing upon the findings of the present evaluation.

**Figure 20 | Program logic model for Adult Step Up Step Down.**



SUSD services provide sub-acute treatment for mental illness in home-like residential facilities with a clinical and recovery-focused approach. The service is designed to support those both stepping up from community care and those stepping down from acute care in hospital. It provides consumers with a pre-acute and post-acute service alternative. The recovery-based approach to mental health, focusing on both psychosocial and clinical support, should contribute to consumer's recovery, enhanced service experience and improved mental wellbeing (Ngo et al, 2020).

SUSD offer a range of supports, including therapeutic interventions and one-on-one time with clinicians, peer-support, skill development, psychosocial education. These interventions should in turn lead to reduced psychological distress, the development of coping skills, mental health literacy, and a sense of autonomy. NGO staff provide 24-hour care, implementing psychosocial group education sessions, assisting skill-building, and advocacy to consumers, family and carers, whilst clinical staff utilise a bio-psychosocial assessment framework and deliver clinical interventions.

Sub-acute mental health residential services in Victoria have shown marked improvement in personal recovery and satisfaction, with consumers identifying they felt connected, found a sense of purpose and self-empowerment (Waks et al 2018). An evaluation in North Queensland found similar results in terms of recovery, and encouraged consumers to develop personal recovery goals and self-manage recovery plans (Heyeres et al 2018). Therefore, through providing an alternative service option to ED or the community, SUSD should reduce the number of ED presentations for mental health crisis and facilitate the consumer's recovery process.

