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# Mental Health Community Support Services Evaluation

## Final Report

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This evaluation was commissioned by the Mental Health Alcohol and Other Drugs Branch (MHAODB), Clinical Excellence Queensland, Queensland Health and conducted by the Mental Health Evaluation Stream at the Queensland Centre for Mental Health Centre (QCMHR) and School of Public Health at The University of Queensland (UQ).

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## Contents

List of Tables .....	7
List of Figures .....	7
Acknowledgements .....	8
Acronyms .....	9
Glossary .....	10
1. Background .....	11
1.1 Mental Health Community Support Services and Evaluation Commissioning .....	11
1.2 Evaluation Framework .....	12
2. Aims and Objectives .....	13
2.1 Aims .....	13
2.2 Objectives .....	13
3. Method .....	14
3.1 Steering Group .....	14
3.2 NGO Audit .....	15
3.3 Ethics and Research Governance .....	15
3.4 Participant Recruitment .....	15
3.4.1 NGO Staff and Consumers .....	15
3.4.2 HHS staff .....	17
3.4.3 Stakeholders .....	17
3.5 Data collection .....	17
Quantitative Data .....	17
Qualitative Data .....	18
3.6 Data Analysis .....	19
Quantitative Data .....	19
Qualitative Data .....	19
4. Key Findings .....	20
4.1 Reach .....	21
Targets .....	23
Barriers to appropriate referral .....	29
Facilitators to appropriate referral .....	31
Summary .....	33
Reach Recommendations .....	34
4.2 Adoption .....	37
HHS Handover to NGO .....	37
NGO's first contact with a consumer .....	38
Early delivery of MH CSS program .....	39
NGO staff interpersonal factors .....	40
Referral from individual-based MH CSS program onto GBPRSP .....	41

Consumer capacity and readiness.....	43
Summary.....	44
Adoption Recommendations.....	46
4.3 Implementation.....	49
Program Delivery.....	50
Barriers and Facilitators to Program Implementation.....	53
Summary.....	57
Implementation Recommendations.....	58
4.4 Maintenance.....	61
Application of developed skills.....	61
Exiting from MH CSS programs.....	61
<i>Exit into GBPRSP</i> .....	62
<i>Exit into NDIS</i> .....	62
<i>Exit into other services</i> .....	63
<i>Exit into the community</i> .....	63
Follow-up post-program.....	64
Independence.....	64
Length of program.....	65
Summary.....	66
Maintenance Recommendations.....	66
4.5 Effectiveness.....	69
Consumer recovery.....	69
Observed outcomes.....	69
Outcome measures.....	71
Summary.....	72
Effectiveness Recommendations.....	73
4.6 Key Ingredients.....	75
Relationships.....	75
Training.....	75
Staff Qualities.....	75
Recovery-Orientated Framework.....	75
Person-Centeredness Approach.....	76
Consumer Capacity/Readiness.....	76
5. Program Specific Findings.....	76
5.1 IRHP.....	76
Consumer complexity.....	76
Housing.....	77
GBPRSP needs.....	77
Advocacy work.....	77

No discretionary funds .....	77
Recommendations:.....	77
5.2    TCFP .....	78
Access to housing .....	78
Staff security clearances.....	78
Lockdowns/lockouts impacting contact.....	78
Conflicting NGOs providing services.....	79
Lack of appropriate groups.....	79
Complexity of consumers .....	79
No discretionary funding.....	79
Release location.....	80
Recommendations:.....	80
5.3    GBPRSP .....	80
Referrals.....	80
Delivery and Access .....	81
Group offering .....	81
Reducing isolation .....	82
Recommendations:.....	82
6.    Additional Findings .....	83
6.1    Rurality.....	83
Access to and flexibility of services .....	84
Mental health literacy and stigma.....	85
NGOs serve as gateway to consumers' additional services/external supports for consumers .....	86
Referral processes .....	87
Awareness and emphasis on local services/people .....	87
6.2    Peer Workforce.....	88
Relatability.....	88
Mental health normalized .....	88
Consumer interest in becoming a peer worker.....	89
Support (including training) for peer workers.....	89
Unhealthy dynamics related to peer work.....	90
6.3    Inclusivity.....	91
6.4    COVID-19 .....	92
No impact (+).....	92
Decreasing isolation (+).....	92
Additional funding (+).....	92
Consumer loss of employment (-).....	92
Increasing isolation (-).....	93
Impact to delivery of services (-).....	93

Increase in mental health concerns (-) .....	93
7. Limitations .....	94
8. References .....	95
9. Appendices .....	100
A. Royal Brisbane & Women’s Hospital Human Research Ethics Committee Approval.....	100

## List of Tables

<b>Table 1:</b> Membership of MH CSS Evaluation Steering Group .....	14
<b>Table 2:</b> The number and mix of participants who consented, were sampled, and took part interviews .....	18
<b>Table 3:</b> MH CSS 'client numbers' by MH CSS program and year .....	21
<b>Table 4:</b> The number and percentage of consumers by MH CSS program, gender identity and year .....	21
<b>Table 5:</b> MMM and ASGS classification scale.....	83

## List of Figures

<b>Figure 1:</b> Interactions between macro-, meso-, and micro-levels in Queensland's MH CSS programs.....	12
<b>Figure 2:</b> Recruitment process diagram for NGO consumers .....	16
<b>Figure 3:</b> Recruitment process diagram for NGO staff.....	17
<b>Figure 4:</b> MH CSS Best Practice Process Diagram.....	20
<b>Figure 5:</b> The proportion of consumers by age group and program in 2019-21.....	22
<b>Figure 6:</b> The proportion of consumers by age group and program in 2021-22.....	22
<b>Figure 7:</b> The number of referrals in 2019-20 for each of the four MH CSS programs by source. ....	25
<b>Figure 8:</b> The number of referrals in 2020-21 for each of the four MH CSS programs by source. ....	25
<b>Figure 9:</b> Length of service 2019-2020 .....	49
<b>Figure 10:</b> Length of service 2020-2021 .....	50

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We would like to thank all who contributed to this Mental Health Community Support Services (MH CSS) evaluation, including those who were interviewed and those who provided guidance throughout the project's duration. We would like to acknowledge each and every one for their contributions and for generously giving their time to this important evaluation and report.

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## Acronyms

Acronym	Definition
CALD	Culturally and linguistically diverse
COVID-19	Coronavirus Disease 2019
FT	Full Time
GBPRSP	Group-based Peer Recovery Support Program
HHS	Hospital and Health Service
HREC	Human Research Ethics Committee
IRHP	Individuals at Risk of Homelessness Program
IRSP	Individual Recovery Support Program
LGBTQI+	Lesbian, gay, bisexual, transgender, queer, intersex, and other orientations not listed
MHAODB	Mental Health, Alcohol, and Other Drugs Branch
MH CSS	Mental Health Community Support Services
MH NGOE NBEDS	Mental Health Non-Government Organisation Establishment National Best Endeavours Data Set
NDIS	National Disability Insurance Scheme
NGOs	Non-government Organisations
PHN	Primary Health Network
QAMH	Queensland Alliance for Mental Health
QCMHR	Queensland Centre for Mental Health Research
QMHC	Queensland Mental Health Commission
RBWH	Royal Brisbane and Women's Hospital
RE-AIM	Reach, Effectiveness, Adoption, Implementation and Maintenance
SG	Steering Group
SMI	Severe mental illness
T	Transgender (used only in participant quotes)
TA	Thematic Analysis
TCFP	Individual Recovery Support – Transition from Correctional Facilities Program
UQ	The University of Queensland

## Glossary

Acronym	Definition
Gatekeeper	The Gatekeepers were NGO staff members identified by each NGO to act as the contact person for participant recruitment of consumers and staff from each NGO.
Oversampling	“A sampling strategy in which certain subsets of participants are overrepresented in a study group compared to the larger population from which they are drawn. Oversampling involves deliberately selecting greater numbers of such participants than would be obtained via random sampling in an effort to enhance the accuracy of parameter values estimated through statistical procedures” (VandenBos, 2007).
RE-AIM Framework	The RE-AIM (Reach, Effectiveness, Adoption, Implementation, Maintenance) framework provides a practical means of evaluating health interventions. This framework was developed by Glasgow et al. (1999).
Socioecological Model	The Socioecological Model is a framework put in place to understand the multifaceted levels within a society and how individuals and the environment interact within a social system. This model was developed by Bronfenbrenner (1979).
Thematic Analysis	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.

# 1. Background

## 1.1 Mental Health Community Support Services and Evaluation Commissioning

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

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

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

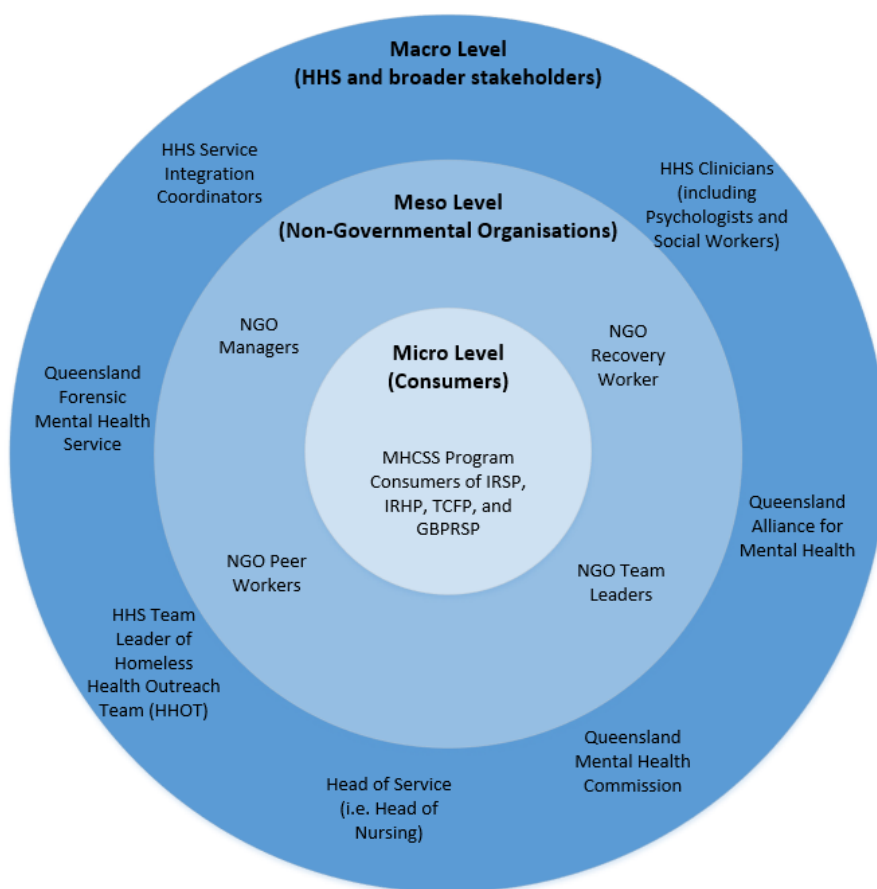
Individuals living with persistent severe mental illness aged 18 years and over (with a priority given to those not eligible for National Disability Insurance Scheme (NDIS)) are referred into MH CSS through recent or current access to mental health clinical care delivered by Queensland HHSs; this includes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

Across the four MH CSS programs that are funded in 14 HHSs across Queensland, 14 separate NGOs are contracted to deliver services. As part of the commissioning of these four MH CSS programs, Queensland Health’s (QH’s) Mental Health, Alcohol, and Other Drugs Branch (MHAODB) committed that an independent evaluation would take place, at which point Queensland Centre for Mental Health Research (QCMHR) was engaged as the independent evaluators.

## 1.2 Evaluation Framework

As outlined above, the MH CSS programs form one part of a complex mental health care system in Queensland. To best evaluate these programs, their efficacy will be examined at the micro- (consumer), meso- (NGO), and macro- (HHS and broader stakeholder) levels. Each of these levels interacts with and dynamically influences the other two (Figure 1).

*Figure 1: Interactions between macro-, meso-, and micro-levels in Queensland’s MH CSS programs*



When micro-, meso- and macro-levels work effectively within themselves, and successfully function in relation to each other (Bronfenbrenner, 1979), health care is efficient and effective; and patients experience better health (World Health Organisation, 2002). Dysfunction within and among the levels creates waste and ineffectiveness.

It is accepted that interventions should be evaluated to examine whether they work as intended, particularly when applied outside of rigorously controlled intervention trials (Glasgow et al., 1999). To best identify the complex factors that determine the efficacy of the MH CSS programs and how this may differ by program type, the evaluation will follow the RE-AIM Framework (Glasgow et al., 1999). The RE-AIM framework

provides structure and depth to evaluations by examining the **Reach, Efficacy, Adoption, Implementation and Maintenance** of interventions, providing a deeper understanding as to whether the programs work, and why (not) (Glasgow et al., 1999).

## 2. Aims and Objectives

### 2.1 Aims

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

### 2.2 Objectives

1. To use existing program level Mental Health Non-Government Organisation Establishment Data Collection (MH NGO NBEDS) data to describe the *Reach, Adoption, and Implementation* of the MH CSS programs.
2. To collect and analyze primary qualitative data (using semi-structured interviews) at a micro (consumer), meso (NGO) and macro (HHS and broader stakeholder) level to determine:
  - a. the efficacy of the 4 programs related to their *Reach, Effectiveness, Adoption, Implementation and Maintenance*, and
  - b. factors that affect the *Reach, Effectiveness, Adoption, Implementation and Maintenance* of the four MH CSS programs in people living with SMI across Queensland.
3. Present a “best practice” process map to reflect how the RE-AIM elements relate to the IRSP (including TFCP and IHRSP) and GBRSP.
4. Pose recommendations for how the four MH CSS programs could be improved.

### 3. Method

#### 3.1 Steering Group

The role of the MH CSS Evaluation Steering Group (SG) was to provide guidance to the research team as they undertook the evaluation. The membership of the SG is outlined in Table 1 (below). Members used their expertise and experience within the space of mental health services in Queensland to inform, guide, reflect, and improve the evaluation’s design, methodology, data collection, and findings. The SG met monthly via videoconference, and were specifically asked to provide feedback on the following:

- The research plan (March/April 2020),
- The interview schedule (March/April 2021),
- Data collection activities (May/June/July/August 2021),
- Early findings (September/October 2021)

As part of the reflexive Thematic Analysis (TA) methodology (outlined below in *Data Analysis Section 3.6*), the consumer representatives of the SG attended a face-to-face meeting to review the results to provide a sense check and face validity. The final SG meeting (February 2022) took place to discuss the overall key findings, conclusions and recommendations outlined in this report.

**Table 1: Membership of MH CSS Evaluation Steering Group**

Member	Position	Organisation
<i>Zoe Rutherford*</i>	<i>Co-ordinating Principal Investigator</i>	<i>Queensland Centre for Mental Health Research</i>
<i>Meaghan Enright</i>	<i>Research Officer</i>	<i>Queensland Centre for Mental Health Research</i>
<i>Sally Arthur</i>	<i>Research Officer</i>	<i>Queensland Centre for Mental Health Research</i>
Sandra Eyre	Senior Director	Mental Health Alcohol and Other Drugs Branch
Fleur Ward	Manager	Mental Health Alcohol and Other Drugs Branch
Sharon Orapeleng	Principal Policy Officer	Mental Health Alcohol and Other Drugs Branch
Michelle Perrin	State-wide Program Coordinator; Prison Mental Health Service	Queensland Forensic Mental Health Service
Tonita Taylor	Manager; Knowledge, Planning and Performance	Brisbane North Primary Health Network
Jennifer Black	Chief Executive Officer	Queensland Alliance for Mental Health
Ivan Frkovic	Commissioner	Queensland Mental Health Commission
Deborah Pratt	Program Manager; Policy and Program Delivery	Queensland Mental Health Commission
Jacqui Heywood	Senior Director; Community Services Funding Branch	Queensland Health
Marlene Berry	Contracts Manager; Community Services Funding Branch	Queensland Health
Janet Wilson	Consumer Representative	Health Consumers Queensland
Grace Sholl	Consumer Representative	Health Consumers Queensland

*Italics* denotes the members of the MH CSS Evaluation Research Team,

\* denotes chair of the MH CSS Evaluation Steering Group.

## 3.2 NGO Audit

Throughout February 2020, the team had virtual communication with each NGO ( $n = 11$  via Zoom/Teams/Phone call,  $n = 3$  via email exchange) in Queensland currently delivering a MH CSS program(s). The purpose of these discussions was three-fold:

1. To introduce the evaluation and the evaluation team at QCMHR to the NGO in order to build rapport and trust early on.
2. To gain key information about the NGO/programme delivery to inform the recruitment processes (contacting consumers and stakeholders for participation in the evaluation), and logistics of where and how interviews will be conducted in the field.
3. Determine how to best manage participants' confidentiality and anonymity while minimising participant burden.

Organisations were generally supportive of the evaluation and willing to actively engage in the process. The results provided the following valuable information that informed the final project methods:

1. How NGOs communicated with consumers (*and therefore the various mechanisms to use for recruitment*).
2. Where they interacted with consumers and accessibility of places and spaces *informing the logistics of interviews*.
3. What demographic information they collected about consumers and how best to obtain this information from consumers (*to reduce participant burden and increase participation*).
4. Identification of previously unidentified risks for consumers and staff as a result of the interviews *and how to mitigate them*.

These discussions also provided an opportunity to ascertain individuals from within each specific MH CSS program who would serve as NGO staff and consumer gatekeepers.

## 3.3 Ethics and Research Governance

Following the finalisation of the project methods, ethics approval (HREC/2021/QRBW/73074; [Appendix A](#)) was received from the Royal Brisbane and Women's hospital in March 2021 and ratified through The University of Queensland (April 2021) before recruitment of consumers and NGO staff commenced. To allow for the recruitment and data collection of Queensland Health staff across the 14 HHSs, the team undertook 14 separate Site-Specific Agreements (SSA) and a Brisbane Diamantina Health Partnerships (BDHP) agreement. This process was lengthy and finally concluded in February 2022.

## 3.4 Participant Recruitment

### 3.4.1 NGO Staff and Consumers

In April 2021, once ethics approvals were obtained, our team made contact with the relevant NGO consumer and staff gatekeepers to outline the process for recruitment. As a result of the prior consultation with NGOs, recruitment materials were provided to ensure gatekeepers could invite participants to take part in an interview in a number of different ways, and as such were able to employ strategies that aimed to facilitate recruitment to ensure that as many people as possible were reached:

- Gatekeepers were provided with a range of recruitment templates (email/letter, text, flyer, and script).

- Each NGO was able to apply the recruitment process in a way that was suitable for their organisation and consumers/staff (e.g. emails for those with email addresses, or discussed during usual support appointment or staff meeting).
- NGO staff were able to help consumers understand the recruitment material and complete the required documentation, but it was made clear that participation was completely voluntary.
- To minimise the need for consumers to provide their personal data ‘again’, they could consent for the demographic information to be provided by their NGO service provider.
- Consumers were offered a \$40 per hour gift voucher to thank them for their participation; the gift voucher type was determined by access/location and where possible, was not redeemable by a licenced vendor.

For NGOs, an initial recruitment window of 2 weeks was proposed from the point of first contact with staff and consumers. After one week, the team checked the number of consent forms received and provide the NGO with a prompt to follow up on the initial invitation with a reminder. This process was repeated at the end of week 2 (Figure 2 & 3). The aim was for each programme to have six consumers consented by the end of the 2 weeks and if this was not achieved, the recruitment window was extended, and the team proposed other mechanisms or means of supporting the process. Two such ways were for the team to visit the programme informally for a “cuppa and a chat” or to attend a group-based activity such as the weekly BBQ. The aim was for the team to meet consumers in a familiar/safe space and remove barriers of having to provide informed consent or making the team more accessible.

**Figure 2:** Recruitment process diagram for NGO consumers

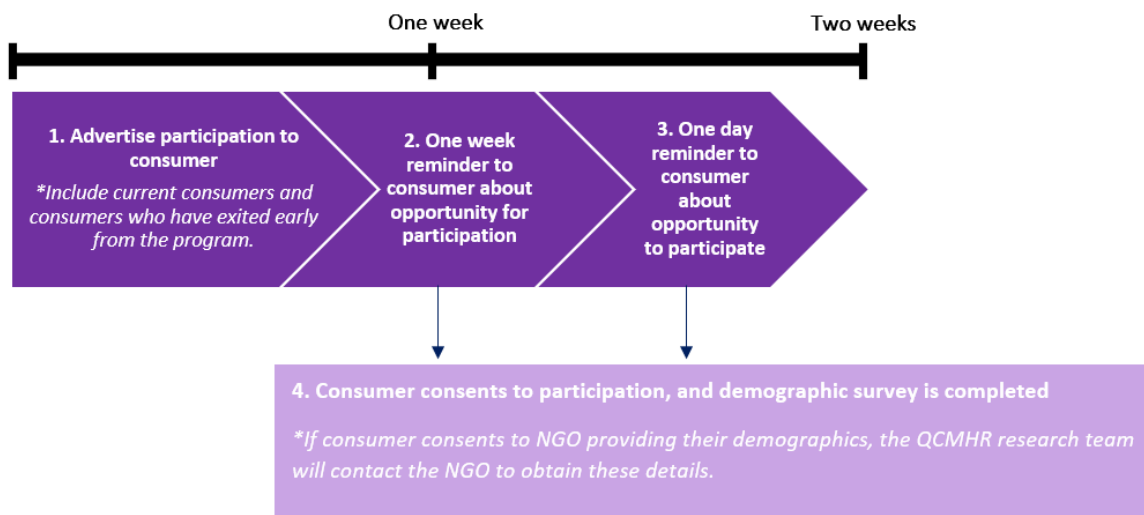
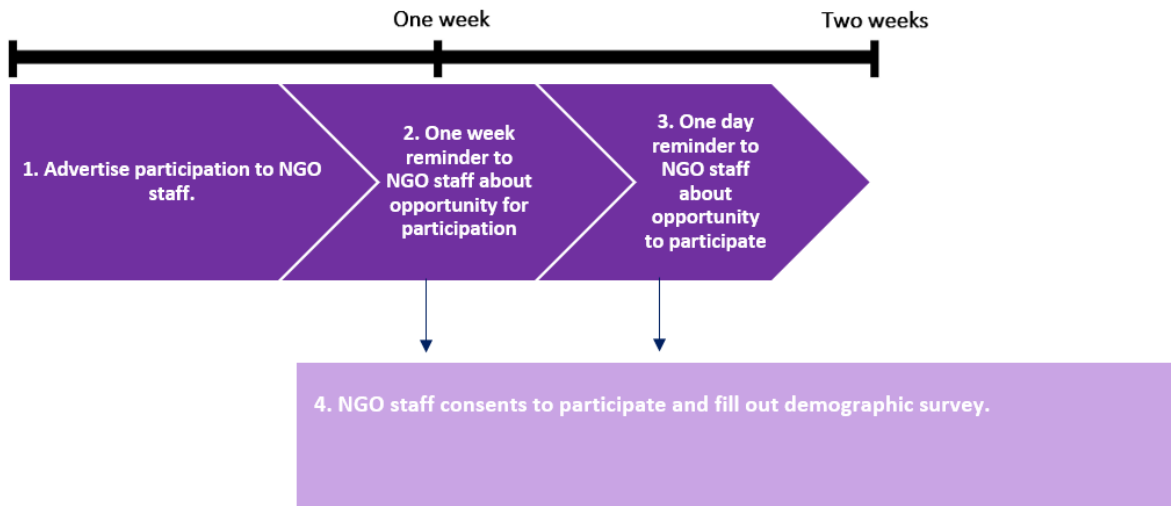


Figure 3: Recruitment process diagram for NGO staff



### 3.4.2 HHS staff

Within each HHS, the Site Specific Investigator identified in the SSA was the gatekeeper for the relevant HHS staff, unless they delegated the task.

Stakeholders were suggested by HHS staff and/or Steering Group members. The communications making potential participants aware of the evaluation and inviting them to be interviewed included the participant information and consent form, as well as a demographic screening survey. A link to an online version, using Qualtrics, was also provided. Details specific to the recruitment of consumers, NGO staff, and HHS and stakeholders are presented in the following sections.

- Each gatekeeper was provided with an email template for recruitment
- Each HHS was able to apply the recruitment process in a way that was suitable for their organisation

### 3.4.3 Stakeholders

In order to gain a broader Macro level perspective, additional stakeholders were discussed and chosen during Steering Group Meetings, to include representatives from Metro North Primary Health Network (PHN), Queensland Mental Health Commission and The Queensland Alliance for Mental Health. Purposively sampled participants from each organisation were invited to take part via email by the Principal Investigator (Dr Zoe Rutherford).

## 3.5 Data collection

### Quantitative Data

The Queensland MH NGOE NBEDS tool collects consistent information on the activity of mental health NGOs at the service level, which aim to provide reliable data to better inform policy, practice, and planning of NGO activities at a state and a national level. Organisations are required to report against the MH NGOE NBEDS data elements to meet their contractual agreements. In addition, NGOs collect outcome data for their programs, which are also returned with the quarterly data. To inform the Reach, Adoption and Effectiveness components of the evaluation, data requests for MH NGOE NBEDS de-identified data for 2019-20 and 2020-21 were made to the Systems and Collections Team at MHAODB for the following variables:

- Number of clients

- Number of attendances
- FT equivalent paid staff
- FT equivalent paid peer workers (average)
- Number of Individuals by Age Groups (<18years, 18-24 years, 25-34 years, 35-44 years, 45-54 years, 55-64 years, ≥65 years, Not Stated)
- Number of Individuals by Gender (Male, Female, Other, Not Stated)
- Number of Individuals Source of Referral (Hospital bed-based service, Community bed-based service, Community treatment service, Group program, Individual program, GP, Other)
- Number of Individuals by Length of Treatment (≤1 week, 1 week to 1 month, 1 to 3 months, 3 to 6 months, 6 to 9 months, 9 to 12 months, Full year)

Information related to the outcomes data collected by each NGO were also requested. It was determined that across the 38 separate programmes, there were approximately 17 different questionnaires/tools being utilised, however the data from these tools were not utilised in the evaluation due to the variability in collection across the NGOs. Questionnaire data at the programme level were not available.

Consumer demographic data were collected at an *individual level* via the recruitment survey in Qualtrics and following data cleaning were presented in Microsoft Excel for analysis.

## Qualitative Data

### Sampling

In total, 194 consumers and 80 NGO staff consented to take part in an interview (see Table 2). To guide the stratification of consumers, the MH NGOE NBEDS data from 2019-20 were used to match against the individual demographic data, to ensure the sample was representative of the four MH CSS programs, including age groups and genders. To ensure that Aboriginal and Torres Strait Islander consumers and those from the LGBTQI+ community were sufficiently represented, these particularly hard-to-reach groups were over sampled by comparison. Additionally, in order to capture any changes to program delivery and a spread of people with various duration of service, equal representation from current and previous consumers was achieved.

The sample of NGO staff were stratified by HHS/NGO/program and then a senior staff member, a recovery support worker and peer worker from each were invited for interview. While several attempts were made to engage them, for some staff in NGOs, there was a limited response.

**Table 2:** The number and mix of participants who consented, were sampled, and took part interviews

Participant Group	Participant Sub-Group	Consent	Sampled	Interviewed
Consumers	Mix of IRSP, GBPRSP, IRHP, TCFP	194	84	70
NGO staff	Mix of peer worker, recovery support worker, manager and senior staff.	80	49	47
HHS staff	1-3 individuals connected to MH CSS from each HHS.	18	18	18
Stakeholders	Incl. QMHC, QAMH.	2	2	2
<b>Total</b>		<b>294</b>	<b>153</b>	<b>137</b>

## *Interviews*

The primary data for the program evaluation were collected using semi-structured interviews. Semi-structured interviews were chosen due to the ability to gather specific information while providing scope to explore any additional points raised by the participants (Braun & Clarke, 2013; Willig, 2013)

Once sampling had occurred, the consumers were contacted by phone to check their capacity to consent and to organise an interview at a time and location of convenience. Most consumer interviews were conducted via face-to-face interview ( $n = 67$ ; phone,  $n = 1$ ; video conference,  $n = 2$ ), which took place local to them and was facilitated by the NGO in most cases (providing location and/or transport). Reminder text messages were sent to the consumer the day before the interview. Each face-to-face interview was conducted by two of four individuals who all have experience with qualitative research. All but two consumer interviews were audio-recorded and transcribed verbatim. Notes were taken and written up for analysis for two participants who did not provide verbal consent to record.

Sampled NGO and HHS staff were contacted by a member of the research team via email to arrange an interview. In this instance, the majority of staff interviews took place via videoconference with one researcher. All interview participants were invited to review their transcript to ensure accuracy and allow for corrections.

## **3.6 Data Analysis**

### **Quantitative Data**

Using the de-identified MH NGOE NBEDS and consumer demographics data, descriptive statistics relative to each MH CSS program were conducted in Microsoft Excel. All results are reported as percentages, means ( $\pm$  standard deviation) and total group numbers.

### **Qualitative Data**

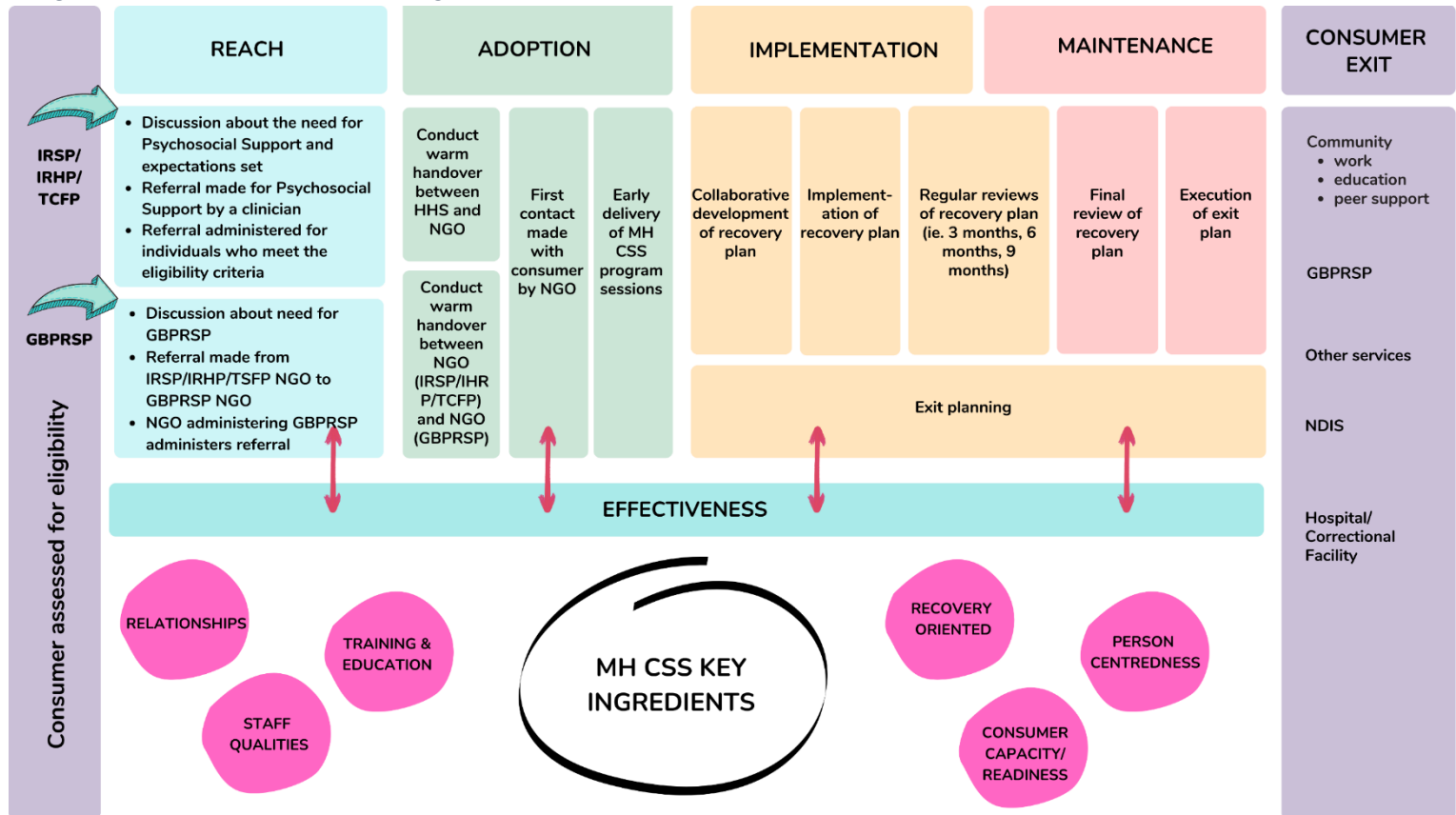
The method of reflexive TA devised by Braun and Clarke (2013) guided the analysis of all the qualitative data. For the TA process, each component of RE-AIM was initially treated as distinct. Each participant's interview transcript was coded individually using RE-AIM as the framework, without reference to others in that component, or the entire data set. Once the research team was familiar with the data, a review meeting was held to determine and agree how these higher order themes could be categorized into themes and sub-themes and codes were produced. The team then proceeded to code the data under those themes and sub-themes and using a reflexive approach, subsequent meetings were held to review. Throughout the analysis process, any discrepancies were discussed between the coders until collaboratively resolved. The use of multiple researchers to analyze the data, with discussion to resolve discrepancies, reduces bias on the researcher's behalf and improves rigor (Berends & Johnston, 2005).

As is common with qualitative data, the themes were further refined as the findings are written. Once the findings were finalized within the research team, the lived experience consumer members of the evaluation steering group took part in a review of the findings. Their feedback was considered by the research team and the findings were endorsed.

## 4. Key Findings

The purpose of this evaluation was to use existing and new quantitative and qualitative data to determine the effectiveness of the four MH CSS programs across Queensland using the RE-AIM framework (Glasgow et al., 1999). RE-AIM provides a comprehensive framework for assessing intervention effects at different levels of the behavior change continuum. It also yields insights into the effectiveness and the process by which the outcomes of the interventions may be obtained. Using RE-AIM as guiding framework key themes/subthemes are presented using excerpts from the interviews with consumers, NGO and HHS staff and broader stakeholders. To represent the consumer journey across the four programs, the results of the evaluation will therefore be reported and discussed under the headings *Reach*, *Adoption*, *Implementation*, *Maintenance* and *Effectiveness* with a summary provided of the recommendations for best practice. The MH CSS Best Practice Process Diagram (Figure 4) represents the different stages of the MH CSS programs that align to the RE-AIM framework and the resultant best practice from our evaluation.

Figure 4: MH CSS Best Practice Process Diagram



## 4.1 Reach

*Reach* refers to whether the four MH CSS programs are being reached by the people they were intended and the reasons why they do/do not. This section therefore relates to 1) the quantitative data related to the uptake of referrals onto the MH CSS programs between 2019-21, including the absolute number, proportion, and representativeness of those consumers; 2) the proportion of programs who met and did not meet their targets; and 3) the qualitative data related to the referral process.

Traditionally, data related to *Reach* would be presented as a percentage of eligible people who agreed to be referred to the MH CSS programs respective to the number of people with severe mental illness who are estimated to need psychosocial support. At present, referral data are not collected through MH NGOE NBEDS and so the evaluation was unable to present *Reach* in this way. The number of consumers reported by the MH NGOE NBEDS data therefore represent the number of consumers who *Adopted* the programs (i.e., took up the referral and engaged in the program) and are presented for the four MH CSS programs in 2019-21 and 2020-21 in Table 3. The total number of consumers who adopted each program increased between 23%-173% from year one to two. It is postulated that the large increases are likely due to improved implementation processes and embedding of the programs. The COVID-19 pandemic also likely had an impact on MH CSS 'client numbers' across 2019-2020 and 2020-2021, particularly with the aforementioned development of processes early on and subsequently in the more metro HHSs where there was more exposure to lockdowns and face-to-face restrictions. This will be further elaborated on in the *COVID-19* section of the report (*Section 6.4*).

**Table 3:** MH CSS 'client numbers' by MH CSS program and year

MH CSS Program	2019-20	2020-21	% Increase
IRSP	2997	5361	79%
GBRSP	509	1386	173%
IRHP	506	899	78%
TCFP	472	579	23%
<b>Total</b>	<b>4484</b>	<b>8225</b>	<b>83%</b>

The gender split of the consumers who accessed the IRSP and GBRSP marginally favoured females (54%), with more men than women accessing the IRHP (58%) and TCFP (73%; Table 4) programs. These percentages changed little between 2019-20 to 2020-21. According to the MH NGOE NBEDS data, only 1% of IRSP and GBRSP consumers identified as "other" during that time and only two consumers from the qualitative sample identified as transgender.

**Table 4:** The number and percentage of consumers by MH CSS program, gender identity and year

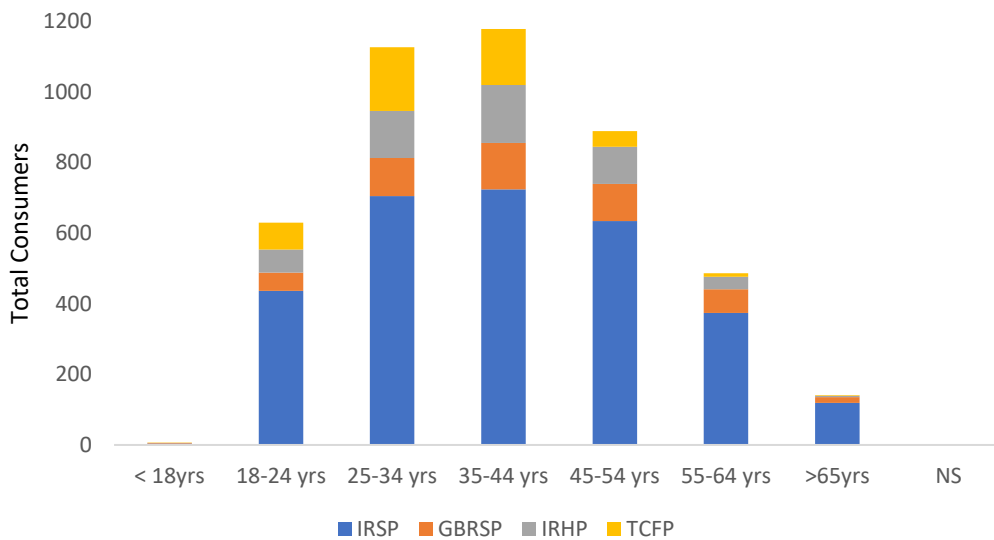
Program	2019-20				2020-21			
	Male	Female	Other	NS*	Male	Female	Other	NS*
IRSP	1382 (46%)	1602 (53%)	7 (0.5%)	6 (0.5%)	2413 (45%)	2912 (54%)	31 (1%)	5
GBRSP	219 (45%)	269 (55%)	3 (1%)	0	631 (46%)	740 (53%)	12 (1%)	3
IRHP	314 (62%)	192 (38%)	0	0	518 (58%)	379 (42%)	2 (<1%)	0
TCFP	345 (73%)	127 (27%)	0	0	424 (73%)	145 (25%)	1 (<1%)	9 (2%)
<b>Total</b>	<b>2260</b>	<b>2190</b>	<b>10</b>	<b>6</b>	<b>3986</b>	<b>4176</b>	<b>46</b>	<b>17</b>

\*NS = Not Stated

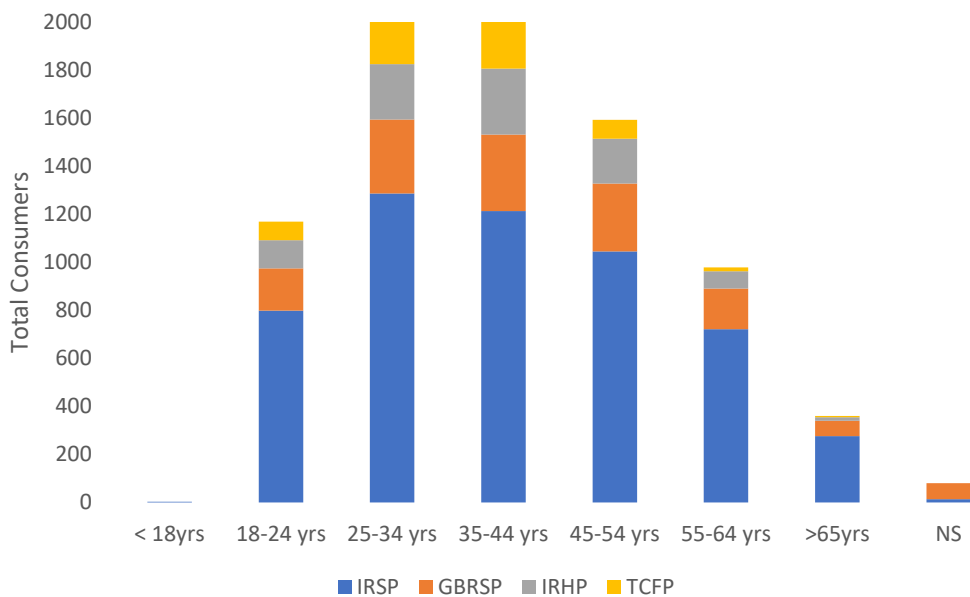
The majority of consumers (71%) across the 4 programs were aged between 25-55 years; this has not changed by more than 1% between 2019-21 (Figures 5-6). While those under 18 years of age were not eligible for the programs under the criterion, the programs allowed flexibility at a local level where there was a need for the service and there was capacity to accommodate.

For the younger age group, staff commented that “Young people are extremely difficult to engage but if you have the right staff, that can happen. We have more and more young people that we are supporting now to what we did when we first started the programme.” (F, multiple programs, NGO staff) With group-based programs, this may be particularly due to the types of groups on offer or their ability to relate to older adults: “Not so much because a lot of it is just social interaction. A lot of them are a lot older than me so I don’t really – I can talk with them but I don’t really connect with them.” (M, 18-24yrs, multiple groups, consumer)

**Figure 5:** The proportion of consumers by age group and program in 2019-21.



**Figure 6:** The proportion of consumers by age group and program in 2021-22.



The number of consumers who were 65 years and over are fewer than the other age groups, but when speaking to them, their need is just as great an in fact, may be greater in terms of social isolation:

“Well, on a Monday I go to the [NGO] men's group. On a Tuesday [organisation] takes me out for an hour and a half; that's a bit of shopping and sit in the park. Because where I am at [place] the ones on NDIS go for a drive to the beach and hang around and go for a walk. I can't do that. It's almost half an hour to get there and half an hour to get back; there's no time. So we just go to a park and sit there. Then - so that's - but St Vincent's have been - they've been great but they can't help me anymore because I just haven't got anymore funding; they don't get paid. Wednesday I come here and the rest of the week I don't go anywhere. Every second week my daughters pick me up and I go and stay at their place for the night and they bring me home the next day. That's it.” (F, 34-44yrs, GBPRSP, consumer)

“Nobody ever came and visit. Even though friends are all at the retirement village. Nobody ever bothered coming out, even though some of them had cars. So yeah, it was just to meet people.” (Transgender (T), 65+yrs, multiple programs, consumer)

As discussed elsewhere in this report, for many of the older consumers this is the first time that they have received psychosocial support and they recalled how they would have liked to have accessed services earlier, “I reckon if I was helped at a young age when I had this sort of thing happen to me before, I wouldn't have had to go back to them and help as much as I need them now in my adult life.” (F, 35-44yrs, GBPRSP, consumer). Reasons of a lack of mental health literacy and stigma were proposed for consumers not getting psychosocial help sooner, in addition to support not being more readily available.

The demographic data collected via the recruitment survey identified thirty consumers as Aboriginal and/or Torres Strait Islander ( $n = 20$  interviewed) and twenty-one consumers from the LGBTQI+ community ( $n = 7$  interviewed). Despite a targeted recruitment strategy, no consumers from the CALD community took part in the evaluation. This will be further discussed in the *Inclusivity* section (*Section 6.3*). Furthermore, these demographic data are also not captured within the MH NGOE NBEDS reporting, which therefore does not allow for an assessment of whether people from these communities are represented on the programs. By including these variables in the MH NGOE NBEDS dataset reported by NGOs delivering the MH CSS programs, stakeholders would be enabled to identify inequalities in access and target strategies to better address these disparities.

## Targets

Each IRSP provider were given targets for the number of consumers as part of their service agreement with MHAODB, based on 20% of the estimated need for psychosocial support services in people with severe mental illness. In 2019-20, 4/14 HHSs were meeting IRSP targets for client numbers, with some IRSP programs falling some way short (41%) and others far exceeding them (168%). Following a revision of targets in 2020-21 and an increase in funding to support, the number of HHSs meeting their IRSP target increased to 8/14 (a real increase of 4), with the percentage of target range improving to 72% - 185%. This suggests that while there was an increase in the numbers who *adopted* the IRSP programs during 2020-21, there is still a gap in the number of people who could be serviced with psychosocial support in different parts of the state. The reasons for this are multi-faceted but likely relate to issues of staff capacity, which will be discussed under the *Implementation* and *Maintenance* themes. For the programs who are exceeding their target, these NGOs tend to have small target numbers and it is likely that the targets in these areas should be reviewed at a local level to better understand the need and capacity.

Targets were not only based on need but also on the optimal level of support required for the individual after exit from hospital care and were captured as the number of contact hours on the program. Accounting for variation in the support requirements of the initial 12 week 'intensive period' and subsequent 'non-intense' period, an average of 76 hours of support in total was allocated for each individual consumer. As this relates to the program delivery and intensity of support, this will be discussed alongside staff capacity in the *Implementation* section (*Section 4.3*).

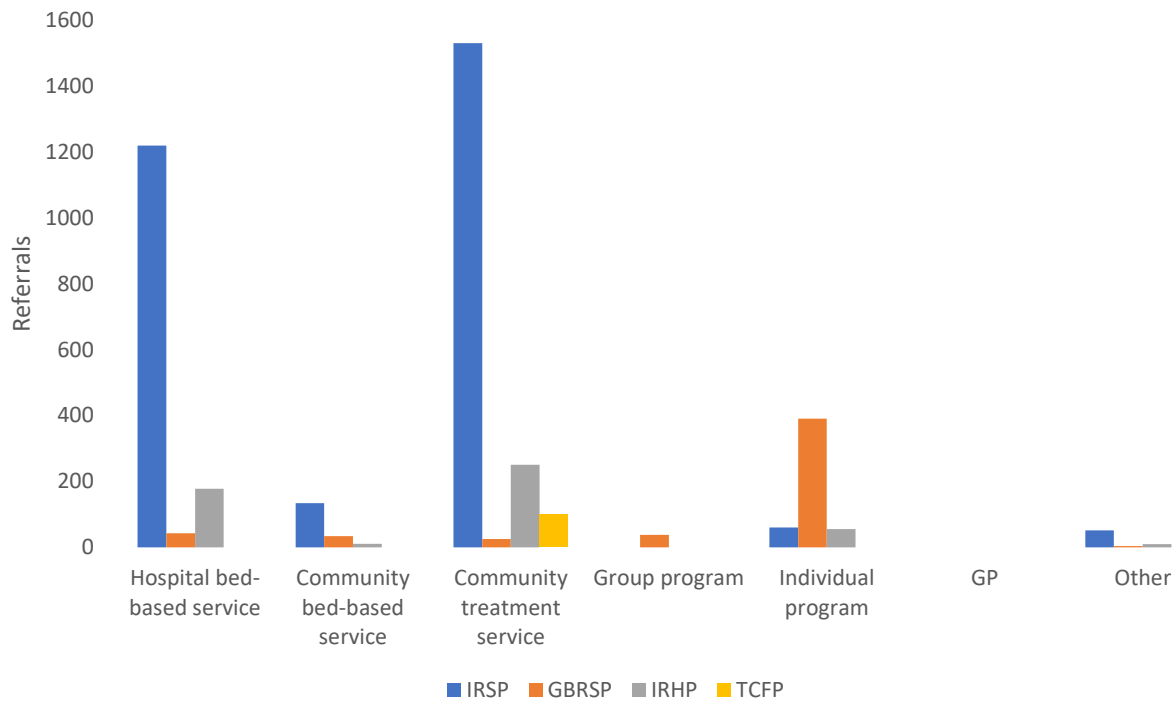
During the interviews with NGO and HHS staff, questions were asked in relation to the reasons programs may or may not be meeting their consumer targets (i.e. reaching the people that the programs are intended) and the referral process was identified as a key factor; "Yeah, I'd speculate the referral process needed some fixing." (M, GBPRSP, NGO staff). Fundamentally, the reasons why staff feel the process requires attention can be categorized into 'Insufficient Referrals' and 'Inappropriate Referrals' and these are discussed below.

### *Insufficient Referrals*

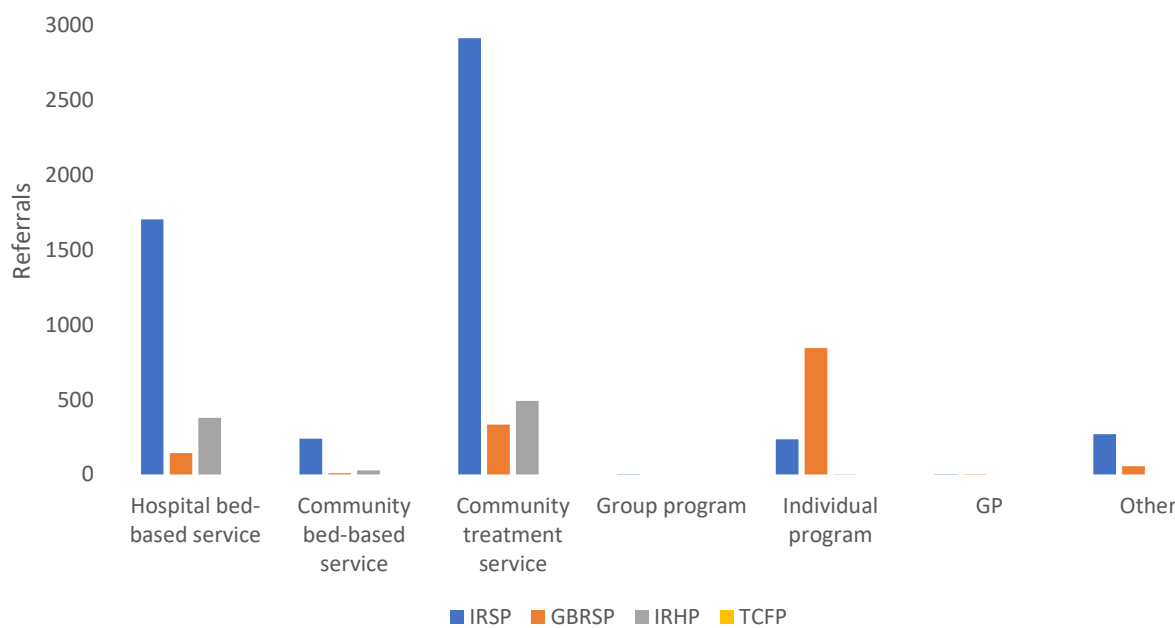
Despite the clear need for psychosocial support for people with severe mental illness, the NGO staff feel that in a large number of HHSs, they are receiving much fewer referrals than they expect to or have capacity for: "I thought we were going to be absolutely swamped when our program started. So much so that I was worried that we weren't able to recruit enough people quickly enough. However it turned out that we only got a trickle of referrals. It gradually built up and now we've got ongoing around about 25. We exit some. New ones come on. But we've got this spare capacity which is incredibly frustrating when we see the demand outside of the hospital setting." (M, IRHP, NGO staff). For some, this is notably different between the old and new contracts: "It has been very slow with referrals. It's very limiting. I guess the biggest thing that we noticed transitioning from the old contract through to the new. We had a lot more participants on the old contracts because people were able to get referred from GP's. They would refer into the program. There's quite a lot of people in the community and surrounding areas with severe and persistent mental illness that aren't willing to engage at that clinical level...especially, so the homelessness program." (F, multiple programs, NGO staff)

From the MH NGOE NBEDS data, we can see that for the IRSP and IRHP, most referrals come from hospital bed-based services and community treatment services (Figures 7-8).

**Figure 7:** The number of referrals in 2019-20 for each of the four MH CSS programs by source.



**Figure 8:** The number of referrals in 2020-21 for each of the four MH CSS programs by source.



As eluded to in the last quote above, part of the reason for this may be because it is a common interpretation that the eligibility criterion for referral onto the MH CSS programs is that consumers must have had a hospital stay to be referred, which is not the case and is a barrier for reaching eligible consumers: “So I think with [NGO] it’s pretty fluid in terms of the person’s presenting issues so they’re not limited to any particular diagnosis or age group or anything like that, other than ours. I think probably their criteria where it started to cause some issues with our service is around – are they receiving ongoing care from the mental health service and whose definition of ongoing care? What does that look like? Is that three years in a community

team or is it two months follow up with the Acute Care team afterwards? So that was probably a grey area that needed to be nussed out... In terms of the peer based group support programs and the homeliness outreach stuff, obviously their criteria is quite different and they've had a number of referrals that they've received where we've wanted them to help with something but because of the particular accommodation type they didn't technically fit into their criteria. But even that hasn't been a problem because behind the scenes they just then refer it on to the other service anyway which is really nice. They don't send it back and say, 'No. Not our gig.'" (HHS staff member)

As one consumer described, "Well, first of all, I didn't know they existed. And that's a problem. Because it takes until somebody is near death in either a psychiatric ward or at a rehab unit before somebody says "I can help." (M, 45-54yrs, IRHP, consumer)

Many individuals with severe mental illness discuss negative experiences associated with being in hospital or dealing with mental health clinicians and they cite this as a reason why they don't seek help before it isn't their choice. As described by a consumer, "I wouldn't wish upon anyone to go into mental health because it's absolutely atrocious and you're treated like shit and yeah, it's pretty fucked up in there. Yeah. And the information that they give you like here, this is what you're going to have to be doing this, people coming around to see you. You don't have a choice and say in at the time, that you think you don't have a choice and say in, which we do, but they don't give you that." (F, 45-54yrs, IRHP, consumer)

The stigma of mental illness and seeking help is another barrier, particularly in rural communities and older people, preventing those experiencing mental ill health from reaching out beyond their GP for psychosocial support and therefore in the MH CSS programs reaching those intended, as described by one consumers' experiences below:

"They didn't even know [NGO] existed and what services there could - there was nothing between Queensland Health and, you know, with GPs or anything like that. They were more sending people - because I actually know - I'll give you a prime example. My cousin here experiences mental health issues and she's never been to a hospital. So she's never going to get the services, you know. There's a lot of people that don't actually go to the hospital when they are experiencing these problems... Yeah. Well, even away from that - because, like, she's spoken to her doctor about her issues but - and she thinks that's all she needs to do. When I've been to the hospital in the past I've - its been more because I was getting inside my head and I knew I just needed that, you know, that escape kind of thing. But there's - I've known a lot of people that will never ever go to a hospital for mental health issues. So... Well, people who struggle with - you're more inclined - if you've been with your doctor for 10 you're more inclined to mention to them that I've got, you know, I'm experiencing issues. They're not going to go off and talk to an absolute stranger and, you know, because that's one of the hardest things to do when you're experiencing mental health is, yeah, talk. Yeah, if you don't have that respect or you don't know people it's a very hard - it's harder... When I was trying to explain mental health to my family growing up I always said to them, "It's harder to actually get help than what it is to not. It's harder to step out of your comfort zone and go and ask for help." They used to say, you know, suicide's a cop out and all the rest of it. Well, it's easier to suicide - it's easier to attempt suicide than what it is to go to the hospital and ask for help. That, unfortunately, is why I believe, yeah, there needs to be some sort of, you know, if it's from the GP, like, a referral process from the GP to here." (F, 35-44yrs, IRSP, consumer)

In rural areas, access to clinical mental health staff is also a limiting factor:

**Interviewee:** I would really like them to go thought the doctors. I would really like ... instead of waiting for [name] to come up, because he only comes up probably once a month I think or whatever,

you're waiting for that week. You've only got that certain amount of time. You want to talk to more ... I don't think this first sentence makes sense

**Facilitator:** You're ready and you don't have that much time with him and then he's gone again.

**Interviewee:** For another month and if you don't remember to ask him for a referral or whatever, you're waiting for another month. I think if it can go through the doctors and there is a [name]. She's a ... what's it called?

**Facilitator:** Is she the mental health nurse?

**Interviewee:** Yeah, she's a crisis person, and she said, "Yes, [name] has actually worked with us up here sometimes and at the hospital sometimes." I said, "She's very good." I think it needs to be more easier to get here than actually ... and acknowledge that they're here, knowing about it, because they're not ... as I said, I want here, there, trying to find something.

**Facilitator:** It took you three goes to get to someone ... many people would have stopped after one.

**Interviewee:** They won't go further because they think, "No, you're not helping me. I need something more." I'm putting a big hat on their heads, but they're the only ones that really have got deep down under for me, and slowly. If you had the 12 sessions with the thingamabobs, with the Flying Doctors, that's not enough.

**Facilitator:** You'd be done in three months if you did it every week.

**Interviewee:** It's not enough for a person that's got very deep problems. (F, 65+yrs, IRSP, consumer)

Given these barriers, when asked, many consumers, NGO and HHS staff agreed that if the referral pathway was open to and utilized by GPs and private clinicians (e.g. psychiatrists and psychologists), that additional eligible consumers might be reached: "So on average we probably have about between 120 and 150 consumers on our books at one time, but then there's a huge cohort of patients we never see that are managed by GPs on to have care plan with RFDS counselling and they can't refer into the program. So, I imagine there's probably lots of eligible people that we would never see and therefore not have the chance to refer through to them." (HHS staff member) This increased reach is likely to be achieved where a relationship and trust is built and managed in the community with a consumer's existing clinician, such that when a deterioration in their mental health occurs (as it is likely to do, given the episodic nature of severe mental illness), they are able to get the support they need before they present to an emergency department in crisis.

In line with the notion of preventing a decline and crisis presentation (which may result in a stay in hospital), and due to the differences in the way that they serve their consumers, some of the more rural HHSs have reported the inclusion of consumers with moderate diagnoses in their referrals. When asked if the MHCSS programs were to not be available, one HHS staff member said, "We [would] just end up carrying more of the load again. I think our team functions very differently to a standard community team. You would find, on the coast, in those Metro areas, half the people we work with wouldn't even get a hello. They wouldn't even assess them. They would be like, 'no, you don't meet our criteria.' Some places won't even open new people if they're not even on the Mental Health Act. Do you know what I mean? So, we see people across that mild to moderate spectrum and I would say that we work much more assertively with our clients in this community to keep people well because if someone gets unwell, they've got to be retrieved through to [location] on an airplane. It's easier to work hard and keep people well than it is to let people get unwell. So we work really proactively in the community. So we probably take on a lot more than we should, and we know that. So we do try and be better with that, but we do tend to pick up quite a lot of what isn't picked up elsewhere. So we just end up picking more stuff. We'd keep people open for longer, we'd have our caseloads, you know, it's that, yeah." (HHS staff member)

For the GBPRSP, many delivering NGOs reported low numbers being referred to them from the individual recovery programs, an issue exemplified by this NGO staff quote: “So we haven’t received any referrals from them. So the pathway is there but we haven’t received. And they seem to think they would never have that many because I think they have very few numbers themselves. But yeah and they haven’t been able to identify anyone to date...And even within the IRSP program we actively promote it but it may have been something that they thought they would get more numbers too via the IRSP. I know when we met with someone from our funding body you know a suggestion whether I put forward [unclear] opening up the groups. So that the model doesn’t require referrals to come from the IRSP. My view is that I think from branch they would still want the referrals to come from Queensland Health. And that’s where I think the uptake is limiting. Where I guess what I’ve seen more in the local [area] community is often the people who are wanting to join in peer recovery groups are people who might be a bit further along their own journey of individual recovery” (F, multiple programs, NGO staff) As discussed in more detail in the GBPRSP section of the report (Section 5.3), the evaluation was not able to ascertain referrals are being made from any of the TCFP programs (and very few of the IRHP programs) into the GBPRSP despite it being part of the service model. This will be further discussed in the associated section.

### *Inappropriate Referrals*

In terms of the referral process, there is variability across the state, with some clinical teams directly referring to the NGOs, while in other HHSs the referral goes through a central Service Integration Coordinator (SIC). While there are pros and cons to adding an additional layer of administration, NGOs are reporting that whichever approach being taken, they are receiving a number of referrals for people who are either not eligible (due to referring staff misunderstanding) or that they have incomplete information to enable triage and risk assessment. For example, this quote : “I think as much as possible we try and keep them as brief and easy to use. But sometimes in a hurry a clinician can be just too brief and it’s not considerate in terms of who’s receiving the information and what they might need to act on to make sure their staff are safe and things like that.” (HHS staff member)

The consequence of the missing information is a likely delay in the referral process, missing the window of opportunity for the engagement with a consumer, which in turn will be discussed in *Adoption* (Section 4.2). This again highlights the need for referring teams to be adequately educated about the role of psychosocial support and the MH CSS programs, which is reinforced by regular communication and contact with NGO staff to build and maintain relationships and trust between the stakeholders.

From an HHS perspective, some NGOs require a lot of information before they can process a referral, which increases the likelihood of referrals missing data “... I think it can be improved. It’s too ambiguous, some of the wording and...maybe there is a slight expectation from us, as a service, on what can be provided, because of how that referral is written and the questions that they were asking us.” (HHS staff member)

For the IRHP services, some NGO providers felt that they initially accepted ‘inappropriate referrals’ because they had capacity at the start of the contract, but the referrals did not fit the criterion:

**Interviewee:** So we were actually taking all of those at risk of homelessness and that's because [NGO] are really well known for supporting those clients and we have that really great skillset to deal with that sort of stuff and know who and how to best refer and support our clients with that. Whereas the other organization have no - they were like whoa this is not our area, we don't know how to do this. They were asking [NGO] to do in-services to tell them basically how to do it once we found out that it had to change over. So, I mean I quite liked having the diversity I'll be honest, and I think that just because someone's living in a boarding house

doesn't necessarily mean that they would be the only types of people living there to be at risk of homelessness. My gosh I was working with a lot of clients in the beginning who were living in social housing and they were really struggling to maintain their tenancy and did a lot of liaising with the Department of Housing property managers and things like that trying to assist them with their complaints if that's what they wanted to do.

**Facilitator:** Is that something you think that it then impacts who comes through? Are there then gaps? Are there people that may not be being appropriately referred that...

**Interviewee:** Yes.

**Facilitator:** Because of the awareness of the supports their clinical...

**Interviewee:** Yes. Yes. I would say that's happening. (F, IRSP, NGO staff)

Once these programs were better established and no longer accepted these ineligible consumers due to capacity, this had the potential to undermine the relationship between the referring team/clinician and the NGO if they felt that the organization was not delivering. For some HHSs, re-setting these unrealistic or inappropriate clinical expectations took a long time to achieve:

"If the clinicians don't trust that service they won't refer through to them so it was around really building that trust with those individuals and that's been challenging at times." (HHS staff)

"I think, as I say, that comes from the examples of things not being knocked back. I think some other services have done that occasionally and then our mental health service just gets a bit fed up with it and just stops using them. That's probably one of the biggest learnings that the NGOs could have." (HHS staff)

Another identified issue that impacts on services meeting targets is that some programs (either the type of program or their location and complexity of consumers) have a large number of consumers who exit the program and get re-referred after a stay in hospital or prison. NGOs report that these consumers cannot be counted as a new referral, but they do take up resources: "In our service agreement, we're not allowed to kind of flag every referral. So we can't count that as a referral. We're only allowed to say our referrals are brand new, never been in the program before. But there's no time parameter on that. So we've got somebody that we're engaged with and we might exit them. And then they'll be re-referred because they identified themselves that they needed ongoing support. But they were engaged with the program before we picked it up for three years. And we've had it for two years. So they're still in and out of prison, still asking for support. And there's no way that we can actually reflect that this person has been referred six times and still believes that they get benefit from it. And there's probably three cases that are very similar to that, in context." (M, TCFP, NGO staff)

This finding is of particular note, as it is possibly an unintended contractual issue, but the problem is not captured in the MH NGOE NBEDS data, because there is no requirement to report individual consumer journeys. By collecting and tracking individual level data, a more detailed analysis could identify issues such as this and allow for targeted evaluations and problem solving in the future.

## Barriers to appropriate referral

### *Clinicians as gatekeepers*

One of the two sub-themes associated with barriers to an appropriate referral are 'clinicians as gatekeepers'. This is an issue because NGO and HHS staff and consumers talked about how many clinicians were not aware of the psychosocial supports available and/or their role in the rehabilitation of people with severe mental illness, which also led to consumers recurrent admission to hospital:

“So the referral pathway through the Queensland Mental Health team here has been very challenging because initially I think the initial conversation we had to have was really around the clinician’s understanding Stride’s place in the great scheme of things. Some clinicians understand extremely well what a psychosocial support would look like and the benefits of it. Some clinicians call us the Tea and Tim Tam Therapy and will just have no respect whatsoever for what we do and literally do think that we do cups of tea and Tim Tams and just have a loose little chat. There’s no respect for the recovery, for the very hard recovery work that we do. So the conversations have been challenging around us being able to – and often, you know yourself, often words don’t have a lot of meaning if the actions don’t match. So we had to really – because we’d been here before, we’ve had the existing clinicians here in [location] understood what we were doing and just went, “Are you continuing doing what you’re doing?” and we said, “Yes” and they went, “Yes.” So they were all good. The new people, some of them didn’t completely understand.” (F, multiple programs, NGO staff)

**Facilitator:** “How do you think being linked in with a service like this in the past could’ve helped you, or would it have helped you? Would you have needed it, would you have engaged with it if you’d known it existed? Do you think it would’ve been useful for you?”

**Interviewee:** “Yes, very much so. From when you leave hospital they sort of go, “See you”, and that’s about it, which there’s multiple reasons for that being the way it is. But even just like this business card that I’ve got in my wallet, the fact that someone gave me that and I actually used it, not that it’s [NGO], but I used it and that was the link to [NGO]. Little things like that on a hospital exit would be great.” (F, 55-64yrs, IRSP, consumer)

“I wanted to, because previously I was discharged from [MH facility] in beginning of March and I didn't have any supports in place, and I think that played a big part in me being admitted to [hospital].” (F, 35-44yrs, IRSP, consumer)

“They did tell me before I went up to rehab [from stroke] that because I wasn't in their catchment, I wouldn't be entitled to any of their outpatient services. But they did tell me that before discharge, they would look at providing places that can support me in my catchment, which wasn't followed through with.” (F, 35-44yrs, IRSP, consumer)

For one consumer who was in crisis, they were advised that they should seek a referral for psychosocial support to manage their mental illness by an ambulance-based MH nurse: “I had contact with a mental health nurse that, she was with an ambulance team and she gave me a card and I’ve still got it. I rang [hospital], that’s the number on the card, and I just demanded that they refer me, I need help. And they referred me to [NGO]. And that’s how the association began.” (F, 55-64yrs, IRSP, consumer). Had this consumer not have advocated for themselves, the inability of the MH nurse to be able to refer them to the relevant NGO may have missed an opportunity to support their recover, with dire consequences.

### *Interaction with NDIS*

The other sub-theme is related to ‘gateway to NDIS’ and this relates to the referral criterion and the juxtaposition between consumers not currently accessing NDIS and a judgement about being eligible for these services. For a proportion of consumers, their exit from the service is into NDIS support, which will be discussed in the preceding sections. Some HHSs and NGOs have interpreted this criterion in different ways and while the majority of NGOs are accepting consumers who they support through the NDIS application process, some do not. While exiting the services to NDIS is likely to be the desired goal or outcome for many consumers, the purpose of the MH CSS programs is to support consumers’ recovery. It has been assessed that when consumers have been identified as eligible for NDIS supports, and their time on the MH CSS

programs is focused on progressing this application, recovery becomes a secondary goal and focusing solely on NDIS leads consumers to be dependent and in some case causes regression (particularly once transitioned onto NDIS support).

### Facilitators to appropriate referral

The two sub-themes associated with the facilitation of an appropriate referral are the antithesis of the barriers described above. These facilitators include 'staff awareness and understanding of psychosocial support' and 'adequate consumer information on referral'. From consumer accounts of their referral process, it is clear that when the referring clinician is able to explain what psychosocial support is and how they can be supported, their expectations are clear: "They pretty much said the [IRSP] program would be a good way to get me supports for once I go home and even up to a year after I'm home to help with things like getting other supports like with [other service name], and also to help with just any other needs that I have in terms of maybe accessing NDIS and other mental health services and supports. And as well as [name] herself providing support, whether in home or out in community." (F, 35-44yrs, IRSP, consumer). One of the ways that HHS staff develop their knowledge and understanding of the role of psychosocial support is the co-location of NGO staff into services and their attendance at case management meetings: "Well we're just fortunate because we host - they come and sit with us one or two days a week on each end. So they co-locate and that means that they're able to wander round, see the clinicians, meet the clinicians so the [NGO] clinician and our health clinicians can just catch up and have that conversation. In that conversation of course be able to just one-off - a one page - it's basically a one pager that they've come down for referrals." (HHS staff). NGOs also provide many services with material and talks to HHS staff to explain how they support consumers in their recovery, but due to large staff turnover in some areas, this could be required more often: "Not all the time, and I suppose the reason for that is a big chunk of the referrals come from what we call resident medical officers...basically, they're interns who rotate through the hospital. So they don't have that information, but their consultants would. So I'm hoping they filter that information down, and not just say, "Hey, they need a H2H referral," but I can never be completely sure" (HHS staff).

For programs where HHS and NGO staff report an acceptable number and type of referral, the quality and quantity of referring information is a key facilitator: "So it's a very sort of basic thing like obviously name, contact number, case manager diagnosis, supports needed and sometimes the case managers can be very vague. That's sort of very basic and then we get a risk screening which actually details things... and sometimes - not always - we'll get a care plan which is kind of I guess what the case managers or the hospital is doing with them so we sort of take into account that because that's pretty much all that we get." (M, IRSP, NGO staff). For more complex consumers, the inclusion of a risk assessment is helpful, "Yeah, so we would get the referral form. Sometimes as well they attach their own risk assessments or if they need to. If there is any particular risk, they would attach those so we can have a thorough read, or we've got thorough information. Then the general process would be that in the initial first meet and greet appointment between us and the client, the clinical case manager would also come as well and do a bit of a collaboration. Then after that, the communication is as needed." (F, IRSP, NGO staff). However, for some HHS staff, there is a concern that NGOs should not rely on possibly outdated risk assessment information and have the capacity to conduct their own.

Where information is missing, as previously discussed this can delay the referral process, but where HHS and NGO staff have good working relationships and open communication, this is often compensated for and results in improved processes: "So it comes through and we'll obviously have as much information as we can and as I said sometimes it's involved going back and clarifying some communication and some of the

information really around I suppose the safety concerns, risk screening, if there's any questions around that. That might look at how we try and work with the clients and we're not looking at information that precludes people from the service. We're actually trying to work with the referrer and the participant around how we might be able to provide the service. Sometimes depending on what that is it might need to be taken up to a management level for direction and then we would still look at trying to look at the parameters around safety and then try and work with the client/the referral." (M, IRSP, NGO staff)

The implications of these themes will be explained and developed further in the *Adoption* section (Section 4.2).

### *Factors underpinning effective referral process*

The main factor underpinning an effective referral process is the relationships between the HHS and NGO. These relationships may be at an organizational level in terms of the MH CSS governance process and how staff work together in ensuring that there are appropriate referrals, or at a staff level, in terms of NGOs connecting with HHS clinical teams and sharing their knowledge and experience and building trust. When it works well, it can be a fundamental facilitator towards improving consumer experiences and the service itself, as described by this NGO staff member below:

"I think that it's the same wherever you go, but it's who you know, not what you know. So, the relationships that I've built 10 years ago working in the step-up-step-down program, are providing fruition, let's say. Maybe not the best term. But they're coming to fruition now in this program because I know [name], the team leader in Q Health, and say: "[name], we got a KPI of 92 referrals a year. We need two referrals from you guys a week, a fortnight. A week? A fortnight. A week." And we got seven in the last quarter. And three of those are people that were already engaged in the program. So it looks like there's not many people that are interested in it, but there's a ton of people interested in it." (M, TCFP, NGO staff)

For the settings where HHS and NGO staff report strong working relationships and a shared purpose that is consumer focused, there is routinely a clear governance process and regular meetings with stakeholders; NGO staff are co-located within community teams and on hospital wards and they attend weekly case management meetings and reviews:

"Absolutely. I definitely think that helps build confidence. So when the mental health clinicians repeatedly see and work with the NGO staff, they can see that they understand our consumer presentations, the difficulties, the challenges, and I guess over time they also feed back. They give good news stories the next fortnight at ward rounds so they can actually hear that they did some good work with that person, so I'll refer again. That's absolutely helped... So in the early days we did try and get some case by case good news stories and we would report those monthly. I think that probably set the program up well in terms of having a good perception among clinicians. I think it just also happens naturally as well with the regular presence. The other thing, they get a good reputation with staff when they don't knock back really challenging situations or they don't send them back saying it's too risky for us to manage. So I think that has built a lot of bridges as well." (HHS staff)

"Yeah. I definitely think you need the relationship. One other tangible thing that we do that might help for other services to be aware of, is we actually give the NGO workers an ID badge, so they do come into the wards and can access and go to meetings and things like that, so they're seen as part of the team a bit more." (HHS staff)

For referring staff, this means that they have developed personal relationships with staff, which is built on trust:

“Always relationships. Case managers are inherently protective of their consumers and consumers and case managers alike have been burnt from having lots of new providers, lots of people who are presenters and new NGO on the service only to go or not deliver what they promise. So one of our key delights with our program is the inclusion of us being allowed to be on the tender of the local HSSs, to be able to avoid these national brands coming in with no local knowledge and being able to tender to local providers. It’s been a critical component to the success of the IRSP. [NGO] is a trusted provider with long standing good relationships and positive relationships with all the teams across mental health service so their brand is already in high regard with the teams.

As well as that there’s an interface. We’ve had [NGO] workers come and work as case managers in our service and we’ve got crossover between the two agencies with lots of strong – both friendships and professional partnerships – over probably 20 years. I don’t know if that’s unique to the [AGREA] or it exists in different forms across all the HSSs, but certainly you can have as many processes as possible and as many criteria and you can do all of it, but nothing beats face to face relationships and friendships and connections where case managers can trust that they’re handing over their consumers to regular, nice, professional people who are going to do a good job.” (HHS staff)

Conversely, where these types of working relationships do not exist, staff (NGO and HHS) report feeling like there is little buy-in and support from the clinical teams, that psychosocial support is not valued or trusted and that the MH CSS programs are a means of exiting consumers from the service:

“No. I think when you talk about psychosocial I think there's a very broad understanding of that. No. I think some absolutely get it, the ones that work very closely with that and build that relationship absolutely do. I think the ones that potentially don't use it or don't have that relationship or don't take the time, yes, it's there, they know about it but it's very broad stroke information rather than actual detail about sitting down and actually saying well this is what it actually does, this is what they can do. Again what we have found between the snapshot of the actual program that was given to us and what even the recovery worker's understanding is very, very different. So we were referring to what information has been provided to us by the provider but the recovery worker...” (HHS staff)

“...There's a mistrust in services, since we're being open about ... There's a mistrust and a lack of understanding of what each service can provide. So when you come from a government model, like a medical model that we work from, and then you've got a psychosocial model, you just don't understand what each other's doing. So it's about breaking down, "This is what we do in our job. This is what we have identified the needs for our clients... I can't really speak to that because I wasn't in the position. I can only speak to at the time when I came in the position, and there didn't look like to be a relationship between [NGO] and the community mental health. You had staff on one side and they never said a thing, and they're good like that. Again, building that trust, and then you've got [NGO] telling us how wonderful they are and they can do this, this and this, and unfortunately, at that time, at that meeting, it was like, "This lot don't look convinced at all." So how do we improve this?” (HHS staff)

## Summary

In summary, the programs have been successful in targeting services to people identified as having severe mental illness and ineligible for supports through the NDIS, as these are the people who have taken up the referral and engaged with the programs. **However**, only 58% of programs are meeting their client targets

(which are based on only 20% of population need), suggesting that some programs are not able to reach the number of people intended, despite there being significant need. This is likely due to systemic issues related initially to the referral process (including awareness and understanding of what psychosocial support is, the understanding of the eligibility criterion for the MH CSS programs and who could/should be referring into them), and later to the administration of the referral which will be presented in the following *Adoption* section (*Section 4.2*). Of particular note regarding the interpretation of the eligibility criterion, while the people adopting the programs do not currently receive NDIS support, many of them would qualify and a large proportion of the ‘recovery’ work with the NGOs is applying for NDIS, and they subsequently exit to those supports. This was identified as a ‘grey area’ within the criterion and therefore may also affect the number of people being reached.

**N.B:** While these programs may be appropriate for consumers applying for or awaiting an NDIS decision, a note of caution with having programs as a ‘holding place’ for NDIS is that, when they do exit to this support, it can often leave consumers in the middle of their IRP and without the specialist support to enable them to develop their independence and recovery. It should also be noted that for those NGOs who offer NDIS support and care coordination as well as the MH CSS programs, this could be perceived as a conflict of interest, especially if they go on to inherit that consumer.

## Reach Recommendations

Based on the barriers, facilitators and key factors discussed, the following recommendations are intended to support the development of an effective referral process for the MH CSS programs.

### *HHS & NGO Collaborative Governance*

Research indicates that whilst it can be challenging to achieve effective collaborative governance and relationships across key stakeholders (Johnston et al., 2010) it greatly increases the likelihood of process and program successes (Hicks et al., 2008). Collaborative governance includes fostering trust, shared commitment, mutual accountability and willingness to share risk (Klijn & Koppenjan, 2015).

A key to facilitating *Reach* and further *Adoption* of the MH CSS programs is a strong working relationship between the HHS and NGOs and a shared purpose that is consumer focussed and built on trust. Ways that this can be facilitated and improved is through regular governance meetings between stakeholders, the co-location of NGO staff within the HHS and their inclusion on regular case management meetings.

### *Clarify inclusion/exclusion criteria for HHSs & NGOs*

Research into the structure and function of community mental health supports has indicated that a key issue for these programs is how they gate-keep access to their services (Belling et al., 2011; Singh, 2000). When community mental health supports were introduced as the primary service for individuals who were “severely mentally ill” in the Netherlands, they saw a four-fold increase in referrals between the 1970s and 1990s (Verhaak et al., 2000). In a review of the referral processes of community mental health teams in the UK Chew-Graham et al. (2007) found that that gate-keeping decisions had been largely determined by individual clinicians and teams, rather than through formal strategic control, and this caused ongoing issues for the management of the community programs.

For the program to reach those consumers who meet the criteria of experiencing severe and persistent mental illness it is recommended that the inclusion/exclusion criteria are clarified and reiterated for all stakeholders of the programs. Through the evaluation it was found there were inconsistencies in the

interpretation and therefore delivery of the program according to the inclusion/exclusion criteria, including the nuances of NDIS eligibility.

In addition, and to support this recommendation, it is recommended that the referrals and risk assessment templates utilised by the HHS's and NGOs are standardised according to best practice.

### *Extending Referrer Options*

It is recommended that a review is conducted into the feasibility of extending the opportunity for General Practitioners (GPs) and private mental health clinicians to be able to refer into the MH CSS programs. This does not relate to changing the eligibility criteria of the consumers to join the program, rather is recommended as a means of addressing the concerns raised by many consumers as to the distress and discomfort caused by having to present at the HHS prior to being referred onto the program. Several consumers reported that they would have much preferred being offered the chance to engage in the MH CSS program before having to engage with the HHS. It was found through the evaluation that the consumers would likely have met the eligibility criteria of experiencing severe and persistent mental illness whilst under the care of their GPs or mental health clinicians prior to engaging with HHS. This extension recognises the transient and episodic nature of severe and persistent mental illness and would enable these consumers who have a regression in their mental health to seek support earlier and likely avoid a crisis that results in an emergency department presentation.

### *Psychosocial Support Training/Education*

Through the evaluation it was identified that there is variability in the understanding from HHS staff of the role that psychosocial supports play in supporting consumer mental health recovery, which has an effect on the reach of the MH CSS programs. The focus of psychosocial supports is to assist consumers with severe and persistent mental illness to participate in community, manage their daily living tasks, to work, find secure housing, to maintain connections with family and friends. Psychosocial support is recognised in the literature as a vital component of the mental health system, alongside clinical care and disability support (Gaster et al., 2018; Reyes, 2006). Psychosocial interventions have gained popularity over the past two decades and training clinical staff in the function and role of psychosocial support in treating mental disorders has been shown to help clinicians conceptualise their patients' problems with a more empathetic framework, facilitating non-judgemental attitudes and developing realistic expectations (Ewers et al., 2002; Morgan et al., 2018).

It is recommended that the referring teams review and refresh their knowledge about what psychosocial support is and its role as a mental health intervention. In addition, it is recommended that the HHS and NGOs embed regular NGO delivered psychosocial support education/training for referring teams as part of a comprehensive care and continuum of service that augments clinical mental health support. Periodic updates and feedback to referring teams from outcomes data and/or successful outcomes/case studies from consumers via NGOs may help to reinforce the referral process.

### *Additional MH NGOE NBEDS data collection*

It is recommended that to gain more information about the number of consumers who are being offered psychosocial support, that referral data are collected and reported. Regular reporting and review of these data could help HHSs to identify when referral numbers fall short of what would be expected and prompt them to identify blockages to referral and deploy strategies to increase them. These data could also be used to calculate the percentage of consumers to take up the referral and *adopt* the programs. Regular reporting

of these data could then be used to identify potential issues with the *Adoption* process (discussed in *Section 4.2*), which could prompt HHSs and NGOs to discuss and identify any barriers or problems with this process.

To allow for superior monitoring and evaluation of the MH CSS programs, the collection and more detailed analysis of additional demographic variables and individual level data is necessary. This would enable stakeholder groups to identify gaps in service consumption and issues of inclusivity within programs and provide a platform for further enquiry and collective problem solving in the future.

## 4.2 Adoption

*Adoption* refers to the barriers to program adoption and key factors that facilitate an effective process. The point at which *Adoption* begins within a consumer's journey through the MH CSS programs aligns to the HHS referral into an NGO-delivered individual program (IRSP, IRHP, or TCFP). This HHS referral almost always originates from a clinician within an HHS service such as a hospital or a community mental health team, however occasionally it was found to come through an aged care service for older consumers. Appropriate referrals into an individual MH CSS program require a 'handover', in which important and relevant details about the consumer (demographics, medical history, diagnoses, risk assessments (if any), etc.) are passed along to the NGO. *Adoption* then continues during the consumer's transition from the referring HHS service onto the NGO-delivered MH CSS program. Adoption 'ends' after the on-boarding sessions into the respective MH CSS program (and early delivery of the program), at which point the consumer begins the *Implementation* phase of the individual program.

*Adoption* also refers to the transition from the individual MH CSS program (IRSP, IRHP, or TCFP) onto the group-based program. This secondary adoption phase begins once a consumer is referred to the GBPRSP and continues through handover from the individual program to the group-based program, including the first few sessions of attending the group-based program. *Adoption* of the GBPRSP concludes once a consumer decides to engage in one or more groups.

### HHS Handover to NGO

#### *Poor handover*

There was found to be great variability among the calibre of handover from HHS staff to NGO staff. Consumers described instances in which they had very little to no knowledge they had been referred onto an MH CSS program, nor any knowledge of what this specific program entailed.

Facilitator: "So when you first found out when you were in the hospital and they said we had this program called [NGO-specific program name], what did they tell you?"

Interviewer: "They didn't really tell me much at all, quite frankly..." (F, 45-54yrs, IRHP, consumer)

NGO staff also supported this notion that consumers had little to no knowledge from the HHS about their referral, highlighting this barrier to adoption at both the consumer and NGO staff levels.

"Well firstly I mean it seems obvious but actually being aware of the referral because a lot of people just are given these referrals. They [consumer being referred] have no idea." (M, IRSP, NGO staff)

"The other issue I came across is that a lot of the times we would get a referral from them [referring HHS team], we'd ring the client up and they'd go well who are you and why are you ringing me? Meaning that they [HHS referrers] didn't even have a discussion with the client that hey look we've had a discussion about what you're presented with here, we feel that this is what's going on for you and we'd like you to be linked, we'll refer you to a service who would be more appropriate to deal with your issues there. They [HHS referrers] didn't even do that. So they'd [consumer being referred] have this random person like me ring them and basically say look I'm from [NGO]... you recently went up to mental health, I believe we've seen a referral from your local mental health service. Oh they [HHS referrers] didn't tell me they were going to refer me to you." (M, IRSP, NGO staff)

Another finding indicated at times, the HHS referral contained incomplete or inadequate referral documentation, which presented a major barrier to the NGO staff receiving and understanding the referral; *A document comes to us. At best, it's wishy washy. The information that we're provided is completely inadequate, and I'm always advocating for a lot more information for the purposes of not retraumatizing a client.* (F, IRSP, NGO staff)

### *Warm handover*

There were few instances where a 'warm handover' occurred between the referring HHS and the NGO. When this occurred, the referring HHS provided sufficient documentation and information about the referred consumer to the NGO and was open to communication with the NGO staff about the referred consumer.

*"We do have a good relationship with the [HHS] referrers in general. We have good communication with them. We all have the contact details for everyone so we can email or they can call us. It's notoriously hard to get a hold of anyone within the acute care team, so we email because you can never call them...It works well, because they [the referrals] always come through the same three or four people because there's a discharge facilitator for each floor. So we know who those people are. They know us well. They'll flag a potential referral to discuss if it's suitable before it even comes through. So that's a little bit easier, especially because we're literally 100 metres away from the hospital. We go up there all the time."* (F, IRSP, NGO staff)

### **NGO's first contact with a consumer**

The next step within the adoption phase is the NGO's first contact with an HHS-referred consumer, in which there continues to be variability in delivery. As described above, many times consumers are 'blinded' to the fact they have been referred into an MH CSS program upon exit from their referring HHS service, which makes an NGO's first contact with a consumer difficult. In these instances, the NGO's first contact includes additional tasks of introducing themselves and their NGO (sometimes explaining how their contact details were obtained), introducing the MH CSS program in which they were referred into, and then attempting to schedule a first meeting with the consumer. An NGO staff expressed sentiment about wanting to be the first point of contact to eliminate confusion on behalf of the consumer, *"So I feel as though if we were able to meet them first and they hear it directly from us in the first instance, it might change the way that they view or understand what it is that we do."* (F, IRSP, NGO staff)

On occasion, a consumer has described an exemplar experience whereby the HHS promptly referred them to the NGO and informed the consumer themselves about the progress of the referral: *"And then when I was in [hospital], they pretty much had got the ball rolling while I was still on the ward, in terms of filling out the paperwork and sending off the referral while I was still in the ward...And that made a big difference, to see them actively starting to get things going. So I was going home with the knowledge of, "Okay, these people have my referral already, it won't be long before I start receiving support."... That also helps mentally to know I'm not just being dumped home to go on my own."* (F, 35-44yrs, IRSP, consumer)

### *Timely first contact from NGO*

In instances where there was not a 'warm handover' from the HHS service, it was frequently reported that NGO staff are quick to respond to this HHS referral by reaching out to the HHS staff who referred a consumer and making timely first contact with a consumer.

*"So we'll get the referral. Myself or my colleague will call them [consumer] and just let them know that we're received a referral and who we received it from, so they know who we are and ask ... we often ask if they*

even knew that that referral happened because sometimes people don't, and then they often don't even know what our program is. So I'll give them a bit of a rundown of actually who we are and what we do, so we're not some scary random person calling them on the phone, just so they get an understanding of who we are. Then I generally ask if they'd like to meet up, just so that we can give them a bit more information about our program and how we might be able to support them just so they can understand who we are." (F, IRSP, NGO staff)

There were a few experiences where consumers were aware of the HHS referral into an NGO-delivered MH CSS program and they expressed there was 'too long' between the HHS referral and the first contact from the NGO, however most consumers expressed they experienced a timely first contact from the NGO. This timely first contact from the NGO, usually less than two weeks from HHS referral, was reflected on favourably by consumers and said to positively impact the beginning of a consumers' relationship with an NGO in which they were referred. For example, "I've been through mental health services since I was eight, like I said. And most referrals take usually a minimum of a month to actually gain any traction. So it was super fast and super efficient." (F, 18-24yrs, IRSP, consumer). NGO staff echoed consumer sentiments about the importance of a timely first contact, indicating it increases the likelihood that a consumer engages with the MH CSS program, as expressed below by an NGO staff: "Well, we like to try and turn it around within seven days to 14 days. Not ...we try and turn them around as quickly as possibly because you find that the longer the time between referral and contact the less likely they are to pick it up." (M, IRSP, NGO staff)

### *Setting/managing clear expectations*

It was assessed through the evaluation that setting clear expectations of the program is an integral element contributing to consumers adopting the program, however is seldom managed consistently or in a timely manner by the HHS referrer. The importance of setting clear expectations is to ensure the consumer understands the type of service they will be receiving, the type of service they will not be receiving, and to manage these expectations of the program's offerings from the start. The variability of setting and managing clear expectations of the program is exemplified with the following two quotes: one consumer who noted that they had received little support through their individual program noting, "Yes, I really don't know what [NGOs] supposed to do" (F, 55-64yrs, GBPRSP, consumer), and another consumer who was engaging minimally in the GBPRSP noted, "No. I don't know whatever they want to offer, I'm not sure what else they offer." (M, 35-44yrs, GBPRSP, consumer). Setting clear expectations of the program also has implications for how the program is implemented and the recovery journey of the consumers; this will be further discussed in the *Implementation* phase below.

### **Early delivery of MH CSS program**

Through the evaluation's interviews, it was found that there are a number of factors that directly impact upon a consumer 'taking up' an HHS referral into an NGO-delivered MH CSS program. As discussed above, these include whether the handover of the consumer from the HHS into the NGO was managed well (i.e. timely, with adequate communication and information shared between the HHS and the NGO) and the consumer's level of knowledge of the HHS referral. Then, once the HHS clinician has 'handed over' the referral to the NGO, and the NGO reached out to contact the consumer, then early delivery of the MH CSS program begins. Almost always, this early delivery of the MH CSS program has been found to begin with an in-person meeting between NGO staff (one or two staff members) and the consumer. Findings from our interviews indicate there have been a few instances where the HHS referrer has also participated in this first meeting between consumer and NGO staff, which has been viewed positively by consumers who experienced this more holistic approach: "So when they came, they came to my house. My [HHS] support worker said that

[NGO] was able to help me...she [HHS support worker] said she'd like to meet her... So [HHS support worker] and [NGO support worker]...came to my flat and that was it and then we just had a yarn and they introduced themselves and told me what they were able to give me and I was like, "Wow. Okay." That was great...It makes a huge difference." (F, 55-64yrs, IRSP, consumer)

### *Access to program*

There are a number of factors during the early delivery of the MH CSS program that were noted to have an impact on a consumer 'taking up' a referral and deciding to become involved in the program. For example, NGO staff described that consumers were less likely to adopt the program if they had difficulty physically accessing the service. This difficulty in physical access was described by consumers in a number of ways, however included lack of transportation (both private and/or public transportation) to/from the location of service delivery, or in more rural areas the NGO's office being too far from consumers' residences to attend as often as they desired. These barriers to adoption were described by NGO staff members, as consumers whom were greatly impacted by these barriers did not actually adopt the program after HHS referral, and subsequently were difficult to engage during recruitment for our evaluation interviews. Below are two examples of barriers related to access:

"Well I guess the unique things are, like a lot of these people are on properties that it's one, one and a half hours, even when I'm going to those outlying areas they've still got to travel those big distances to come in and see me. So that's a big barrier at times and often it just depends what's happening on the farms, sometimes it's too busy for them to get away." (F, IRSP, NGO staff)

"So we keep hearing as well that it's just people have huge anxiety and we're asking them to basically catch public transport, one of the most anxiety-provoking things there is, to get to our groups because they can't afford Uber or taxis. There's barely any transport services out there and the support people, so like the actual case managers and whatnot don't have the time to drive them to a group." (F, GBPRSP, NGO staff)

### *Delivery setting flexibility*

Alongside instances where consumers failed to engage in the early delivery of the MH CSS program due to access, consumers and NGO staff spoke about how being flexible with the delivery setting of the MH CSS program impacted upon consumers adoption the program. Consumers detailed how their meetings with NGO staff members took place whilst, "...fishing, shopping and going down the [beach], going for a coffee...in two hours they take you places" (M, 55-64yrs, IRSP, consumer). An NGO staff member described the flexibility in delivery setting as an important factor which helps people engage in the program: "So we can go to their house. We can go to their favourite café. We can go to the park. We can go for a walk along the river if they want to. So that really helps people engage, and I think that's a really important part of our program, that we're not doing it in that clinical setting. We're doing in their community and helping them establish those links in their community. I think that really helps." (F, IRSP, NGO staff)

## **NGO staff interpersonal factors**

### *NGO staff allocation*

It was assessed that another factor impacting the uptake of an HHS referral onto a MH CSS program is the specific NGO staff member allocated to a consumer, and the process (or lack thereof) of matching this consumer with an NGO staff member. There is variability among how NGOs match consumers with NGO support workers in some instances, which can be a result of inadequate resourcing of staff. This will be further discussed in the *Implementation* phase below. Overall, consumers found how NGO staff were allocated to

them to be a facilitator in adopting the program. Consumers described experiences where they ‘matched well’ with their support worker. For example, one consumer said, “He was who I went and seen. Had a quick talk with him...they matched me up with him and yeah. I've just been talking to him ever since. I hate being passed around, because I feel like I'm a parcel.” (M, 35-44yrs, IRSP, consumer)

As described by one NGO staff member, appropriate allocation can be based on a number of factors, including similar demographics between the consumer and potential NGO staff: “I think [NGO] are very good at matching as well. So because I’m elderly unfortunately, I get the older type males usually. It’s just a better fit because you can appreciate if someone is in their late 50’s or 40’s even and you get told by a 20-year-old, you know, yeah, so it’s just a better fit.” (M, IRSP, NGO staff). Another factor that is considered is whether the consumer has a preference with working with a Peer Worker, as explained by this NGO staff member: “When we do the intake, there's requests for a male worker or a female worker. I know our manager is trying to accommodate those where possible. I always share my lived experience ... not my actual experience, but that I am a peer worker. I always share that in the intake, so that they do ... I always find it makes them feel more comfortable quite instantly, that, "Oh, okay this is ..." so I always share that in the first session.” (F, IRSP, NGO staff)

### *Person-centred*

Within the early delivery of the MH CSS programs, and throughout a consumer’s journey, both consumers and NGO staff highlighted the importance of the program being person-centred. Person-centredness appears throughout the evaluation as a key ingredient underpinning the effectiveness of the MH CSS programs, however in adoption is seen to be a facilitator in consumer’s taking up the program. One consumer said, “I like how it’s kind of just a non-linear kind of thing that they – like their mission is very just like dealing with it not curing it.” (F, 18-24yrs, multiple programs, consumer), highlighting the importance of the program shifting to meet the needs of the consumer where they were at within their recovery journey. An NGO staff member explained, “You’re almost working yourself out of your job. So it’s always individual, it’s always person-centred, for a better word, strength-based but yeah, you’re working them out of service land, I guess is a good way to put it.” (M, IRSP, NGO staff), emphasizing how the consumer is always at the centre of service delivery, and their individual needs drive their recovery journey. Across the majority of NGOs, person-centredness of the MH CSS programs was discussed to be a vital pillar in successful delivery of the program.

Following on from person-centredness, the majority of consumers and NGO staff discussed the importance of a strong relationship between a consumer and their NGO support worker as a facilitator in consumers’ adoption of the program.

“That's one of the biggest things with me; if I would have felt that I was being judged to start with, even before anything else, I wouldn't have come back. So to start with just that unbiased...wanting to help...it's one of the biggest things for me most definitely...So if there wasn't that professionalism and I didn't respect and I didn't, like, people telling me a whole heap of bullshit I wouldn't have come back either. It wasn't, yeah, I could tell sincere, you know, it wasn't, "Oh, I'm just here to, you know, do my time...You pick up on things like that...that care factor is there. It's not an act...you pick up on stuff like that. You pick up on the genuine...the caring and the non judgemental.” (F, 35-44yrs, IRSP, consumer)

### **Referral from individual-based MH CSS program onto GBPRSP**

Another adoption phase was when consumers transitioned from the individual programs (IRSP, IRHP, and TCFP) onto the group-based program (GBPRSP). Similar barriers and facilitators were found for this transition

compared to the transition from HHS referral onto the individual MH CSS program (described above), however with slight variation.

An important factor to note, however, is that the majority of this transition occurred from IRSP to GBPRSP. Consumers from the two specialised individual-based MH CSS programs (IRHP and TCFP) were seldom seen to transition to the GBPRSP. In particular, there were few examples of transitions from IRHP onto GBPRSP whilst there were no examples where an individual from the TCFP transitioned to a GBPRSP across the state.

### *Handover from IRSP to GBPRSP*

#### *Same NGO delivering*

A key facilitator of the referral and subsequent uptake of the GBPRSP is whether the same NGO is delivering both the individual MH CSS program and the GBPRSP. In instances where there are different NGOs delivering the programs, there are less referrals onto the GBPRSP and as a result less uptake of the group-based component. One staff member noted that on the days the NGO he worked at was due to deliver the GBPRSP, “...most of the time I sat and read. I did a lot of reading. So I just sat on the couch and read” (M, GBPRSP, NGO staff), because the referral pathway from the NGO delivering the individual program into the different NGO delivery the GBPRSP was not effective.

When an NGO does deliver both the individual-based program and the group-based program, it was noted the referrals are more appropriate, communication between program-specific staff is made easier and more frequent, and as a result the transitioning of consumers from IRSP onto GBPRSP is much smoother. One consumer noted, “Well, the groups they told me about the groups, when they first, [Support worker] first explained the program to me, he was like these, like the social things they do. So then when I met up with [Peer worker], she gave me like a monthly sheet with all the groups on it. And we discussed availabilities, can she drive me, times volume, blah, blah, blah, all that stuff. And we kind of, at the beginning of the month, we would pick out what we would plan on doing and book it in advance.” (F, 18-24yrs, IRSP, consumer)

#### *Warm handover*

A facilitator identified during the process of transitioning a consumer from an individual-based MH CSS program onto the GBPRSP is a ‘warm handover.’ An NGO staff member described this ‘warm handover’, highlighting its importance in the uptake of the group: “But we always try and do a warm introduction, so during one of our sessions together, we might take that person to the [GBPRSP], so meet some of the people there, who's going to be there.” (F, IRSP, NGO staff). In instances where there was no introduction to GBPRSP staff made, consumers expressed hesitation towards attending, which can impact adoption, as described below:

Interviewee: “So she was the one that actually mentioned about all the different group activities they have every week and she just said “Yeah, if you want to participate”, and she gave my number out to a couple of the people that run the groups and we get like a message every week and if we want to go we can go....Yeah, I have told her a couple of times, like I’m anxious about going to this group, and she’s like “You’ll be fine. Once you’re there you’ll...””

Facilitator: “Does she go with you?”

Interviewee: “No, she usually will just drop me.” (F, 25-34yrs, multiple programs, consumer)

### Group offer

Another important factor contributing to uptake of a GBPRSP referral is related to the actual offer of the group. As expected, there is large variability across and within NGOs on their group offer, however the content directly impacts a consumers' willingness to take up the referral and join the GBPRSP. When the content of the group appealed to a consumer, this acted as a facilitator towards adopting the program; conversely, when the content of the group did not appeal to the consumer, the group offer acted as a barrier towards adoption.

"I'm sitting there and playing cards, some are doing a bit of gardening and some are doing this and some are doing that, but that just didn't interest me whatsoever. I don't have the concentration to play cards any more." (M, 55-64yrs, IRSP, consumer)

"They give us a programme every month. There's lots on there. But a lot of it you have to be quite active to do and I'm no good on my legs anymore. But they have lots more activities; peer group. I tried that once and I didn't really like that much. But I found the men's group and this have been a Godsend." (M, 65+yrs, multiple programs, consumer)

One consumer summarised this factor well in their assessment of why the groups work, "I think part of it would be the group it is because, obviously there's certainly different types of groups. The people that are interested in those things go to those groups, so you don't spend much time meshing with people that don't want to be there. So everyone sort of has the same interests at the groups you'd go to." (F, 18-24yrs, IRSP, consumer)

### Consumer capacity and readiness

Findings from the evaluation support that in some instances, even when all the above facilitators are present during the adoption phases of the MH CSS program delivery, adoption of the program is ultimately dependent upon the individual consumer's capacity and readiness to be engaged in a recovery orientated psychosocial program. Some consumers during our interviews indicated ambivalence towards the program:

"They can't do anything for me. I feel like I've tried every avenue. I just don't know what they can do. Nobody's going to make my life any better, and stop bad things from happening, and all that sort of stuff. That's what it comes down to. Yeah, I just don't know how they can help." (M, 25-34yrs, IRSP, consumer)

"Well, nothing helps. I think I'm doing it because it's procedure and I've got to be seen to be doing it or otherwise I won't get any treatment when I really need it." (M, 65+yrs, IRSP, consumer)

The above examples illustrate scenarios in which consumers' lack of readiness or capacity to begin their recovery journey acts as a barrier to them adopting the program. Conversely, some consumers were able to reflect upon their previous lack of capacity or readiness to engage in a recovery-oriented program, identifying their capacity and readiness now as a facilitator towards adopting the program:

Interviewee: "Well I've been through therapy a lot in my life. But never how it is now, I seem to be wanting to engage more, to find out what's wrong with me. So I'm not just thinking, I've got to take medication because the doctor said I need to take it, I like to find out. They explained it. Explaining what medications do what and how it affects you."

Facilitator: "Yeah."

- Interviewee: “You know, I seem to be more wanting to know a lot more about the therapy side of therapy. Rather than just...”
- Facilitator: “What they’re actually doing.”
- Interviewee: “Yeah. Instead of just sitting there going yeah, yeah. Whatever. And just, I only used to go there because I was forced to, whereas now I want to get sorted.” (M, 35-44yrs, TCFP, consumer)

In terms of consumer capacity and readiness to engage in the GBPRSP, there was varied sentiments about becoming involved in this program for a number of reasons described above, however consumers also indicated their capacity/readiness as a barrier to engaging:

“I think [NGO support worker] was trying to do that at one point, but I think, I just wasn’t in the right headspace at the time. And there’s been a few times, I’ve been a bit, like, iffy and that. There’s been a couple of times, where I wasn’t...I really wasn’t in a good mood at all, but I was just smiling just to make it look...but I was doing everything I needed to do. Yeah, sometimes, I’m not in a good spot.” (M, 35-44yrs, IRHP, consumer)

In addition, both the IRHP and TCFP programs face challenges related to a consumer’s complexity and capacity in ability to adopt the program as intended. A major challenge in encouraging adoption of the IRHP and TCFP programs is consumer access to housing, and whether their basic needs are being met prior to being able to attend to their psychosocial needs (i.e. post-release from prison, financial constraints, and at risk of homelessness). One staff noted, “Yeah, housing probably is the number one, we can’t really do much without that, and we’ve really only got the awful hostels here to work with from prison. So we use them but sometimes we feel like we’re setting them up to fail but that’s all the options we’ve got.” (F, TCFP, NGO staff). Challenges for these two specific populations have been identified within the literature as vulnerable population service gaps (Stergiopoulos et al., 2018). To address the psychosocial needs of these populations, complementary funding and supports are required, particularly relating to broader factors such as housing, food security, and poverty (Stergiopoulos et al., 2018). Until these broader factors are addressed, psychosocial needs will continue to come second.

## Summary

The *Adoption* phase encompasses the transition of a consumer from an HHS-delivered service onto an NGO-delivered MH CSS program. This phase is made up of three smaller components: (1) HHS Handover to NGO; (2) NGO’s first contact with consumer; (3) Early delivery of MH CSS program. It was assessed by the independent evaluation that there is significant variability among each of the above sub-phases, subsequently impacting on consumers’ adoption of the program.

1. HHS Handover to NGO
  - a. Substantial variability exists within the first sub-phase of adoption, which is the HHS handover to NGO. Whilst it was reported that HHS staff in some locations provided a ‘warm handover’ to the NGO, findings indicate there were difficulties with the strength of these handovers. It was found through the evaluation that consumers benefitted substantially from ‘warm handovers’. This ‘warm handover’ specifically includes:
    - i. Sufficient documentation and information being provided by the HHS referrer to the NGO about a referred consumer.

- ii. Open communication of the referral with both the NGO staff and the consumer themselves.
  - iii. The HHS referrers setting clear expectations with the consumer about what the program they are being referred to includes (and subsequently what it does not include).
- 2. NGOs first contact with consumer
  - a. Due to the variability of the strength of HHS handovers to the NGO, it was found that the onus of introducing the MH CSS program to a referred consumer was placed substantially on the NGO during their first contact with a consumer. It was assessed that overall, NGOs responded well to this increased need and consumers reported the importance of the below in relation to their first contact with NGO staff:
    - i. Timely first contact from an NGO staff, as close to the HHS referral date as possible (a few days or within a week of discharge from HHS service).
    - ii. A timely, in-person first meeting that includes a member of the HHS referral team **and** the NGO staff performing intake, for comfort when meeting the new NGO staff delivering the service and for ease of information sharing between the HHS referrer and NGO staff.
    - iii. NGO staff during this first contact and meeting with a consumer managing clear expectation of the MH CSS program in which they were referred (or setting these expectations if the MH CSS program has not been adequately explained to the consumer by the HHS referrer).
- 3. Early delivery of MH CSS program
  - a. The early delivery of the MH CSS program as a sub-phase was found to significantly impact the adoption of the MH CSS program, and consumers described a variety of important factors within this sub-phase that facilitate this adoption. During early delivery of the MH CSS program, it was assessed by NGO staff and consumers the importance of the below factors:
    - i. Flexible deliver of these early MH CSS program sessions in a location/method as guided by the consumer themselves (i.e., at consumers' homes, at a safe space within the community, or even at the NGO's offices).
    - ii. Person-centeredness of early MH CSS program delivery, including matching the right NGO support worker to a particular consumers' needs and just generally in wrapping the service around the consumer to meet their specific needs within the recovery-orientated program framework.
    - iii. An understanding that despite optimal delivery within all the above adoption sub-phases, that adoption of the program relies heavily on an individual consumer's capacity and readiness to engage in a recovery-orientated program.
- 4. Referral from Individual program onto GBPRSP
  - a. Similar to adoption of one of the individual MH CSS programs, adoption of the GBPRSP was varied due to a number of factors including strength of handover, whether the same NGO was delivering both the individual and the GBPRSP, and what groups were offered to the consumer (and whether they aligned to the consumers' particular interests). As a recommendation, adoption of the GBPRSP can be improved by ensuring the below:
    - i. A warm handover from the individual program (IRSP, TCFP, IRHP) into the GBPRSP, which includes a consumer's expectations being set and managed regarding what the group-based program can offer and if possible, the NGO staff providing individual support offering to co-attend the group with the consumer being referred.

- ii. Where possible, the same NGO delivering both the individual program and the GBPRSP.
- iii. The GBPRSP offering both activity-based and psychoeducational-based groups, to cater to a wide range of consumer interests.

## Adoption Recommendations

The below recommendations are a summary of what is assessed to be best practice in the adoption of the MH CSS program.

### *HHS handover to the NGO*

The HHS handover to the NGO is a vitally important first step towards successful adoption of the MH CSS program for a number of reasons:

- (1) Its logistical importance for the NGO to receive any relevant details about an incoming consumer and compile any documentation that can impact the delivery of their individual support.
- (2) Continuing care for consumers during their transition from a clinical service (many times due to a mental health crisis) to a community-based service.
- (3) Maintaining and building trust with the consumer to transition them onto psychosocial supports within the community.

### *Warm handover*

It is known that a 'warm handover' is vital when transitioning consumers from clinical services to community-based services (Britton et al., 2019; Cleverley et al., 2018; Taylor & Minkovitz, 2021). In particular, warm handovers are even more vital when transitioning consumers from a hospital-based setting to a more stigmatised community-based service, which includes community mental health services (Cleverley et al., 2018; Taylor & Minkovitz, 2021). As the literature suggests, best practice in this first component of adoption (transition from HHS clinical service into NGO-delivered community-based service) should include a warm handover to maximise consumers' uptake and understanding of the referred program.

Warm handovers in this specific MH CSS context are characterised by HHS staff communicating the referral to both the NGO and the consumer being referred. As discussed in the *Reach* section (*Section 4.1*), governance meetings within each HHS comprised of HHS staff, NGO staff, and other stakeholders should be held regularly to build strong relationships among referrers and service providers. This relationship can then be a pathway for open communication about potential referrals, the purpose and value of psychosocial support, consumer needs, and anything else impacting a referral. This open communication pathway can then ensure HHS staff provide NGO staff with as much documentation as possible about a referred consumer (including demographics, medical history, diagnoses, risk assessments (if any), etc.). HHS staff making the referral into the MH CSS program should also discuss the referral with the consumer themselves, including explaining the type of program (community-based psychosocial support) and setting clear expectations about when the NGO will get in contact and what this service can/cannot provide. This will eliminate the risk of non-engagement if consumers are aware and bought into the referral into an MH CSS program.

Best practice would see this warm handover of a consumer from the HHS into the NGO continue through an NGO's first contact with a consumer and include the HHS referrer in this first conversation/meeting. Consumers who experienced this 'two on one' scenario with both the HHS staff and the NGO staff during their first conversation/meetings highlighted how important and helpful it was to have clinicians and NGO staff together, on the same page, and in the same room discussing their care.

## *NGO's first contact with a consumer*

### *Timely first contact*

Logistically, the first consumer-staff meeting should also happen as soon as possible, preferably prior to a consumer being released/discharged from HHS care (if the consumer is referred from an inpatient setting) (Britton et al., 2019). Research has shown that the period directly following hospitalization carries many risks for individuals living with SMI, including relapse of symptoms, hospital readmission, an increased risk of homelessness and the possibility of violent behaviour or suicide (Cuffel et al., 2002; Hegedüs et al., 2018; Keogh et al., 2015; Nelson et al., 2000; Olfson et al., 2005; Viggiano et al., 2012). As a result, it is imperative that engagement with any outpatient services (including community mental health services) occur as soon as possible once discharge is on the horizon (Britton et al., 2019; Viggiano et al., 2012).

### *Setting/managing clear expectations*

As described in the above section, studies show the transition from hospital-based, clinical services into community-based psychosocial services can be difficult for consumers for a number of reasons (Cuffel et al., 2002; Hegedüs et al., 2018; Keogh et al., 2015; Nelson et al., 2000; Olfson et al., 2005; Viggiano et al., 2012). Specifically, research conducted by Hegedüs et al. (2018) found that the addition of pre- and post-discharge briefings upon consumers' discharge from psychiatric inpatient care to community-based care had impacts on consumers' mean coping scores.

Therefore, it is recommended that clear expectations are set at the point of referral (at latest) by the HHS referrers. Subsequently, management of these expectations should include both the HHS referrers (during any further involvement with a consumer during their transition into NGO-delivered services) and the NGO staff once handover is conducted. This management of expectations should be reiterated during the handover, and then reinforced during the first few interactions with the consumer whilst introducing the relevant MH CSS program.

### *Early delivery of MH CSS program*

#### *Flexible access to program*

Further logistical recommendations for the early delivery of the MH CSS program, including the above first meeting with a consumer (including HHS staff and NGO staff, preferably prior to discharge), would include flexibility in access for consumers. Kendall and Frank (2018) describe this flexibility in consumer care as 'flexibility with fidelity,' and highlight its importance in allowing clinicians to offer support to a wide range of clients whilst maintaining key implementation features of the intervention being delivered.

This notion of 'flexibility with fidelity' can be applied to the early delivery of the MH CSS programs as well. It is recommended that delivery of these early sessions take place in a location/method as guided by the consumer themselves. This might mean at their home, or at a safe space within the community, or even at the NGO's offices, however this preference should be guided by the consumer as much as possible. If meeting at an NGO's office is the preferred option, one NGO staff member highlighted the importance of physical location for consumers with the below quote, highlighting the importance of ease of access to MH CSS consumers: "So that's one of the major things...we don't have the facilities where my office is, so some sort of amazing space, room where it's accessible, central, lots of free parking, close to public transport [would be beneficial]." (F, GBPRSP, NGO staff)

### *Person-centred approach to consumer-staff fit*

Another important component during the early delivery of the MH CSS program is related to NGO staff interpersonal factors. Person-centeredness within recovery-oriented mental health care is widely accepted within the literature to be best practice (Tondora et al., 2014). Specifically, person-centeredness within the MH CSS programs would include factors such as matching the right NGO support worker to a particular consumers' needs and just generally in wrapping the service around the consumer to meet them where they are at. Findings from the evaluation supported that person-centredness should be at the core of delivery of the MH CSS services, and consumers observed the most positive outcomes and experiences in instances when service delivery was centred around their specific recovery goals, journey, and needs. This is further discussed in *Implementation* below.

### *GBPRSP adoption*

Adoption of the GBPRSP loosely requires all the above components for adoption, including a 'warm handover' between referring entity (in the GBPRSP case, the referring NGO into the NGO delivering the GBPRSP). This was found to be most functional in cases where the same NGO was delivering both the IRSP and the GBPRSP. As such, the recommended model would be that the same NGO deliver both the IRSP and GBPRSP to facilitate referral from the individual into the group-based program (including the warm handover). Recommendations to facilitate the adoption of the GBPRSP would also include offering a suite of group-based programming that includes a mix of psychoeducational programs and activity-based programs, to appeal to a wide variety of consumers.

### 4.3 Implementation

Implementation explores the NGOs fidelity to the delivery of the four MH CSS programs as intended.

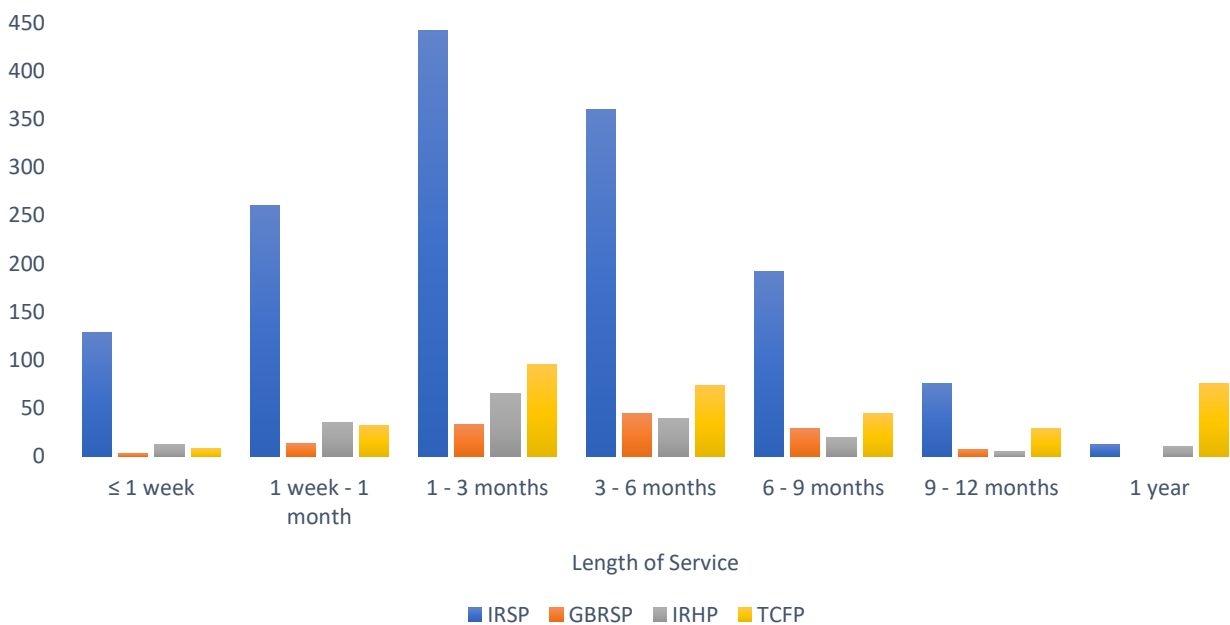
This RE-AIM component speaks to how the MH CSS program is being delivered by the NGOs and experienced by the consumers throughout their time on a program (IRSP, IRHP, TFCP and GBPRSP). Implementation is assessed at the point at which adoption ‘ends’ and a consumer has agreed to take up the referral and commence the program, and continues through to them exiting the program.

A consumer’s journey through the program is anticipated to follow the below path:

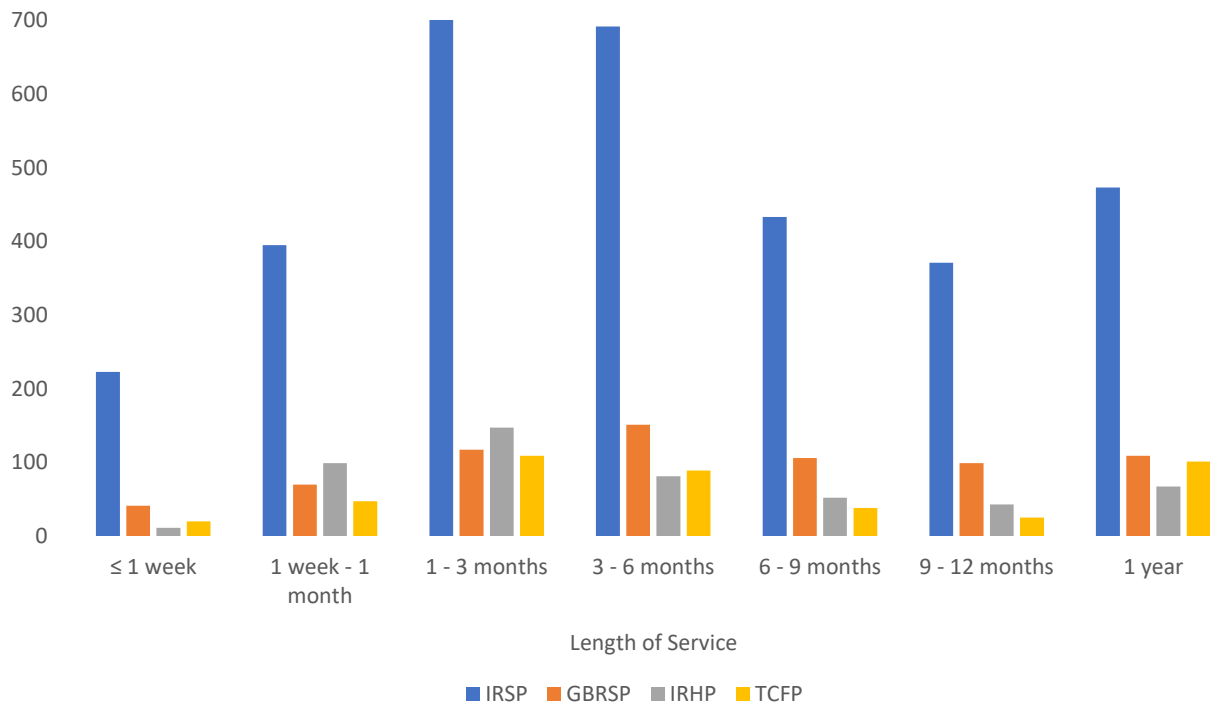
- i. Taking up of referral and engagement in program
- ii. Recovery planning (within first 2 weeks)
  - a. Goal setting
  - b. Identify progress review points
  - c. Exit planning
  - d. Utilising evidence-based recovery assessment tools
- iii. Phase 1 (up to 3 months)
- iv. Phase 2 (up to 9 months)
- v. Exiting/Transitioning

From the contact hours per consumer and length of time that consumers stay on the programmes (Figures 9 & 10) reported in the NGOE NBEDS data alongside the qualitative data, it was assessed that there is considerable variability in implementation of the MH CSS program both across the different NGOs and within the NGOs resulting in inconsistent service delivery, consumer journey experiences, and recovery outcomes.

**Figure 9: Length of service 2019-2020**



**Figure 10: Length of service 2020-2021**



While there appears to be an increase in the proportion of consumers who continue to access the programmes after one month from 2019-20 to 2020-21 (77-82%), 18% of consumers do not continue with the programmes beyond this time. Some of the reasons for this can be attributed to the issues raised in *Adoption* but others are identified and discussed below.

As outlined in *Reach*, the Individual Recovery Support Programs had targets attributed to the number of contact hours per consumer (76hours) that was based on 3 hours per week for the intensive and 1 hour per week for the non-intensive phases. The data show that in 2019-20, the average number of contact hours per consumer was 34hrs, with no one programme meeting the target (range 8-62 hrs). The average number of hours remained at 34 in 2020-21, but there were some ( $n=3$ ) who met the target, with the range moving from 8-82 hours per consumer. It is difficult to extrapolate much from these aggregated data given the variability in length of stay on the programme, for example, but the collection of individual level data would enable a more thorough analysis. The qualitative data below provide further insight.

## Program Delivery

### *Consumer capacity to engage*

There is substantial variation in the complexity and needs of the consumers who adopt the MH CSS programs, and this impacts their taking up of a referral, and also the delivery of service. Variations in consumer mental health concerns range from lacking work and social supports, experiencing ongoing substance use issues, financial distress, homelessness, criminal history, undereducation, suicidality and physical health comorbidities: “I am socially isolated and nothing makes the black dog happier than social isolation and not having a job, things like that.” (F, 55-64yrs, IRSP, consumer), “I actually dropped out of school in year nine because that’s sort of when things got to the worst. I sort of just reverted into a very low functioning state. I never really left my room for four years.” (M, 18-24yrs, IRSP, consumer), “Oh yeah. Some things happened to me in my life, before I came down here and really affected me mentally... I tried to take my life twice... I had a couple of cracks at it and got it wrong.” (M, 55-64yrs, IRSP, consumer). There are examples of staff

having to attend to major issues or concerns of the consumer's prior to commencing psychosocial support including addressing housing, access to food or financial support. In addition, these complexities can also prevent a consumer who meets criteria for the program from engaging.

### *Recovery planning*

It was assessed that there is variation in the implementation of Individual Recovery Plans (IRPs) for the consumers across NGOs and within NGOs. The function of an IRP is to detail a consumer's recovery goals, it is to be reviewed at regular intervals and be a collaborative plan incorporating clinical care teams and others (as appropriate). Contractually, the IRPs are required to be in place within two weeks of the consumer commencing supports.

Whilst some consumers could clearly speak to the existence of their IRPs others reported that they had not developed such a plan with their support worker. The majority of consumers who could refer to their IRPs gave positive feedback of the use and function of the plan. Examples included: "I think the recovery plan was, it was mostly social stuff. So me getting out of the house, being more independent from my mum. I think it was also stuff like, doing more bonding stuff with [friend]. Because I had a bad attachment problem with him. I think it was mostly just independence and that sort of stuff." (F, 18-24yrs, IRSP, consumer), "Yes. So we have like our little plan of what are steps to get better are, which is mainly just finding those things." (M, 18-24yrs, multiple programs, consumer)

There was little evidence that IRPs were being developed in line with the contract criteria and in place within two weeks of the consumer commencing supports. There were a range of reasons given for this including consumer complexity and capacity to complete plans, and staff not being adequately trained or bought into the process of developing IRPs collaboratively with consumers. Consumers reported, "No. I did hear that you've been approved and everything and they came - somebody from [NGO] came out with sign-ups, a few paperworks and asked me what days do I need. I said I need Monday, Wednesday and Friday to pick up tablets. So then we just worked out the shifts around those days." (F, 35-44yrs, multiple groups, consumer), and another stated, "Definitely not as formalised, there was nothing formal about a treatment or recovery plan, nothing like that. It was the [NGO] got a hold of me, they told me about [NGO], it said "Well that could be good for you...basically, and that was..." (M, 45-54yrs, GBPRSP, consumer), and staff also noted they were not developing the IRPs, "But as a support worker, I don't sit down with them and – oh, sometimes we do. We have those [IRPs] that we're supposed to go through. But in my experience, I tend to find they usually have psychologists and all those sort of things." (F, IRSP, support worker), "So it was agreed a few weeks ago that there wasn't any goals, we'd done some goal work, some value work, she didn't identify anything that she wanted my support with." (F, GBPRSP, support worker)

Of the consumers who did have IRPs in place, it was not frequently reported that they were reviewed at regular intervals throughout the consumer journey. It was most often reported by consumers that an IRP was developed at the early stage of their supports and not collaboratively reviewed again by the consumer and their support worker. An observed effect of not reviewing the IRPs throughout a consumer's supports was that they were not able to identify the progress they had made through the program. Consumers gave examples, "I don't know. I forgot what goals I made or I probably didn't achieve any of them." (M, 65+yrs, IRSP, consumer), and another noted, "It's very hard for people to remember things. You know how we say the goals that we want to have? So [Support worker] has got a copy of those. I don't have a copy of those. Maybe, which ones do you want to target first? So you know where you're going. And then a bit of a timeline or along the way, like milestones. 'Let's review. Let's evaluate how you're going. How do you feel? Are you feeling more well?' One out of 10 or something, like a care plan." (F, 55-64yrs, IRSP, consumer) and another

consumer noted, “But it wasn't like they didn't put, like they wrote a recovery plan, but none of the workers really stuck to it or came back to it. Like it was kind of just, oh, there's this protocol we have to follow, so let's just do some paperwork and then do whatever we want.” (F, 18-24yrs, IRSP, consumer)

### *Phase 1 (up to 3mths) and Phase 2 (up to 9mths)*

A common response from consumers and staff across the programs is that few of the consumers are serviced in line with the contract criteria of a higher intensity recovery support phase (up to 3 months) followed by a lower intensity recovery support phase (up to 9 months). Majority of the consumers who stay the length of the program will interact with their support worker on a weekly or fortnightly basis for approximately an hour or two at a time. This is reported as being due to support worker capacity, scheduling and resourcing issues and not often reported as being linked to consumer capacity or need as is intended. Consumers stated: “The support lady that I was connected with had some health issues and then her daughter had some health issues so support was sporadic and they didn't always have someone.” (F, 55-64yrs, GBPRSP, consumer), “We've caught up a couple of times on a Friday afternoon because that's when I finish work. But I think she's a bit snowed under at the moment” (M, 35-44yrs, IRHP, consumer), “Yeah, once a fortnight or once a week.” (M, 45-54yrs, TCFP, consumer). “No, still once a week...unfortunately, I would have liked to have more time...more with her but that was not possible” (Transgender F, 65+yrs, multiple programs, consumer), “Not so much that I'm not a priority. It's just the amount of clients that the service itself has gotten compared to the amount of workers is not a very fair balance at the moment. So a lot of people are beginning to miss out because the workload is getting too intense. They've gone, I think a lot of them are over capacity at the moment trying their best, but it does sometimes feel like, you're not a priority or you're missing out on things because of other people.” (F, 18-24yrs, IRSP, consumer)

The intended goal of the two-phase approach is to prioritise the consumer's recovery needs and stabilise their supports (phase 1) in order to address longer term recovery goals, develop and utilise psychosocial skills and increase community support networks (phase 2). There is little evidence across the NGOs that this aspect of the MH CSS program is being implemented consistently for consumers as is contracted. Staff report :“Yes. It's too many and I can't have the amount of contact that I want with the clients because of that...It's hard to not feel like you're letting them down when you're just working with too many clients and you can't get everything done.” (F, IRSP, support worker), “It's that for what we're being asked to do the level of funding and the amount of staff we can hire under that level of funding is ridiculous like there's no way” (F, GBPRSP, team leader)

In addition, upon transition into phase 2 it is anticipated that consumers will be referred into GBPRSP (as appropriate) during the lower intensity period. It is important to note that the GBPRSP referrals can be made at any point in a consumer's journey through the program and should be being made in line with consumer recovery goals. There is substantial variation across the NGOs as to the consumer journey of being referred into the GBPRSP. Some NGOs refer a consumer into their GBPRSP as soon as they adopt the individual program and offer the support alongside their individual program for up to 12 months, other NGOs refer at the exiting stage of their individual support extending support for up to 12 months, whilst other NGOs do not refer into GBPRSP programs at all limiting support to the individual program. This is also implemented differently depending on the same NGO offering individual and group programs, or different NGOs managing the programs. One staff member noted, “I've never been aware of that [GBPRSP programs]...not that I'm aware of. Well at least in Logan it was never talked about at all. I don't think it was - it could be here and it hasn't really been brought up. (M, IRSP, support worker), and another described how they manage the GBPRSP referrals, “So it basically runs alongside each other. They get their referrals sent through at the start and they can decide whether they want just one or one or group, and if a few weeks down the line, they're

like, "I really want to try group," they can definitely do that. They can swap and change at any given point, but it's still within that 12 months." (F, multiple programs, team leader). A clear finding throughout the evaluation was that the GBPRSP referrals are not being guided by a consumer's recovery goals, rather they are predominantly related to the delivery of the service at the NGO level.

### *Exiting the program*

It is expected that NGOs develop and routinely review comprehensive exit plans that summarise a consumer's progress (in alignment with their goals) and recommendations for ongoing supports and/or services. Exit planning is designed to incorporate strategies for relapse prevention, crisis management and re-entry into the program as required. If a consumer requires ongoing supports beyond the length of the program it is recommended that an NDIS access request should be considered.

In assessing that there was substantial variation in the development and implementation of IRPs for consumers, it followed that the process of exit planning was not routinely completed. Consumers noted, "Exiting was totally informal, like I let them know about the walking, I just said I'm not interested in doing that any more just because of what's been happening, and pretty much the only contact I've had from them, apart from coming to the games...but there was no other real interaction with them until they contacted me about this research." (M, 45-54yrs, GBPRSP, consumer), "I'm not sure. I don't think so, not yet. I don't think I have." (F, 45-54yrs, GBPRSP, consumer), "No, no. [Support worker] and [Support worker] said, "They're there as long thing as I need them..."(M, 45-54yrs, IRHP, consumer), "No. It just finished up, I think, from memory. It's a bit dodgy on that. She said, "We've got a couple more sessions left," and let me know it's coming to an end. "If you'd like to leave a review," and I was a bit grumpy that day and didn't leave a review." (Transgender female, 35-44yrs, IRSP, consumer). Some staff reported that they were not regularly preparing consumers for exiting as it was not part of their roles, "That's probably more a question of someone who's been in the role for a couple of years" (M, GBPRSP, support worker), and one staff member noted that consumers were simply taken off their roster when the program length had been met, rather than them being managed through an exit or transition plan (F, IRSP, support worker).

It was assessed that for the consumers who did have an established IRP, they benefited from an openly communicated and clear exit or transition plan in the lead up to their supports ending. Consumers noted, "Yeah. She prepared me for it, because leading up to it, the two appointments that I had previous to the last one, we were talking about it and stuff." (F, 35-44yrs, multiple programs, consumer), "That's right, they tell you right at the start so that you know straight away that it's not going to be forever, but they'll do everything in their power to help support and keep you going...Enough time for them to put you into any other avenues that you might need to keep the support going, if you want it." (M, 35-44yrs, TCFP, consumer), and one staff member explained the process, "People I work with, I always, you know, like there's a couple coming up to their 12 months now, I will be saying, like I've been saying for the last couple of months, you know, we need to transition you out in 12 months. We need to start finishing off what we're working on. We're looking at other services if they're not going with the NDIS or we're still waiting or whatever is happening..." (F, IRSP, support worker)

## **Barriers and Facilitators to Program Implementation**

### *NGO staff*

It was assessed that NGO staff play a crucial role in the implementation of the MH CSS program and can act as barriers or facilitators to the recovery journey for consumers.

Throughout the evaluation it became clear that there were common facilitators related to the NGO staff that positively impacted the recovery journey for consumers. These included NGO staff being and receiving adequate training, displaying person-centred characteristics towards consumers, having broader connections to community services for onward referrals and the contribution of peer support workers (as appropriate and available).

### *NGO staff adequately trained*

Adequate training is a clear facilitator to the delivery of the MH CSS programs and observed recovery outcomes for the consumers. Consumers noted, “Not many people go into too much detail, but if someone's bringing up something really intense, like they're very good at, as opposed to just saying, shut up, stop talking about it. They're very good at like distracting, changing the conversation, talking about card games or talking about the food. They're very good at navigating it and then usually talk to that person on their own.” (F, 65+yrs, IRSP, consumer), “[B]ut being better educated and having the opportunity to further their own knowledge is really helpful.” (F, 18-24yrs, IRSP, consumer), and staff also explained the importance of their training and experience, “As you'd appreciate, some of our guys are very severe and we've got to be, how can I say it, be prepared because you don't want to trigger them and you don't want to say the wrong thing. So it's not as easy as just rocking up. Do you know what I mean? There's a lot of preparation beforehand, even in your own mental health.” (M, IRSP, NGO staff), “We call ourselves recovery workers. I hand-on-heart believe that's true. We are recovery workers, not just support workers. It's a skill base that not many people even have.” (M, IRSP, NGO staff), “Nearly everybody in our team has got degrees. I've got a diploma, I've got 15 years' experience. So we've got a lot of depth in our team. We've got a great team and I've been around a long time. It's probably the best team I've worked for, to be honest.” (M, IRSP, NGO staff). An important part of working in the MH CSS is ongoing training and one staff member outlined the various training opportunities available to them to enhance their skills, “Since February I think I've been to six or seven different types of training. And you know, some of that like we did our suicide awareness training, but we did it with an Aboriginal group so it was really, it was fantastic, because I could then throw it back to those indigenous clients that I have and work with them in such a better way...And yeah, so anything that we want to do, the company will pay for, you know, pretty much anything that we want. And then we are also encouraged to do anything...And they are so flexible with it.” (F, IRSP, NGO staff)

### *Person-centred characteristics (empathetic, reliable, non-judgemental, trusting)*

There were consistent NGO staff characteristics that were identified by both consumers and staff that facilitate relationship and rapport building and support recovery outcomes for consumers. At the core they were focused around staff taking a person-centred approach to consumers. Consumers described, “I think how easy they are to talk to and they get things out of you that you don't want to talk about.” (F, 65+yrs, IRHP, consumer), “An understanding and not to be shocked about what you just said. She would never do that, she's very understanding.” (F, 65+yrs, IRSP, consumer), “I guess to be able to trust – I was noticing because I have this big thing, just my personal thing just to share with you, I have this thing about asking for help outside of my friends and my family, so trusting other people in, and I never used to, you know.” (F, 55-64yrs, IRSP, consumer), “[The support workers] always look at you when they're talking, not, you know, I'm over here and they're over there, but they sit and talk to you like you're a human being.” (F, 65+yrs, IRHP, consumer). And staff noted, “So there's a real skill in being able to allow that space and able to listen without judgement and be able to encourage at the right times and not make someone feel like a baby. So it's a developed skill, yeah. You can't just walk off the street and do these jobs.” (M, IRSP, NGO staff)

### *Community connectedness*

Staff having broader connections to community services was identified as an important facilitator in delivering the programs and supporting recovery outcomes for consumers. Consumers gave examples, “But I don't know where I would've been if it wasn't for those two... I was looking at being homeless, estranged from my family...He helped me get the housing, and that is a hurdle... And so he was able to navigate a lot of the housing stuff that could have led to me getting so fed up or downhearted or disappointed.” (M, 45-54yrs, IRHP, consumer), “[Support worker's] great because...like I don't need support coming to appointments, just the psychiatrist appointment, they can be a bit confusing and sometimes like I just tune out and then we caught up the next day and I was like “What did he say in the last 15 minutes?”, and she just described it and I was like “Oh, thank Christ”.” (M, 18-24yrs, multiple programs, consumer)

One staff member described her approach, “We'll certainly be part of the open and ongoing communication with the treatment team and that's made very clear at the start when we're talking about consent and talking about our role that obviously we're a mental health program. We're separate to the HHS. But however we work in conjunction with them in providing support. That's pretty open and clear to the participants.” (M, IRSP, NGO staff)

### *Peer support workers*

There was clear benefit to incorporating peer support workers in the programs with consumers noting, “I don't know. Some people can... It's hard to know what someone's feeling unless you've felt it yourself, and some people don't even try to understand, because they haven't felt it. And I've met a lot of people like it that I've had to deal with, and it makes me feel like, “How can you relate to me at all?” They tell me something from a text book without any real experience.” (M, 25-34yrs, IRSP, consumer), “But it's been good coming here because also they've got lived experiences and stuff. Because I know it's weird, it's like, what I have is no different from anybody else, or anybody normal, it's just different. It's nice to be able to talk to people who have the same thing and try and understand what I have because to me it's just normal stuff because I hide everything.” (F, 45-54yrs, GBPRSP, consumer)

And staff described the benefits of their lived experience, “...I explain that we are all lived experience. And then you just see that all of a sudden they're not shaking, they're not overwhelmed. And it's like oh finally someone who gets me, because I think in a clinical role you've got to be stone faced a little bit. Not show the emotion.” (F, GBPRSP, NGO staff), “And the whole premise of peer work is that other people with mental illness – well the theory is that other people with mental illness feel more comfortable working with someone else who's had a similar struggle with mental health as they have had and that gives them a sense of connection and safety and so forth and empathy or whatever.” (F, multiple programs, NGO staff)

In evaluating the implementation of the MH CSS program across the NGOs it was found that there were common barriers related to the NGO staff that negatively impacted the recovery journey for consumers. These included inconsistent staff/turnover, inadequate training, staff resourcing and management of consumer-staff boundaries.

### *Inconsistent staff/turnover*

Where it was assessed that there was a high turnover of staff, or that the support workers were inconsistent in their supports and availability, consumers noted the negative impact this had on their experience in the program: “She'd make appointments, and then she wouldn't show...I just felt like...She wasn't doing anything for me. She just... She was just there for her job.” (F, 55-64yrs, IRSP, consumer), “...And I think if you have

too many people, like as in case workers, it's not consistent, and it can fuck with your mental health." (F, 45-54yrs, IRHP, consumer), "No one day was different, but to see the same person on one day but the other day they kept changing? It's hard to get someone to stay. I don't know why they change them, but they change them." (M, 55-64yrs, IRSP, consumer), "Got about 10...Yeah on a Thursday they keep changing...Yeah last Thursday has been the same bloke. I'd rather one person, but they seem to be changed around." (M, 55-64yrs, IRSP, consumer), "Yeah, and again because there's been no real relationship building I guess with [NGO staff], especially with staff chopping and changing, [NGO] hasn't helped either, so I've almost felt I've been left to my own devices so to speak" (M, 45-54yrs, GBPRSP, consumer)

Staff also spoke to the effect of delivering inconsistent support, "I'm really trying to think because, well, as a support worker again, we sort of get shafted at that part, I guess. There's been some consumers I have had a chance to say, "See you later. Best of luck. I'll be thinking about you" and others are just off your roster and that's it and you won't find out unless you go and speak to them." (F, IRSP, NGO staff), "Yeah, and I just find from past experience when you've maybe done a client reshuffle and changed workers, if that wasn't to happen and the new worker just made contact with them, then, "Hey, your old person is gone. It's me now", you've got a much higher risk of people disengaging from the service and not being happy." (F, IRSP, NGO staff)

### *Inadequate training*

There were occasions where consumers could identify that staff were not adequately trained or connected to their roles and this influenced their experience on the program and had potential to impact their recovery outcomes. Consumers gave examples, "If they - if I walked here on the first day and I just felt as though, "Oh my God, this place isn't even being run properly or who have they got?", yeah, there's lots of little things, like, those first initial things. If they're there you can't get past them. You need to have that professionalism, that good body language, that good rapport to be able to work on the issues. Because if you don't that you're not going to, yeah, you're not going to have that respect for them." (F, 35-44yrs, IRSP, consumer), "She wasn't doing anything for me. She just... She was just there for her job." (F, 55-64yrs, IRSP, consumer), "I guess I'm probably more educated a little bit...Whereas when the support worker kind of, the fellow he sort of gave me the goal plan and I guess initially I was okay is was like a tick and flick thing that had to be done...But I guess the forms are more like tick and flick rather than and I guess that was something that he didn't see the value in sometimes." (M, 35-44yrs, TCFP, consumer)

There were examples given by staff that indicated they were not adequately trained in the implementation of IRPs, "Yeah, so we just file it away pretty much and then re-evaluate it at a date that we sort of put down that we think is sort of – that is a really sort of goal then to sort of look at it. But yeah, I do these but then once again they sort of get lost, and I don't know if that's just because it's me..." (F, TCFP, NGO staff), and they identified areas for further skill development required to support consumers with severe and persistent mental illness, "I think probably more access to training and professional development would be key as well, because we work with [a] person that had a diagnosis of autism, I'd never worked with anybody with autism before. I haven't worked a heap with people... so it would be good to get a little bit of training on those contributing factors. And of course always around best practise and trauma informed. We do get access to a bit of training around trauma informed practise and stuff, but there can't be too much of that. I think that's always going to be useful for people to understand people's behaviours. And I think the more you understand people's behaviours, the less you find it frustrating and the less burnout you're likely to get" (F, GBPRSP, NGO staff)

### *Staff resourcing*

Consumers often noted that their support workers were extremely busy and under-resourced, which was identified as a barrier to receiving adequate supports: “But [NGO], I mean they have a hectic schedule too so they weren’t, you know, able to drop things when you needed to...Or if you made a booking, it would get cancelled because they have to prioritise somebody getting out of jail.” (M, 45-54yrs, TCFP, consumer), “the support lady that I was connected with had some health issues and then her daughter had some health issues so support was sporadic and they didn't always have someone.” (F, 55-64yrs, GBPRSP, consumer), “All I can say is they’re really good and they’re probably if anything a little bit understaffed, like their client load. You could tell when she’s slumped and when she’s not.” (M, 35-44yrs, IRHP, consumer). One staff noted that a typical day for them was “[i]nsanely busy” (F, IRSP, NGO staff). An important finding through the evaluation was the incongruity between the majority of NGO’s not meeting targets and the consumer’s and support workers regularly reporting they do not have enough time together to address the consumer’s psychosocial needs. A review of the targets/resourcing is required to address the incongruency between target numbers and capacity to support the needs of the consumer.

### *Unhealthy staff-consumer boundaries*

An integral part of the support worker role is establishing and managing relationship boundaries with the consumer so that they are not negatively impacted by the relationship both throughout and upon exiting the program. Consumers gave examples that spoke to when boundaries were not appropriately managed, “There was a situation where we were talking about my parents, and then he started talking about his parents. And then he was talking about his Mum up in heaven, gave her the finger and all that. And I was like, "Whoa, you’ve got more issues than me, mate."...I don't mind listening, I like getting perspective on stuff like, but it just went a bit too far. I'm like, "Whoa, I don't think you've really healed from that." (M, 25-34yrs, IRSP, consumer), “As I said before I couldn't speak any more highly of [Support worker], and I miss her so much. I actually want her back again. If you ever want to do me a favour, get her back for me.” (M, 55-64yrs, IRSP, consumer), “I hope they'd be able to come and see me indefinitely, but I understand that they'll have constraints and I'm sure they would like to come and see me indefinitely as well. I'm sure.” (M, 45-54yrs, IRHP, consumer)

Examples were given by staff that suggested they had not adequately managed the boundaries of the consumer-staff relationships, “I would say, any of my guys that don’t want to be exited from me, it’s more so the fact that they just enjoy seeing me as the individual.” (F, IRSP, NGO staff), “I told her last week that I was going to be resigning and she burst out in crying and she was like “Why you people always come to my life and always walk away?” And it actually broke me.” (M, multiple programs, NGO staff)

### **Summary**

It was assessed that there was substantial variation both across and within NGOs in how the MH CSS programs are being implemented. This variability was evident in the NGOE NBEDS data (particularly contact hours), in how IRPs are being implemented (in some cases not at all), in how the consumers understand the function of the program, in how Phase 1 and Phase 2 are being delivered and in how consumers are exited/transition from the individual program into either GBPRSP or alternate supports. A major implication of the variability in implementation of MH CSS programs across NGOs is the recovery outcomes and long-term maintenance for consumers. The key findings of the evaluation are outlined below:

1. Consumer capacity and readiness impacts the implementation of programs and the taking up of referrals. Through the evaluation it became clear that consumer capacity directly effects delivery of

psychosocial supports as critical needs must be addressed prior to attending to the psychosocial needs of consumers. Examples include consumers without secure housing or those experiencing mental health crisis (suicidality, harmful substance use, domestic violence). Support workers are required to address these needs prior to engaging in the MH CSS as is intended and this directly impacts on an adequate length of service for a consumer.

2. Individual Recovery Planning is not being implemented consistently across or within NGOs. Consumers could rarely identify their goals, progress points or exhibit an awareness of exit planning. There are a number of flow-on effects for the consumers where IRPs are not developed and implemented including improved mental health outcomes and an understanding of the overall function of the program.
3. Implementation of the two-phased approach to delivery of the programs, in line with consumer recovery needs, was not clearly identified across NGOs. The evaluation also identified incongruency between NGOs not meeting targets (relating to contact hours and referrals) but staff and consumers reporting time constraints impacting their ability to address the needs of the consumer. It was identified that there are staff resourcing issues across NGOs.
4. NGO staff are integral to facilitating the successful implementation of MH CSS programs particularly where they are adequately trained, exhibit person-centred qualities, have strong community connections and networks and display lived experience of mental health (peer workers).
5. NGO staff can become barriers to the implementation of MH CSS programs particularly where there is inconsistent/high turnover of staff, inadequate training, problems with staff resourcing, and unhealthy staff to consumer relationship boundaries.

## Implementation Recommendations

The below recommendations are a summary of what is assessed to be best practice in implementing the MH CSS programs:

### *Person-centred approach*

Research indicates that the experience of living with severe and persistent mental illness is fundamentally disempowering (Stevenson, 2000), and the medical model of clinical care can add to an individual's experience of disempowerment (McKay et al., 2012). A person-centred approach addressing the psychosocial needs of the individual increases the individual's right to autonomy, supporting identification of their values and achievement of goals (Barker, 2001). Despite the growing recognition of person-centred approaches as essential components of recovery-oriented practice, research indicates that there is variability in the uptake of this approach in mental health care practices (Smith & Williams, 2016) and this has been found through the current evaluation.

Given the variability in implementation of the MH CSS programs across and within NGOs it is recommended that a person-centred approach be taken by all NGOs in order to elicit positive outcomes for the consumer. This approach should incorporate the consumers' needs at the centre of the program ensuring they are treated as a person first. The supports should focus on achieving the consumer's goals considering their life experience, age, gender, and cultural identity. The service should be delivered flexibly and focus on the strengths of the consumer. The national framework for recovery-oriented mental health services acts as a guide for practitioners and providers in imbedding a person-centred approach into everyday practice and is a recommended resource for all service providers (Australian Health Ministers' Advisory Council, 2013).

Ensuring a person-centred approach will incorporate the needs of consumers across age groups, genders, sexuality, and cultural backgrounds. By taking a person-centred approach and utilising a flexible delivery model the needs of the consumers are kept at the forefront irrespective of their demographics. It is recommended that the person-centred model be introduced at the point of induction for new staff and consistently reviewed by NGOs as an underlying factor and requirement in delivering the MH CSS programs.

One consumer summarised the approach: “I think because she adapted to me. She did really like suss me out, sort of thing. After the first meeting I think, she knew that she couldn’t push me too far or she couldn’t ask me too many questions. She just moulded her support service around what I required at the time, so she would ask me a lot of questions and stuff and just say, “What have you been doing today?” At the start, I wasn’t even showering regularly, I wasn’t brushing my hair, I wasn’t looking after myself, I wasn’t even changing clothes half the time. I would be the same clothes and sleep in them for days. She was encouraging me and she got me to buy a diary to write down daily how I was feeling. She got me to try.” (F, 35-44yrs, GBPRSP, consumer)

### *Individual Recovery Planning*

Mental health policy literature supports the incorporation of recovery-oriented processes and planning in delivery of mental health services (Higgins et al., 2012). Recovery-oriented action planning supports individuals to identify goals, tools and skills that will promote and support their recovery and maintain wellness (Winsper et al., 2020). Recovery planning is a collaborative process involving both consumers and support workers and is underpinned by core elements including hope (whereby the consumer is supported in believing they can fulfil their goals and get well) responsibility (where the consumer takes personal responsibility for their recovery goals), psychoeducation (where the consumer is supported in understanding their mental health triggers and coping strategies) and support (where the consumer actively engages in the supports they receive) . The application of recovery-oriented principles promotes recovery across a consumers life including their clinical mental health concerns as well as personal, social and functional outcomes (Lloyd et al., 2008).

It was assessed that there was considerable variation in the development and implementation of IRPs across NGOs. The IRPs play an integral role in supporting recovery outcomes for consumers and should be collaboratively developed in line with their needs and goals and reviewed and updated throughout the consumer’s time on the program(s). All NGOs should be implementing clear IRPs within the first few sessions with the consumer, they should follow a recovery-oriented framework and be guided by the consumer’s goals and needs. The IRPs should be regularly reviewed and updated, and consumers should play a collaborative role in the management of the plan. Consumers must be introduced to the function of the IRP in the initial stages of the program, and to the length and breadth of the service. Exit planning should occur at the start of the program as part of the IRP and should be addressed at regular intervals to ensure that, come the point of transitioning out of the program, the consumers are prepared for exiting.

### *NGO staff training and characteristics*

The NGO staff are required to be adequately trained to support consumers across the spectrum of severe and persistent mental illness concerns. Training should be guided by a recovery-oriented framework and focussed on a person-centred approach. A crucial element of support worker training is around the development, delivery and updating of the IRPs. The staff characteristics that were identified as being aligned with successful delivery of the programs included (but are not limited to) empathetic, trusting, non-

judgemental, reliable. These staff characteristics should be incorporated in NGO recruitment strategies and fostered through MH CSS program delivery.

### *Resourcing*

Given the variability in implementation of both Phase 1 and Phase 2 of the program across and within NGOs it was assessed that there are issues with resourcing across NGOs. It is recommended that there is a review of the targets and expectations placed on staff in order to deliver the program as intended and in line with consumer needs. A review of the targets and resourcing is required to address the incongruency between NGOs not meeting targets and staff's reported inability to support the needs of the consumer.

## 4.4 Maintenance

Maintenance explores whether consumers maintained the skills they learnt and developed as a result of the MH CSS programs and were able to apply them in different contexts and also whether the MH CSS programs (IRSP, GBPRSP, IRHP, TCFP) and associated policies become part of the NGO's routine practices. It is also defined by the long-term effects and behaviour change experienced by consumers during and after completion of the program (Glasgow et al., 1999).

As maintenance assesses the development of long-term skills and abilities acquired throughout the length of the program, it can be measured throughout the program as well as post consumer exit from the program, including where and how the consumer exits post-completion. The evaluation sought to measure maintenance by assessing whether consumers have learnt and attained skills that they are actively applying in their everyday life. Specifically, the assessment of maintenance occurred towards the end of Implementation until the beginning of Effectiveness. Not to be confused with Effectiveness, maintenance assessed whether consumers can function independently by the time they are due to exit the MH CSS programs. Successful maintenance would see evidence to support the program has served consumers (i.e. through learned skills; an adequate program length; gained independence) and that they have been appropriately exited (into the GBPRSP, NDIS, other services, to the community) and whether there was any need or desire for follow-up from the NGO.

### Application of developed skills

Over the course of the individual MH CSS programs (IRSP, IRHP, and TCFP), NGO support facilitators work with consumers to teach skills that will benefit them in their recovery journey. Whether this be directly or indirectly, the aim is that consumers acquire and importantly are able to apply their newly attained skills. Demonstration of these new skills is a reflection of the quality of the recovery plan, an indication of improvement and a sign of the consumer's readiness for change. For example, one consumer described development of skills as a result of the MH CSS programs below:

**Interviewee:** I've got it under control. I think the biggest aspect for me was learning how to write things down in my book and just go okay, well that's what I'm feeling, I'm not going to act on it but that's how it is.

**Facilitator:** And where did you learn that skill?

**Interviewee:** Through [my support worker], through DBT, so yeah, that was a skill that I picked up (M, 45-54yrs, multiple, consumer)

It was found that some consumers struggle to develop and apply these new skills. This could be a reflection of the consumer's capacity and readiness for change, or a reflection of the need for more training on skill development from their NGO support worker. For example, a consumer below, when asked about skills learned through their MH CSS program, could not identify any skills developed:

**Facilitator:** Is there anything from the Transition Programme that...you learned, any skills you learned, or any development you did that you still use today?

**Interviewee:** Not really. (F, 45-54yrs, TCFP, consumer)

### Exiting from MH CSS programs

When the individual MH CSS programs (IRSP, IRHP, TCFP) have come to an end (usually at 12 months duration), consumers are be exited from the program and can be transitioned into a number of places including GBPRSP, NDIS, other health services, or back into the community. This transition was found by

consumers to be a daunting time, however can also be a positive experience when exited into a new support system that suits their needs and adequately supports their continued recovery.

### *Exit into GBPRSP*

The process of exiting from an individual-based MH CSS program onto the GBPRSP had various assessments by consumers. Some consumers found it to be a positive way to exit into a less intensive form of psychosocial support. The GBPRSP was identified by participants (both consumers and NGO staff) as a way for consumers to test out their newly acquired skills in a safe and supportive environment. One consumer noted, *“It’s just another way of being around people and trying to expand my social circle with someone that ... because they’ve all got mental health problems, so someone that will understand what you’ve been through.”* (T, 35-44yrs, IRSP, consumer)

Groups also provide an opportunity for consumers to touch base and continue some support while fostering independence. One support worker described an IRSP consumer’s transition into the GBPRSP: *“She’s well enough now that she is happy to go to the weekly exercise class and I think the art group. She’s back at uni. She’s on track now, so just having that engagement twice a week in the group setting and having the peer workers there to just check in and have a general chat is enough for her now.”* (F, IRSP, support worker)

It is important to note that findings from the evaluation showed that in delivery, not all individual-based MH CSS programs offered transition into the GBPRSP after or in addition to the individual programs. Findings indicated that across the state, all NGOs delivering the TCFP were under the assumption they were not allowed to refer their consumers into the GBPRSP.

### *Exit into NDIS*

Findings showed that some consumers exit into NDIS support after the completion of the MH CSS programs. It was reported that NDIS offers a different level of support for consumers; they indicated this type of support works well when they are well enough mentally to begin work on other areas of recovery (i.e., physical recovery, receiving psychological support elsewhere). One consumer noted, *“NDIS sort of gives me that flexibility to be able to do a little bit more. And I get treatment on my shoulders and they pick me up on a regular [basis]... every Tuesday we are there. They are now getting me onto nutritious meals. So since being here I haven’t, I’ve sort of let my nutritional value go down sort of thing, so there’s no fruit and vegetables and that sort of thing so [they are helping me with that].”* (M, 45-54yrs, TCFP, consumer)

Consumers note that when transitioning from a MH CSS program onto NDIS support, a facilitator of a smooth transition is a warm handover from the MH CSS support workers, so as not to remove all support for a consumer at once whilst still getting accustomed to NDIS support.

**Facilitator:** The NDIS applications here, if they take a particular length of time, can you guys keep adding extensions and support as you need?

**Interviewee 2:** There are precedents there. So, if we’re in the middle of an application, or we’re waiting for something to come through, then we can extend our time, just to ensure that we’re not dropping off of the face of the planet and leaving [consumer] by herself. The idea is to be able to hand her [over] warmly to someone, and hopefully have some support workers that she likes; and NDIS is user choice, so that’s fantastic [for her].” (Support worker (interviewee 2) sitting in on the interview talking about the consumer) (F, 55-64yrs, IRSP, consumer)

Some consumers indicated that transitioning from MH CSS programs onto NDIS support is very difficult to navigate. It was also assessed that once consumers do transition onto NDIS support, the psychosocial support they are meant to receive (and which is necessary for continued recovery) can fall short. One consumer describes the difficult transition experience: “Well, I knew [the MH CSS support] was going to come to an end because I was granted NDIS access. I felt until I had NDIS actually happening I would have liked to have continued on with [NGO] but I know everyone's got their rules. But that transition into NDIS was really, really hard.” (F, 55-65yrs, GBPRSP, consumer)

It was found that a barrier to the success of NDIS support are inconsistent staff, as described by one consumer: “I guess everyone is different. But with me... I'm the type of person when I meet someone and I develop a rapport with them, it's really important that I keep seeing the same person, because I have that rapport and that confidence and that sense of, “I know this person, this person knows me”, and it just makes me feel more comfortable. I get really anxious when I have to keep swapping people and explaining everything to new people and having to get to know new people. And I just think it helps me, mentally and physically, when you have someone that you have that great rapport with.” (F, 35-44yrs, IRSP, consumer)

It was also described by consumers that NDIS support focusses on functional recovery rather than psychosocial recovery. Literature supports the notion that NDIS mental health recovery services can “perpetuate maintenance and dependence rather than recovery and independence” (Rosenberg et al., 2019). As one consumer describes it, “Last year the first part of NDIS was just like getting things together like had to get a new wheelie walker and all that stuff. It's just slow progress of getting these things that I need to do everything.” (F, 35-44yrs, multiple, consumer)

### *Exit into other services*

Consumers described being exited onto a range of different services following finishing the MH CSS program. Following participation in the MH CSS programs, ‘stepping down’ a consumers’ support by transitioning them into another form of support is a of tapering them down slowly from the intense psychosocial support offered by the NGO. Having another service to exit consumers into can positively support consumers rather than exiting them back into the community without any supports. Consumers transition into a range of different services and supports, including disability, aged care, community-groups, etc. For example, one consumer when asked about what they were doing post-exit indicated, “I just signed up today with Blue Care, so I've got an aged care package.” (T, 65+yrs, multiple, consumer). Unfortunately, the services that consumers exit to might not have any form of psychosocial/recovery focus. Despite having functional purpose, psychological recovery may become neglected. One consumer reported “She linked me in with St John’s transport to get to appointments...[and] three months of...home care, someone that comes in to help with vacuuming and cleaning the bathroom. And so those supports that she linked me in with have provided something ongoing, yeah.” (F, 55-65, IRSP, consumer)

### *Exit into the community*

Exiting into the community with an established service that works with likeminded people means consumers have the option to continue to socialise and apply their recently developed skills. One consumer on this journey stated, “We’ve got a men’s group that we’ve just started. We’ve got a collaboration with a Rotary Club here, where the men can go to the shed.” (F, multiple, support worker). However, exiting into the community with no support, can be troubling. Some consumers will exit into nothing and this is to the detriment of the consumer’s ongoing recovery. For example, in one interview a consumer explained this difficult process:

- Facilitator:** So, you mentioned that you've only got them for another couple of months, how's that make you feel?
- Interviewee:** Sad but we've had a good time and, you know, it's time for me to move on I think again.
- Facilitator:** And what have you got in place for when you [finish up?]
- Interviewee:** Nothing. (F, 65+yrs, IRHP, consumer)

## Follow-up post-program

Consumers and staff alike might find following up after the program to be a beneficial part of the consumers' exit and be purposeful for their ongoing recovery. Consumers enjoy having the ability to reach out and keep their support worker updated on their lives, recovery and achievement of goals post-exit. "I should catch up with Steve actually, I feel bad that I've disconnected with him." (M, 35-44yrs, IRHP, consumer) and another noted, "Sometimes they just want to let you know how well things are going in their life." (F, IRSP, support worker). This is thought to be a warm way to exit consumers as a continuation of support that slowly phases out and fosters independence. As opposed to cutting all communication which could be harmful to their ongoing recovery. One worker summarised it, "We would follow up and check and see how things are going. That's just part and parcel because it just doesn't seem right to just say 'okay, see you.'" (F, GBRSP, support worker). A consumer reported the importance of this, "Well, the fact that they come and see me, it's maintenance...You know, everything about recovery and with mental health to a certain degree, is maintenance. It's one thing to get somebody there, but if they've got nothing after that..." (M, 45-54yrs, IRHP, consumer)

Keeping in touch with the consumers can also ensure that consumers have been exited appropriately and have the appropriate support around them. "Yeah, being able to touch in to the people when that sort of trigger stressor happens [as opposed] to letting it snowball a bit, and you don't necessarily want them to get into the community health team [at the hospital] because they might not need that, but they might need different kinds of support." (F, IRSP, support worker). If not executed appropriately, following up with consumers after exiting the program has the potential to lead to continued dependence. Keeping a time limit on the continued support can be an effective way of managing this while also encouraging independence. Appropriately trained support workers will be able to effectively manage this. "We don't really have any contact after the 12 months unless they're re-referred back to us, because hopefully we have put some further ongoing support in place after those 12 months." (F, IRSP, support worker). However, not all NGOs are providing a follow-up service with consumers. With some support workers saying that they are focusing their attention on new consumers rather than maintaining that connection. "But no, I don't follow up. I'm too busy. I haven't got the time." (M, IRSP, support worker)

## Independence

Over the course of the 12-month program, consumers have hopefully learnt skills and are equipped at applying them. Likewise, and in concert with skill acquisition, consumers should have developed independence. Self-rated independence is a sign of recovery and a measure of the effectiveness of the recovery plan (recovery oriented) and speaks to a consumers' readiness for change. For consumers who have gained independence, it was assessed that they have progressed since starting and that the MH CSS has been successful in helping them recover. "[My support worker has] given me confidence...To be able to do things by myself, without my mum." (F, 55-64yrs, IRSP, consumer) and another consumer stated, "Yeah, I'm a lot more independent now." (M, 25-34yrs, IRSP, consumer)

A key facilitator in achieving this is staff having adequate training and understanding how to create a recovery plan that is person-centred and fosters independence. One staff noted, “I guess the different support workers, they were all good in their support and helping me in terms of getting set up. It was just more the next steps that I had to sort of do myself in a sense, they couldn’t...do it for me I had to...do it myself in a way.” (M, 35-44yrs, TCFP, consumer) and another said, “And if you've got a good working alliance with somebody you're always transparently, genuinely asking, "Do I need to be here?" So, I encourage my team to talk to people and say, at the beginning that, "My job is to walk with you not to be in front or behind." And that every step that we [take], ideally, I'm moving away from where you are. So at every point that we meet, we should be more and more, not attached, but further away. So idealistically, we'll go from intensive support which to me is like 14 hours a week. And then that'll drop back and drop back and drop back until we're in the transition to exit phase, where there is a social network, there's a support network.” (M, TCFP, support worker).

However, not all consumers have been able to achieve independence over the course of the program: “I miss [my support worker] so much. I actually want her back again.” (M, 55-64yrs, IRSP, consumer) “I'm dreading [leaving the service].” (T, 65+yrs, multiple, consumer). For consumers who have not gained independence and have, in fact, maintained dependence, it can be surmised there are several barriers in place. These include but are not limited to consumer capacity and readiness for change, the service has not been long enough, they may still be working on functional improvement before focusing all attention on psychological improvement, the service wasn't recovery oriented enough etc. Another barrier to independence and general improvement could be that after exiting, consumers have not been linked in with other clinical supports which may be beneficial to their mental health such as psychologists. Without other sufficient supports in place this may leave dependent consumers lost about where to go from there.

### Length of program

The length of the program according to the MH CSS contract criteria state that the program is to run for up to 12 months (with the GBPRSP following on from, or running parallel to, the individual program). In terms of whether this is an appropriate length of time or not, some consumers said it was a good amount of time. When this was the case, facilitating factors were the consumers' capacity and readiness for change, external supports, have already established stable external lives/supports, and 'functional' components such as housing and finances: “I was ready to exit yeah.” (M, 25-34yrs, IRSP, consumer) “I think 12 months was adequate because now, I'm moving on hopefully to some new things that Richmond couldn't offer, like group stuff.” (F, 55-64yrs, IRSP, consumer) “Hopefully, before the 12 months, they're already linking with external services or friends or they might even come to the realisation, “Hey, I'm doing pretty good now. I don't need you guys anymore” and that's probably the best outcome.” (M, IRSP, support worker)

However, consumers were more likely to say that the 12-month time limit was not long enough. Some barriers that contribute to this include consumer capacity and readiness, lack of independence, poor exit plan and/or inadequate exit-place, lack of follow-up etc. Importantly, everyone's recovery takes different amounts of time and being constrained to a 12-month time limit can be harmful to their ongoing improvement. A person-centred and flexible approach is beneficial to ensuring consumers can effectively begin recovery and gain independence before eventually leaving the program. “[before the contract changed, I was there for] probably about two to three years, because it took a lot to work and a lot of setbacks in between that.” (M, 18-24yrs, IRSP, consumer)

**“Facilitator:** What amount of time would be enough for you?

**Interviewee:** Forever [laughs]. Yeah. I reckon at least a couple years. I reckon at least two years.

**Facilitator:** And is that because...this is the first time that you've opened up about mental health[?]

**Interviewee:** It would be the first time in my life except for going to my doctor who got me a psychiatrist.

**Facilitator:** Yeah. This is the first time you're coming to this. You need more than 12 months to unpack a lifetime." (M, 55-64yrs, IRSP, consumer)

"And I think that's also why it's so, shitty. That [NGO] only goes for 12 months because... obviously [some people's] recovery takes a whole lot longer and they have this amazing thing which helps them. And then when they lose it, they kind of crash again." (F, 18-24yrs, IRSP, consumer)

## Summary

The Maintenance component of the RE-AIM structure for a mental health community support service is critical to the ongoing recovery of the consumer. Barriers and facilitators have been identified to the best practice regarding Maintenance. Some major facilitators for an extremely effective maintenance include: a tailored amount of time in the program, where consumers' independence is fostered and actively apply developed skills, they are warmly exited from the program into another appropriate support with follow-up from the support workers to aid that transition.

\*Note: There needs to be specific consideration taken for the IRHP and TCFP. Given the nature of these programs and the consumers that use them, that results for Maintenance will differ. Most poignantly the length of program. However, these recommendations will be attended to more explicitly later on in the document.

## Maintenance Recommendations

The following breaks down several important factors that contribute to Maintenance, referring to relevant literature that supports our recommendations.

### *Application of developed skills*

For people with severe and persistent mental illness (SMI), a lack of basic skills (prominently social skills) is common and can have significant negative impacts on day-to-day functioning (Lyman et al., 2014). Of the three best-supported psychosocial rehabilitation strategies for SMI (social skills training (SST), cognitive behaviour therapy (CBT), cognitive remediation (CR)) SST was found to be the most empirically supported to indirectly improve social skills and quality of life, reduce stress and help with future relapse (Bellack, 2004). Therefore, developing and applying skills is an incredibly important component of consumer recovery (Lyman et al., 2014). Other important areas that have been identified in the literature as important to SMI rehabilitation and recovery include developing skills related to; understanding the role of drugs/alcohol, relationships, refusal, avoidance, self-care, money management, communication with medical personnel, sleep-hygiene, and self-help groups (Nikkel, 1994).

From the qualitative analysis it has been identified that best practice takes place when the development of skills is a collaborative process, the consumer is ready and interested in developing and applying skills, the skills are relevant and purposeful, and consumers can see a tangible purpose for acquiring said skills. When there is a safe place for consumers to test out the skills they've learned (such as a group setting). Support worker and consumer review progress throughout the 12 months and consumer is able to identify examples of those skills being put to use.

### *Exit from service*

Best practice means having a 'warm' exit (having an exit plan, ability to follow-up, to some form of support regardless of whether it is in the community, GBPRSP, NDIS, or other services. Ensuring consumers are not left in the lurch and feel as though they will have at least one, if not more, options to reach out to. There is broad literature about exiting in-patient mental health hospital facilities that can be applied to MH CSS programs with some research suggesting that "if [the] transition back to the community is not managed effectively it is likely to be detrimental to a person's mental health and recovery" (Griffiths et al., 2015) and that "when clients don't connect with resources after discharge...their overall community adjustment is poorer" (Anthony & Blanch, 1989; Lehman et al., 1994).

### *Follow-up post-program:*

Allowing open communication between consumer and support worker after exit from program. Importantly, this needs to be done with some clear expectations/guidelines (perhaps a time limit on the connection, explaining that they are welcome to share but that support workers are no longer their primary source of support, slowly phasing out frequency of connection etc.). This in turn has the ability to effectively foster independence. Ethically, support workers should strive to do no harm. Not following-up with consumers has the potential to negatively affect their mental health especially if they have exited into the community without any other support, again pointing out that the consumer's adjustment to community might be poor (Anthony & Blanch, 1989; Lehman et al., 1994).

### *Independence*

Measuring independence is an appropriate way of gauging how much a consumer has improved mentally. The literature suggests one way for consumers to gain independence and empowerment is through participation in the development of a 'treatment plan' which reflects their needs and capacity (Linhorst et al., 2002) with a person-centred approach. Research has found that effective treatment plans involve case planning, effective implementation, and reviews of said plans. Having a well-defined, staged process for case management actively reduces service dependency (Henley et al., 2021). Again, the success of this heavily relies on the consumer's readiness to change and general capacity.

To ensure independence is grown and developed over the course of the program, the service needs to be person-centred and recovery oriented. The success of this relies greatly on the consumer's capacity and readiness for change, the adequate training of support workers, and ensuring that at completion, consumers have adequate support to exit to, tailored to their needs. It takes a skilled support worker to know how to 'walk beside' the consumer on their journey and know when to lessen the supports.

### *Length of program*

The length of time needs to be flexible and person-centred in the sense that each person's recovery is an individual journey and thus requires individual and tailored lengths to suit. Throughout the evaluation, the function of completing/achieving 'functional' goals first is commonly discussed (i.e. things that need to get done before psychological recovery can be the focus of the consumer). For someone who has just come out of prison, for example, this process may take up the majority of the time in the program – housing, finances, IDs etc. An anecdotal example is after being hospitalised, first getting through the 'brain fog' is essential before being able to work on other things. If this is considered in relation to Maslow's Hierarchy of Needs, it makes sense that before being able to improve one's psychological health, functional certainties need to be in place. Although the relationship between all these variables is complex health, home, community, and purpose remain extremely important for holistic mental health recovery and this must be taken into

consideration when reflecting on lengths of time (Henwood et al., 2015; Substance Abuse Mental Health Services Administration, 2012).

## 4.5 Effectiveness

Effectiveness is related to the individual outcomes that are experienced by the consumers on the MH CSS programs. It also includes the overall effectiveness of the program processes, which have been assessed and summarised in each of the relevant parts of *Reach, Adoption, Implementation* and *Maintenance* above. This section of the evaluation will focus on the individual outcomes experienced by consumers and the various outcome measures utilised by staff to assess their recovery journeys and the effectiveness of their supports.

### Consumer recovery

Findings during data collection showed consumer hesitancy towards using words such as ‘recovery’ or ‘recovered’; a common conversation when asked about recovery is found below:

- Facilitator: What does recovery look like to you?  
Interviewee: I know I can't completely recover from schizophrenia, but I'm slowly recovering, I reckon.  
Facilitator: Yeah. And how do you know that your recovering?  
Interviewee: Well...  
Facilitator: It's hard to put into words, isn't it, it's just a feeling.  
Interviewee: That's just it. I know I'm getting there slowly.  
Facilitator: Yeah? Just a feeling.  
Interviewee: Yeah, that's it. Some days I'm not going too good, but some days I feel real good. (M, 35-44yrs, IRSP, consumer)

Instead, recovery was more easily assessed through the lens of asking consumers, ‘what are you able to do now compared with prior to engaging in the program?’ This reframing of what recovery might encompass for individual consumers yielded more tangible discussions on observed outcomes related to recovery.

### *Re-admissions*

It was observed that some consumers returned to hospital during the data collection period; whilst the true number of consumers who were readmitted is difficult to determine because it relies on NGO staff and/or consumers voluntarily sharing with the research team information about recent readmissions, our team were made aware of approximately 5-10 consumers who returned to hospital (from a total of 70 consumers interviewed). Some rural HHSs did report anecdotally fewer readmissions to the emergency department of these consumers. Currently, it is unclear how readmission data is captured at the NGO/HHS levels, which impacts the ability to determine overall effectiveness of the MH CSS programs.

### Observed outcomes

Consumers reported several different observed outcomes associated with their recovery. Responses were collated into overarching observed outcome domains and described below:

#### *Ability to recognise need for support*

A number of consumers indicated that where they used to have difficulty identifying the need for support, since engaging in the program they were able to recognise the need for access to the program: “No, I came in on my own because I wanted to find ... I was searching for a person, searching for something.” (F, 65+yrs, IRSP, consumer), “Yeah, well, that was actually a big feat for me to actually admit that myself, like admit that I needed help, like, because, there was like three or four years, where I couldn't admit it. Like it was someone

else's problem and it wasn't me, it was someone else, that was issue and not me. Then I finally admitted that it was actually me." (M, 35-44yrs, IRHP, consumer)

### *Achievement of goals*

Consumers who were well supported through the program IRP were able to identify goals they had achieved through their supports: "Well, one was decluttering. You're learning how to not clutter and hoard things. I used to be a hoarder but the last few years I haven't." (T, 65+yrs, multiple programs, consumer) and another noted, "she'll remind me, like, when I have appointments, write them down or something like that. So, I've been doing other things and slowly I've gotten to the point where I actually do write down my appointment times or I'll have my appointments in a book. And I have reminders of things that I've got to do, during the day. Like, what I have to do, at certain times during the day and like, for my medications because, at one point, I was forgetting to take my meds. And I now have an alarm set to take my medications, which I never did." (M, 35-44yrs, IRHP, consumer)

### *Functional outcomes (e.g. housing, shopping for themselves, return to work)*

One of the major outcomes identified by consumers through their experience on the program were improvements in functional outcomes. One consumer noted, "No, I've really come a long way. I can wash my hair. I mean, I know that sounds like something very simple, but I just couldn't do it. Just for the life of me, couldn't do it. I had no desire to exercise, but now, I can see that I can do that and I can come up with different ways of incorporating that." (F, 55-64yrs, IRSP, consumer). And another spoke to the improvement in their mental health, "I still have my days with the mental health stuff, it's hard. They've helped me push a little bit. [Support worker] always says to me, "you haven't given it 100%, you've given it 200%.", and I'm just like, "thank you!" So I've come a lot forward to back then. I've come a certain distance, yeah." (M, 35-44yrs, IRSP, consumer)

### *Improved relationships*

A number of consumers spoke to the outcome of improved relationships as a function of the supports they received: "However, we've got a brilliant relationship now. And it's funny because I've spoken to him about different things that I've learnt for me and he said to me the other day, he said, "Look I think I might go and get some counselling." I said, "Okay, that's good." (F, 55-64yrs, GBPRSP, consumer) and another consumer noted, "Yeah. I can talk better to my family now, because a lot of them just used to make fun of the fact that I had mental illness. And then, it was me articulating myself better for them to understand that yeah, I do go nuts sometimes but that's okay, because there's a lot more of us than you think. And then in that sense, I had more of my family members say, "Yeah, well I've got this and got that" (F, 35-44yrs, GBPRSP, consumer)

### *Increased confidence*

A tangible outcome for a number consumers of engaging in the MH CSS program was an increase in confidence. Consumers noted, "Yeah, and not to be afraid not to do things, you know, to keep going and expecting that you're going to get things done every day because that's what I want, to do things every day." (F, 55-64yrs, IRSP, consumer), "Yeah so this guy's helped me a lot with you know being able to – like lift my self-esteem up – high self-esteem. I had a very low self-esteem. There's a lot of thoughts going through my head with bipolar. Trillions and trillions like trying to process all this." (M, 25-34yrs, TCFP, consumer), "My self esteem and my confidence it's really, it's back to itself. I'm pretty confident when I come to the meetings, sorry to the groups." (F, 45-54yrs, multiple programs, consumer)

### *Medication (on/off)*

Consumers also noted that through the supports received on the program they were either able to come on or off medication as appropriate, to support the stabilisation of their mental ill-health. One consumer noted, "It's just, I guess the safest thing is me being on pills and to stay away from the people that trigger me." (M, 35-44yrs, IRSP, consumer), another noted, "Sometimes I get a little bit depressed. I'll admit that. But by keeping on the tablets, I'm okay. But I haven't got thoughts of killing myself anymore." (M, 65+yrs, GBPRSP, consumer). And finally, "Throughout this time, I've actually come off medication." (F, 35-44yrs, GBPRSP, consumer)

### *Quality of Life*

Consumers frequently reported that their overall quality of life had increased through the supports on the program. Consumers noted, "Talking to Jason is really good. Bridges has been probably one of the best things that's happened me in the last few years." (M, 35-44yrs, IRSP, consumer), "So that in itself improved my outlook on things, because I was in a pretty bad way when I was referred over to [NGO] and I admit that. So I believe that I'm a lot more stable, a lot more, I wouldn't say flexible, I don't know if that's a word that I would describe me as, but I was willing to look at things." (F, 55-64yrs, IRSP, consumer), "When I first came back I was a total wreck, so I've come a long way since then and [Support worker] has helped me tremendously." (F, 65+yrs, IRSP, consumer)

### *Survival*

One of the more profound responses by consumers of the benefit they had received in engaging in the program was that they had survived. The program clearly contributed to their capacity to navigate their mental ill-health. Consumers noted, "If I don't have it, I don't know where I'd be at." (M, 35-44yrs, IRSP, consumer), "I mean, I wouldn't have survived at all last year if I didn't have [NGO], I would've yeah, I don't know what I would've done to be honest..." (F, 45-54yrs, GBPRSP, consumer), "Well, I would've probably still been the same but worse and I think I would've tried to attempt to take my own life." (F, 35-44yrs, GBPRSP, consumer), "I'd still be homeless, and I'd probably be in jail, which I don't want to go back to." (M, 35-44yrs, IRHP, consumer).

## **Outcome measures**

Through the evaluation staff were asked if and how they measure the effectiveness of the supports they are delivering. It was assessed that there was considerable variation across and within NGOs in how they measure outcomes.

### *Observed data collected*

It was determined that across the 38 separate programmes, there were 17 different questionnaires/tools being utilised:

1. Camberwell Assessment of Need Short Appraisal Schedule (CANSAS); *n*=4
2. Recovery star; *n*=4
3. Here and Now; *n*=4
4. Mental Health Recovery Measure (RAS-DS); *n*=3
5. Living in the Community Questionnaire (LICQ); *n*=2
6. FIT - Feedback informed therapy using SRS & ORS scales; *n*=2
7. Emotional states of depression, anxiety & stress (DASS-21)
8. LSP 16 Abbreviated Life Skills Profile
9. My Better Life Plan

10. WHODAS
11. WHO 5
12. AAQ-2
13. LDQ
14. CDRISC-2
15. K10
16. Your Voice Matters feedback cards to collect suggestions, complaints and compliments regarding service experience
17. WHO-QoL (Quality of life)

Some NGOs use outcome measures throughout a consumer's time on the program, others use them only at the point of exit, and others don't routinely use them at all. In highlighting the importance of measuring outcomes one staff noted, "[m]anagement had flagged that we all talk about all of these really great outcomes, but it's not really captured anyway, so how can we be capturing it so that it is quantifiable so they can see something, because all the good news stories and the things we talk about around the office are awesome, but at the end of the day, we're government funded. They need to see something so that we can keep getting funded." (F, IRSP, NGO staff)

### *Use of outcome data*

A consistent finding across NGOs was that of the measures collected, the results were not utilised to inform the ongoing delivery of the program. Staff noted, "But I don't know what happens with that information once I fill the form out and put it in the system. I don't know if there's something happening in the background where it is recorded." (F, IRSP, NGO staff) "I don't think the data is used in a ... I don't think the data was ever assessed at all. I think it's just sitting there. So they're done, but that data is not being used. So as far as it capturing the right thing, I would prefer to have it a bit more mental health recovery focused, which is what we're all about." (F, TCFP, NGO staff)

### *Capacity to measure change*

It was assessed that the capacity to measure change, by both staff and consumers can impact the overall outcomes measured. Adequate training and sufficient support in the function and use of outcomes measures strengthens the overall effectiveness of the process. One staff explained, "...that's brilliant and all programs do need some kind of tool or measure that's client-driven because they're the only ones that can guide their own recovery." (F, IRHP, NGO staff), and another noted their concern with using a measure "I'll be perfectly honest, sometimes I don't get to do that, it's not mandatory. It is just something we're licensed to kind of utilise. Part of the reason why I don't necessarily get to do it is because it can be a lengthy and confronting tool sometimes, especially a lot of the time when we get a referral in that initial stage, this person has just come out of hospital, they've been put in a boarding house which is just like an experience in itself. They want to get on top of a few different things and if I was to put this huge document in front of them and do a Recovery Star, personally I don't think it's very recovery-based or person-centred." (F, IRSP, NGO staff)

### **Summary**

Almost all consumers interviewed for the evaluation reported a positive experience on the program and a portion of consumers could speak to the importance it has played in their recovery. People with severe and persistent mental illness need individual support whilst navigating their mental health concerns and these programs play a vital part in that journey. Whilst there was substantial variability in the findings of the effectiveness of the process at each of the R-A-I-M stages, consumers who received support through the MH

CSS programs reported overall positive experiences and those who were provided with recovery-oriented supports made gains in their mental health. The key findings of the evaluation are outlined below:

1. It is important to clearly identify what recovery means to a consumer as part of their engagement with the MH CSS program, and to be able to assess effectiveness of the programs. Consumers showed hesitancy towards using words such as 'recovery' or 'recovered' and a reframing of what recovery means to the consumer is an integral part of identifying their goals and observing outcomes.
2. There were several key outcomes identified by consumers as a result of their engagement with the program relating to improvements in their mental health including: ability to recognise need for support, achievement of goals, functional outcomes (e.g., return to work, increased daily functioning), improved relationships, increased confidence, medication (on/off), quality of life, and reduction in suicidality.
3. There is a lack of consistency across NGOs in the use of standardised outcome measures to track the effectiveness of the programs and recovery outcomes of consumers. These are not being routinely used to inform the ongoing delivery of the programs, or in reviewing and tracking consumer outcomes.

## Effectiveness Recommendations

The below recommendations are a summary of what is assessed to be best practice in capturing the effectiveness of the MH CSS programs:

### *Outcomes for consumers*

The importance of measuring outcomes for individuals with mental health problems and mental illnesses was identified in the Fourth National Mental Health plan (Commonwealth of Australia, 2009). Outcomes for consumers can be understood as demonstratable improvements in their daily lives and mental health (de Jong et al., 2012). Outcomes for consumers receiving community mental health supports range from increased quality of life, independence, social inclusion and the attainment of individual goals (Slade, 2002). As noted by Barker et al. (2015) outcome measures form an integral part of any recovery plan and provide an important platform for dialogue and collaboration between the consumer, their support worker and the referring clinical team.

The primary focus of measuring outcomes of the four MH CSS programs is to ensure that consumers continually benefit from the treatment and supports they receive. To adequately assess the effectiveness of the program on consumer recovery across NGOs it is recommended that all NGOs use the same outcome measures with their consumers. It is recommended that the outcome measures used are supported in the literature as efficient measurements of mental health outcomes. The outcome measures should be used in addition to what the HHS already collect, they need to be uniform across NGOs and stand-alone from the HHS data to determine effectiveness of the program(s).

To supplement the routine monitoring and evaluation data collection, the inclusion and analysis of re-admittance and emergency department data would be useful.

### *Feedback informed program delivery*

In addition, it is recommended that the results of the outcome measures are fed back into the program to inform and support ongoing person-centred and recovery-oriented Individual Recovery Planning. Outcome measures should be used in collaboration with the consumers as part of their recovery journey to help with revisiting goals and identify overall improvements in their mental health.

### *Post-program follow-up*

Finally, it is recommended that NGOs follow up with consumers at timepoints post exiting to assess the long-term effectiveness of the programs on consumer recovery outcomes. This could also be used as an opportunity to address potential isolation or a decrease in mental health functioning through referrals back into clinical care, alternative community support programs or back into a MH CSS program.

## 4.6 Key Ingredients

Throughout the evaluation it was assessed that there are several key ingredients that underpin the delivery of the four MH CSS programs across the micro- (consumer), meso- (NGO), and macro- (HHS and broader stakeholder) levels.

### Relationships

A major ingredient to the successful delivery of the four MH CSS programs is relationships. This includes relationships across the socioecological levels, starting with the management of the program at the HHS level, through to the referring clinical care teams, down to the NGO staff delivering the programs to the consumers. It was assessed that where relationships are functional and collaborative at each stage of program delivery, the recovery-oriented outcomes for the consumers are enhanced. The four MH CSS programs are part of a complex mental health care system in Queensland; ensuring that open, collaborative, and functional relationships are maintained is a key element to the effectiveness of the programs.

### Training

Training for all staff across the socioecological levels in the importance and function of a psychosocial support program was assessed as being a key ingredient to the successful delivery of the four MH CSS programs. At the HHS level, where the referrals originate, staff should be trained in identifying eligible consumers for the program, in developing appropriate referrals, in engaging in ongoing collaborative case management with the NGOs and in the function of recovery-oriented practice. At the NGO level, all staff including managers and recovery support workers should be trained in the MH CSS program criteria to ensure eligible consumers access the program, and that they deliver the service in line with contract requirements. In addition, NGO staff should be trained in the development and ongoing management of the Individual Recovery Plans to ensure they deliver recovery-oriented support for the consumers.

### Staff Qualities

It was assessed through the evaluation that there are several important characteristics of NGO staff that are aligned with positive outcomes for consumers. These are all related to how the staff approach the support they provide to the consumers and include displaying empathy, being consistent and reliable, being non-judgmental, and acting as a trusted resource. Consumers identified these characteristics as underpinning the positive outcomes they were able to achieve and their ongoing engagement in the program.

### Recovery-Orientated Framework

The Department of Health published the national framework for recovery-oriented mental health services in 2013 (Commonwealth of Australia, 2013) which highlighted the importance of the lived experience and insights of individuals with mental health issues in their recovery journey. It was assessed through the evaluation that the four MH CSS programs would be strengthened by a consistent utilization of the recovery-oriented framework across the socioecological levels. The framework acknowledges that individual recovery approaches will be different depending upon where a person is on their recovery journey and that recovery is about “gaining and retaining personal autonomy, social identity, meaning and purpose in life, and a positive sense of self”.

## Person-Centeredness Approach

Person-centredness appears throughout the evaluation as a key ingredient underpinning the effectiveness of the MH CSS programs, particularly through the *Adoption* and *Implementation* phases. As outlined further in the *Implementation* section (*Section 4.3*), a person-centred approach incorporates the needs of the consumer at the centre of the service delivery. This can occur across the socioecological levels and supports positive outcomes for consumers.

## Consumer Capacity/Readiness

Finally, a key ingredient that impacts the delivery of the four MH CSS programs is consumer capacity and readiness to change. This can be assessed at each level of the socioecological model and can impact recovery outcomes. The National Mental Health Commission's *Engage and Participate in Mental Health* project (Australian Government, 2018) highlighted the importance of consumer engagement in supporting the delivery of more effective and efficient mental health services. It was assessed through the current evaluation that a consumer's capacity and readiness to change directly impacts their journey on the program – it can act as a barrier or a facilitator depending on the situation and is an important element that needs to be considered from the point of referral through to Individual Recovery Planning.

## 5. Program Specific Findings

### 5.1 IRHP

Throughout the evaluation it was assessed that there were unique considerations in the delivery of the Individuals at Risk of Homelessness Program. These include:

#### Consumer complexity

It was assessed that the IRHP consumer group present with more severe mental health presentations than those commonly accessing the IRSP, and that the workers in the IRHP program are required to manage these complexities. Examples include managing current psychosis, co-morbidities, and ongoing legal issues where they act as advocates and facilitators for the consumers. One support worker delivering support to IRHP consumers noted “[s]o it’s kind of in a way an intensity, if you think of the more complex a person is the more intensity of service supports and resourcing that needs to go around that, so that to me is the distinct difference. But in reality a person with a severe and persistent mental illness is a person with a severe and persistent mental illness. If they’re living at home with their mum and dad they have a severe and persistent mental illness. The main difference is that they have resourcing and informal support and what you’re trying to do is avoid them becoming one of our clients because our clients tend to be people who have – all that’s failed and then by the time they’ve got to us they don’t have informal support and resources and so forth, so part of what we do is to build that up around them. So what makes the difference I think between us and the mainstream is that component is that the person that we’re dealing with is going to come with less assets, and I don’t mean financial, but they’ve got less assets that they can draw upon to recover as opposed to their situation is worse and it continues to worsen because they don’t have those assets in their lives.” (F, multiple programs, NGO staff). Given the mental health complexities of the IRHP consumers it was commonly reported that the consumers return to hospital and this impacts the delivery of the supports and ability for the program to contribute to improvements in mental health outcomes.

## Housing

Given the nature of the referrals for the IRHP, it's not surprising to note that housing is a particular concern for the IRHP program however the lack of access to appropriate and secure housing was raised by the majority of workers as being a constant challenge in delivering supports to consumers. In addition it was reported that the criteria that consumer's had to meet to engage in the current program was interpreted differently by organisations, one worker noted "...we're very restricted in terms of the housing that we can engage in, and the problem is because are we managing a housing group or are we managing homelessness? Because homelessness is completely another kettle of fish whereas at the moment we're restricted to a group of people, we've got kind of a descriptor of people who are at risk of homelessness but only if they live in unstable housing so, you know, like within boarding houses and hostels. So the type of people who reside in boarding houses and hostels are only one segment of people who are at risk of homelessness." (F, multiple programs, NGO staff)

## GBPRSP needs

When done well the groups in the IRHP program reportedly met the needs of the consumer group, they had a particular mental health focus (ie Hearing Voices, DBT) and played a role in contributing to ongoing care when the individual program had finished. The needs of this consumer group in terms of group program offerings differ to the IRSP whereas they were often focused on reducing social isolation and building skills the IRHP GBPRSP predominantly attend to mental health needs and psychoeducation. One IRHP staffer reported "they refer to us knowing that we can get them to [NGO], but [we] don't have the capacity to take the 200 people that the hospital want. So if you've got any ... if you can make a note somewhere that we need more funding for DBT groups, that would be excellent." (F, IRSP, NGO staff)

## Advocacy work

It was assessed that the supports workers in the IRHP program are required to act as advocates in a number of domains for the consumers including in facilitating secure housing, providing support for legal matters, linking in with disability supports and ongoing management of their clinical care. One worker noted "[w]hat I do think is different is that this is our specialisation so I think that it's not just a question of a worker goes and does this, this and this, it is actually the context within which that worker operates and how we see our role and what we do with people... I would like to think that what we do is motivated predominantly through intentional practice and that's what makes what we do different". (F, IRHP, NGO staff)

## No discretionary funds

Given the complex nature of the IRHP consumer group, and their risk of homelessness it followed that they often experienced financial distress and issues meeting their basic living needs. NGOs would benefit with additional discretionary funding that focused on supporting the needs and engagement of consumers (i.e. access to mobile phone, essential needs like food and clothing).

## Recommendations:

- IRHP is a specialised program – NGOs should therefore align the breadth of skills, experience and training required for support workers on this program.
- Consider supporting the relationships between NGOs and Department of Housing/relevant organisations managing housing to address housing access concerns.
- Provide clarification/guidance to allow for consistent eligibility criteria for inclusion to the IRHP program (specifically around housing circumstances) across the state.

## 5.2 TCFP

Throughout the evaluation it was assessed that there were unique considerations in the delivery of the Transitions from Correctional Facilities Program.

### Access to housing

Access to housing is a nuanced problem for the TCFP program due to the complex nature of some of the offences of the consumers. It was commonly reported that this group, once exiting the prison system, do not have secure or long-term housing in place prior to release. In instances where they have arranged such housing, they can be rejected from accessing the housing due to their offences. A support worker noted, "They can't stay at [housing location] because of their sexual offence history. So it's not just accommodation, it's appropriate accommodation. So there are crisis accommodation in Cairns that will not accept [40] to 30% of our consumer group because they've got sexual offences. Makes it extremely challenging. I don't want to presume, but one can't help but imagine that may be the case if they choose to continue to be homeless because that's been their pattern for the majority of their adult life. Even if they did accept support and accommodation, they'd be knocked back anyway. So if they say okay, well I'm choosing to be homeless, at least they're not getting hit with another knock back." (M, TCFP, NGO staff) and one consumer reflected on their release experience without stable accommodation "So trying to go to a new place after prison and then what not was a bit daunting, so I did end up on release day, with a support worker going down to the Gold Coast and I ended up staying in a hotel on the first night, first few nights. But obviously, I wouldn't be able to afford that all the time ...I kind of just followed what my support would tell me and I ended up coming up to Brisbane. I stayed at a boarding house and it's probably not the best boarding house because I did have some issues with bed bugs there." (M, 35-44yrs, TCFP, consumer)

### Staff security clearances

It is a requirement of staff entering the prisons to hold particular security clearances. It was reported through the evaluation that this is a lengthy process that often delays staff from entering the prison to establish rapport with consumers and to engage with them on the possible supports available to them upon release. One consumer reflected on the impact of this noting "It was probably a little bit, at the start probably not well done because my support worker was meant to actually come in and see me prior to my release. But at the initial start of it, I saw probably five different support workers with [NGO] because my support worker didn't have a yellow card and was still waiting on that. But like they were all good so I don't have any complaints with any of them like that, but it was just a bit, the start of it was a little bit, it would have been better if I had more planning prior to my release." (M, 35-44yrs, TCFP, consumer)

### Lockdowns/lockouts impacting contact

Staff working in the IRHP program reported that unplanned lockdown and security issues occurred regularly and often prevent NGOs entering prison at times for unknown/lengthy periods. This was noted as impacting on the staff's capacity to engage with consumers due to be released and to establish relationships and recovery planning prior to their release day. One consumer noted "... but I had to go into isolation then. And so [NGO] missed me because I was in my cell at the time, but I didn't talk to them when I was in prison. But as soon as I was out, they connected me up to [support worker]." (M, 25-34yrs, TCFP, consumer)

### Conflicting NGOs providing services

It was commonly reported by NGOs that there are conflicts with alternate NGOs offering services within prison and that consumer engagement could at times be impacted as a result. There are reportedly a number of various NGOs that access prison and offer services which leads to consumers “playing NGOs off each other” to see who they can get the most support from. This reportedly impacts on the capacity for NGOs to meet targets and to appropriately service TCFP consumers. One IRHP manager reported “the main issues we have is other organisations that go into the prison that might have our consumers on their caseload as well which we don’t know about and so they will do a plan and we will do a plan and then they can be different. This has come up quite a few times because there is ... another program run by [other organisation] in the prison and so they often will go to them for IDs and different stuff, sometimes accommodation, but we’ve had a discussion with them because we don’t mind them sort of working with our consumers, we don’t have money for ID, but when it comes to a lot of the other stuff if they’re with Mental Health they sort of should be with us and not with them.” (F, TCFP, NGO staff).

### Lack of appropriate groups

It was reported by a number of staff that their consumers either cannot or do not access GBPRSP. There were several reasons given for this however the main reports related to the complexity of this consumer group preventing successful referral to outside groups run by other NGO. This could be related to the nature of some of the small towns but also the capacity of alternate NGOs who are not specialised in delivering supports to TCFP consumers running the group programs. One staff noted “[b]ut it is very tricky because Townsville’s not a big place, it’s a big place but it’s not a big place, so nine times out of 10 they know each other from prison so we’ve got to be careful as well about the dynamics in the groups as well.” (F, TCFP, NGO staff)

### Complexity of consumers

The TCFP consumer group have a number of complexities related to their offending histories which can often result in them cycling back in and out of prison, they often have ongoing parole requirements, and many consumers upon release from prison return to toxic environments which impact their capacity for change. Most of these issues impact the overall delivery of the service and particularly the length of engagement in the program and long-term outcomes. At one organization a staff member noted that “[m]ost of them since I’ve come on, once they transition out, they’re gone probably within the first month.” (F, TCFP, NGO staff)

### No discretionary funding

The lack of discretionary funding for the TCFP consumer group was commonly reported as an issue that impacted the delivery of the service to consumers. It was noted that during COVID there was an additional injection of funds into the program which was utilised by some NGOs to provide support to consumers with accessing IDs, or buying a bike for transport or providing crisis food support and this was greatly appreciated and utilised beneficially. Since the funding has ceased the NGOs reflected on the added benefit this had in providing adequate support to consumers. One staff noted “we have no money to support these consumers. We got COVID funding which we will have sort of some of that left which has been a great support because we’ve been able to provide mobile phones, help with accommodation, bikes for transport, stuff like that, toiletries, whereas generally we wouldn’t have. So it can be really quite hard for prisoners being released with no money and having to try and settle that up, especially with home.” (F, TCFP, NGO staff)

## Release location

It has been noted that where consumers are released from prisons in particular locations but then move to an alternate HHS, they may not be linked in with an NGO available to support their referral and so there is a group of consumers who may slip through the gaps. It was reported that consumers who are prisoned in urban HHS but released to Townsville were engaged with TCFP providers in the area, however those who were originally imprisoned in Townsville HHS and released into urban HHS such as Brisbane were not reciprocally supported.

## Recommendations:

- TCFP is a specialised program – NGOs should therefore align the breadth of skills, experience and training required for support workers on this program.
- Consider supporting the relationships between NGOs and Department of Housing/relevant organisations managing housing to address housing access concerns.
- Provide support to facilitate HHS and NGO relationships involved in the TFCPs, particularly addressing the conflicting services provided by alternate NGOs within the prison system.

## 5.3 GBPRSP

Throughout the evaluation it was assessed that there were unique considerations in the delivery of the Group Based Peer Recovery Support Program, along with large variability in how the group programs are being run. The group-based programs have been explored in more detail through the RE-AIM framework, however several common challenges were raised by NGOs in delivering GBPRSP and consumers in taking part in the GBPRSP.

## Referrals

The referral of consumers into the group-based programs are designed to come from any one of the individual programs via the 'parent' NGO. The evaluation found that this is the case with the IRSP and IRHP programs, however our team were not able to ascertain any referrals from the TCFP into the group programs. This is most likely due to a lack of understanding from NGOs that they *can* refer TCFP consumers into the GBPRSP (based on the intended pathway) and exacerbated through not being part of the existing governance meetings structures/ communication with HHS and referring NGOs (i.e., not involved in the 'relationship' key ingredient). Additionally, some HHSs indicated that they would like to be able to refer consumers directly into the GBPRSP.

The evaluation found that where the referral process requires a handover between NGOs, as with the individual program referrals, this requires a strong working relationship between the two organisations, which is not always the case; "we always try and do a warm introduction, so during one of our sessions together, we might take that person to the [Group program], so meet some of the people there, who's going to be there" (F, IRSP, NGO staff). One staff working alongside a separate NGO reported, "it's a very interesting thing because we're competitors as well as partners, and so that always creates a tension because there's an element of agendas, different agendas, you know, and what people are trying to achieve. So sometimes and, you know, over the course of years not specifically just this program but over the course of the years, where you're relying on other organisations to refer through into you sometimes that doesn't always happen because they've got their own quotas to meet and they have their own activities they want to engage in and whatever else, so there's a whole range of motivators there" (F, multiple programs, NGO staff)

## Delivery and Access

Some IRSP/IRHP consumers were able to access the group programs in parallel with the individual program and in these instances the groups were often used to support the IRP work. Other consumers gained access to the groups after a period on the individual program, while others formally exit out of the individual programs and into the GBPRSP. One consumer journey is exemplified by the following quote, “Yeah, so what they did was, I had a year with [IRP NGO] when I tried to do what I did. And then after that you're only allowed a year, and then you go into the [group program]” (F, 45-54yrs, GBPRSP, consumer). One staff summarised their NGO’s approach to delivering the group program alongside the individual supports, “So it basically runs alongside each other. They get their referrals sent through at the start and they can decide whether they want just one or one or group, and if a few weeks down the line, they're like, ‘I really want to try group,’ they can definitely do that. They can swap and change at any given point, but it's still within that 12 months” (F, multiple programs, NGO staff)

It was assessed that consumer engagement tended to be most successful when the *same* NGO delivers both the individual and group-based programs, one staff reported “However [we] deliver group services very differently. It's super structured. We get a fabulous turnout. We get really good feedback and even people coming back to repeat groups and things like that” (F, multiple programs, NGO staff), and another staff reported “People or clients have been happy to know that it's all under the same umbrella. It seems to be reassuring in some way that that collaboration is there because we actually are in the same office” (F, IRSP, NGO staff)

Consumers reported a range of reasons for being wary of or not attending groups including the possible negative effects that group members can have on each other, “There’s another young guy, I give him a lift home, but he smokes a lot of dope, and a lot of these people have got problems that are not ideal people for me to hang out with to be honest.” (M, 35-44yrs, GBPRSP, consumer). And staff have reported issues around accessing groups via another NGO with little consumer engagement, as exemplified by this NGO staff members experience: “[It] doesn't stop me from collaborating with [other NGO] but it's just frustrating when you - I've had experiences where yes, yes, yes, we run these groups and then you take them out. You've spoken to the group facilitator or whatever. They know that you're coming with the client. You get there and your client's the only person and then they don't run the group” (F, multiple programs, NGO staff). There are also a proportion of consumers who will not engage with groups at all and class themselves as ‘not the type’ or specifically do not want to spend time with other individuals with mental illness or do not feel safe in doing so, “They offered me other things that weren’t offered here and I said, “Oh, yeah, I’ll see how I go” because it’s not really my kind of thing to – I like doing group things but I’m kind of – because I didn’t know what other people were like. So sometimes it depends on if I really have a need, that I’d be stepping out into it. But there wasn’t much of a need really. So I haven’t come here at all” (F, 55-64yrs, IRSP, consumer)

## Group offering

The evaluation determined there is a large degree of variability in the delivery of the GBPRSP in terms of what is on offer to consumers. Some NGOs have fewer resources (e.g. cumulative funding, physical resources, access to transport, etc.) and/or consumers and consequently have a narrow suite of activities they can offer. Contrastingly, better resourced NGOs (e.g. larger organisations with more cumulative funding, resources, etc.) can offer a broad range of activities that cater to different consumer wants and needs. One consumer who reported being frustrated by the NGOs group offering noted, “The second one had a couple of other people but they didn’t really engage. Like I tried a couple more times and it was just me and, you know, to me that wasn’t what I was looking for, I was looking for a group, sharing ideas and thoughts and experiences

and things like that. That's what I was led to believe and that's certainly not what happened" (M, 45-54yrs, GBPRSP, consumer). Showcasing the full spectrum of experiences, another consumer described how they could pick and choose a program that suited them best, "I know [NGO]; they give us a programme every month. There's lots on there. But a lot of it you have to be quite active to do and I'm no good on my legs anymore. But they have lots more activities; peer group. I tried that once and I didn't really like that much. But I found the men's group and this have been a Godsend" (M, 65+yrs, multiple programs, consumer).

In addition, those NGOs in rural areas reported difficulties with group engagement and the capacity to deliver diverse and engaging groups. This is summarised by one rural consumer with the following quote, "The reason why I saw the original group ones fail a lot was the people who [NGO staff] was trying to cater that one for, we were too different apart. We'd come from two different, well multiple different paths of life, and sort of putting it into a group and trying to make that puzzle fit was a lot harder. That's why I personally saw that it didn't really work out as well as it could have. I saw what she was trying to do and it was really nice, especially for [small country town], but the trouble was people came from too many different paths" (M, 18-24yrs, IRSP, consumer)

## Reducing isolation

A common theme arising from the evaluation was that those consumers who engaged in group programs experienced a reduction in social isolation, and this was frequently reported as a strength of the GBPRSP. One consumer reflected on their positive experience in groups; "Oh yes, it is, oh it is, yeah, yeah. I look forward to seeing the people, I look forward to it, because I've got friends there and I look forward to it. I mean they invited me to dinner" (M, 55-64yrs, GBPRSP, consumer), and another noted "It gives me an occupation, you know, go and meet everyone and talk and so forth, socialise and social skills, and it teaches you to get into a comfort zone, a relaxed feeling, and not getting stressed out or lost or anything. And like I said, they're non-judgmental and if they could help they're willing to help you out" (F, 45-55yrs, multiple programs). NGO staff also reflected that reducing isolation was an important outcome of consumers engaging in the groups, "I think there's consumers that have a lot of anxiety, some of them even social anxiety, they perhaps don't get out a lot, and so it's an – you know, other than maybe their doctors' appointments and things like that. So it's a way for some of them to confront that anxiety, to be with like-minded people, people that understand them, to come to a safe space where they're not judged. Yeah, so there's a lot of positives I think that come out of using the space" (M, GBPRSP, NGO staff). It was also found that some consumers started leveraging the groups to form ongoing relationships with other similar, like-minded consumers: "and they're starting to build a bit of a bond between them and a couple of them sometimes I've heard them organise to walk down the road together after the group and stuff like that" (F, GBPRSP, NGO staff)

## Recommendations:

- Provide clarification/guidance to all stakeholders around referrals into GBPRSP, including facilitating relationships between NGOs where different NGOs deliver the programs.
- Review the feasibility, acceptability, and need for the same NGO to be delivering the IRSP and GBPRSP at each location across the state to facilitate referrals and simultaneous delivery.
- Ensure that the GBPRSP provides a broad offer (mental health and psychosocial/lifestyle content) to consumers and that sessions take place in accessible and safe places, as determined by consumers.

## 6. Additional Findings

### 6.1 Rurality

From the team’s experiences of visiting most HHS locations, it was clear that there were unique factors impacting service delivery experience for staff and consumers in rural and regional areas. To examine any likely difference in program delivery between rural and metropolitan areas, the evaluation analysed the rural qualitative data separately. For completeness, *rural* in this context is defined as, and refers to, all areas outside of metropolitan and regional centres. As such, rural areas are classified as having an Modified Monash Model (MMM) classification of MM3 – MM7 and Australian Statistical Geography Standard (ASGS remoteness Area) classification of RA2 – RA5 (Australian Government Department of Health, 2021a, 2021b). The below table compares the MMM classification scale with the ASGS classification scale, whilst also listing the HHSs delivering the MH CSS programs at each level (*Table 5*).

*Table 5: MMM and ASGS classification scale*

MMM		ASGS	HHSs delivering MH CSS programs
MM1	Metropolitan areas	RA1 areas (Major cities of Australia)	<ul style="list-style-type: none"> <li>• Gold Coast Wesley Mission (Robina)</li> <li>• Metro North Footprints (Fortitude Valley)</li> <li>• Metro North Footprints (West End)</li> <li>• Metro North RFQ (Aspley, Herston, Redcliffe)</li> <li>• Metro South BrookRED (Beenleigh, Capalaba, Highgate Hill)</li> <li>• Sunshine Coast Steps (Maroochydore)</li> <li>• West Moreton EACH (Ipswich)</li> <li>• West Moreton RFQ (Ipswich)</li> </ul>
MM2	Regional centres	RA2 (Inner regional Australia) and RA3 (Outer regional Australia) areas <i>that are within 20km drive of a town over 50,000 residents</i>	<ul style="list-style-type: none"> <li>• Cairns and Hinterland Mind (Cairns)</li> <li>• Cairns and Hinterland Neami (Cairns)</li> <li>• Central Queensland Anglicare (Rockhampton)</li> <li>• Central Queensland Bridges (Rockhampton)</li> <li>• Darling Downs Momentum (Toowoomba)</li> <li>• Darling Downs RFQ (Toowoomba)</li> <li>• Mackay Mind (Mackay)</li> <li>• Townsville Neami (Townsville)</li> <li>• Townsville RFQ (Townsville)</li> <li>• Townsville Selectability (Townsville)</li> <li>• Wide Bay Bridges (Bundaberg)</li> <li>• Wide Bay Impact (Bundaberg and Hervey Bay)</li> <li>• Wide Bay RFQ (Bundaberg and Hervey Bay)</li> </ul>
MM3	Large rural towns	RA2 (Inner regional Australia) and RA3 (Outer regional Australia) areas <i>that are within 15km drive of a town with 15,000 to 50,000 residents</i>	<ul style="list-style-type: none"> <li>• Central Queensland Anglicare (Gladstone)</li> <li>• Sunshine Coast Steps (Gympie)</li> <li>• Wide Bay Impact (Maryborough)</li> <li>• Wide Bay RFQ (Maryborough)</li> </ul>
MM4	Medium rural towns	RA2 (Inner regional Australia) and RA3 (Outer regional Australia) areas <i>that are within 10km drive of a town with 5,000</i>	<ul style="list-style-type: none"> <li>• Central Queensland Anglicare (Emerald)</li> <li>• Darling Downs Momentum (Warwick)</li> <li>• South West Stride (Roma)</li> </ul>

MMM		ASGS	HHSs delivering MH CSS programs
		<i>to 15,000 residents</i>	
MM5	Small rural towns	All remaining RA2 (Inner regional Australia) and RA3 (Outer regional Australia) areas	<i>N/A; No MH CSS programs run in MM5 areas.</i>
MM6	Remote communities	RA4 areas (Remote Australia) and remote islands less than 5kms offshore and without bridges to the mainland	<ul style="list-style-type: none"> <li>• North West Selectability (Mt Isa)</li> <li>• South West Stride (St George)</li> </ul>
MM7	Very remote communities	RA5 (Very remote Australia) areas and remote island areas more than 5kms offshore	<ul style="list-style-type: none"> <li>• Central West Anglicare (Longreach)</li> </ul>

Some specific factors were identified as having a significantly larger impact on staff (HHS and NGO) and consumers in rural areas that should be considered regarding MH CSS program function and funding. This below summarises the unique barriers present as they relate to delivery of the MH CSS programs in rural settings, yet also the ways in which these areas rise to meet additional challenges to program delivery.

### Access to and flexibility of services

Much of the rural population in Australia has difficulty physically accessing services, especially older people with at least 24% of the population having to drive more than 60 minutes to access mental health services (Gardiner et al., 2020; Gardiner et al., 2019; Health & Welfare, 2019). Given that the MH CSS programs are delivered in the community, support workers in rural settings are often required to devote large amounts of travel time to access consumers, travelling to smaller towns from their NGO's more central location ('NGO town base') or to consumer's properties, where they might then drive the consumer to appointments. One NGO staff member highlights their workweek, inclusive of these additional travel requirements: "I do a lot of outreach work, so this is my week out of the office... So Mondays I head out to [town 1] which is about a four hour round trip, Tuesdays I go to [town 2] and that's an hour there, an hour back, and Thursday I head out to [town 3], and same thing, working with the same cohort of people but...often these people can't get in to [NGO town base] here so it's great that we offer a service that we can go out to them" (F, IRSP, NGO staff). This additional time is resource intensive, the extent of which is unlikely captured in the current resourcing model for the MH CSS programs.

Throughout the evaluation it was also observed that in rural areas, not only are there issues in physically accessing services, but the breadth and depth of services is limited across the board. There are fewer medical supports, mental health supports, social and emotional wellbeing programs and indeed social outlets to engage with and potentially improve mental health issues through reducing social isolation.

Another issue identified by a number of rurally located consumers and NGO staff relates to hospitalisation in these areas, and the difficulties in returning home from these bed-based services. Consumers explained that many times when referred to a bed-based service, these services are located within hospitals most potentially hours away from their home. When consumers are required to travel large distances (sometimes airlifted) to receive these bed-based services, when they are discharged back into the community, they have been required to organise transport home themselves. As one consumer explained:

"Interviewee: My daughter was going to come down and pick me up and [the clinician] said, "Yeah, we'll discharge you tomorrow." ...They couldn't give me an answer if they were going to discharge

me or not, and at about 2 o'clock, they said, "Ring your daughter to come down and pick you up."

Facilitator: Yeah, how far away is [the location of the hospital you were sent to]?

Interviewee: Four hours." (M, 65+yrs, IRSP, consumer)

The consequences of this kind of experience were described by consumers as traumatic, whilst also undermining their trust in mental health services and support available. Consumers indicated experiences like these decreased their likelihood of taking up a referral for psychosocial support, whilst NGO staff noted the difficulties this process had on a warm handover between to the HHS and the NGO.

Whilst rural locations present unique barriers related to consumers' accessing services, many participants (NGO staff and consumers) indicated that having the flexibility to choose the locations in which to meet NGO staff is an important facilitator. In rural locations, having meetings in the community (when NGO staff are not in uniform or identifiable as NGO staff) has been noted to assist consumers who are worried about other community members seeing them accessing psychosocial services from an NGO's office. Alternatively, flexibility for NGO staff to travel to a consumer's home has been a facilitator in reducing the risk of stigmatisation and subsequently increasing access to psychosocial supports. Many NGO staff in rural settings are familiar with offering this flexible access to supports: "[The option of setting-flexibility is] something I provide at that first meeting. It's like, "How do you want this to work? Where are you comfortable? I'm happy to come to your home. We can meet at a coffee shop. We can meet down at the river" (F, multiple, NGO staff)

## Mental health literacy and stigma

Mental health literacy has been shown to be lower in rural areas compared to metropolitan counterparts (Health & Welfare, 2019; Marshall & Dunstan, 2013). With lower literacy surrounding mental illness in these locations, stigma of mental illness which stems from a lack of understanding presents a barrier. This stigma was described by both consumers and NGO staff and can be a barrier not only towards accessing services, but can also impact upon the recovery process. Many consumers from these rural areas, particularly older males, explained that involvement with the MH CSS programs was the first time they sought and received support for their mental health. For example, the consumer below begun describing their experience accessing the MH CSS programs and the desire for

Facilitator: And [do you think you need more time in the program] because...this is the first time that you've opened up about mental health?

Interviewee: It would be the first time in my life except for going to my doctor who got me a psychiatrist.

Facilitator: Yeah. This is the first time you're coming to this. You need more than 12 months to unpack a lifetime." (M, 55-64yrs, IRSP, consumer)

Another facet of rural mental health stigma the evaluation identified was consumers' concerns about other people in their community finding out about their mental illness. The nature of a small town in a rural area means that many people know you and therefore, many people know what you are going through. As was identified by a number of interviewed NGO staff and consumers themselves, this phenomenon can become negative and gossip-like and prevent individuals from accessing health services, hospitals, and even taking part in an NGO-delivered service associated with mental health.

"A couple of my participants asked me... because we have a uniform that says ["NGO name"]. A couple of them asked me not to wear that or, "Can you wear a jumper?" or whatever. So there's still that real stigma

in a small town. However, in saying that, the other side of that is because we're in a small town and I obviously work in mental health and I see quite a few different people for sometimes extended periods of time, they'll often come up to me in Woolworths, or if they see me out, they're like, "Hi." So it's really interesting... in a small town like this, too, everybody knows what you do. You're not anonymous at all, particularly when you've got a uniform shirt that says, [NGO name]." (F, IRSP, NGO staff)

### NGOs serve as gateway to consumers' additional services/external supports for consumers

Given the above identified barriers in consumers accessing support in rural areas, NGO staff often described their role in more rural areas as either a consumer's sole support, or their only pathway towards other required supports (psychological-related or otherwise). Often NGO staff in rural areas recounted they spend significant time organising access to external supports and services for consumers. Whilst this is viewed positively by consumers, who feel their NGO staff can support them with any needs, support workers are not adequately trained, supported, or recognised to be providing that kind of support. One NGO staff described this multifaceted role: "We have such a huge gap in these rural areas, it's really scary. So often, you get a referral from Queensland Health, it'll have things like...medication assistance. It's got nothing to do [with us]...Or they want us to do...referrals for MRIs and we do all of that, or care plans or, "Can you find a psychologist?" That's the stuff that they want us to do, basically. I'm a bit like a case manager's PA" (F, IRSP, NGO staff)

### *Task sharing, collaborative care, wraparound approach*

Research suggests there is a smaller mental health workforce in rural areas, contributing to issues surrounding stigma of mental ill health and prolonged consumer recovery compared to metropolitan and regional areas (Health & Welfare, 2022; Marshall & Dunstan, 2013; Wrigley et al., 2005). Aligning with the literature, NGO staff in rural areas consistently described the scarcity of clinicians; "There's two [psychiatrists]...that come through. One is fly-in, fly-out and there's one that's regular" (F, multiple, NGO staff)

A common solution identified by NGO staff to too few clinicians was the upskilling of clinical and non-clinical staff already existing in these rural areas, or task-sharing. Task-sharing involves using a broad range of local services and involves the upskilling of non-clinicians to create a holistic support network for a consumer who otherwise would not receive clinical services (Patel et al., 2011). In rural areas where few mental health services exist and clinically trained staff are limited, NGOs have the potential to fill the gap by providing some form of psychological support. One rural NGO staff member interviewed described task sharing practices as fundamental to the delivery of the MH CSS programs in rural areas:

"I've got to say, my first six months of working with [NGO], I was absolutely gobsmacked at how few resources we had, how clunky it was with Queensland Health. I was like, 'Hang on, don't we even go to case reviews? Why haven't these people got NDIS plans?' I was just mystified. There is no music therapists out here. There's no psychologists out here. So we are the resource in these parts where [as]... I come from [another NGO where] we had psychologists, OTs, psychiatrists...the whole team. Here, you've got yourself. You are the resource. There are very few referrals. You do a lot of work that you wouldn't normally, like NDIS access, DSP, all of those, because we are it. There is no one else to go to and say, 'Hey, this person really needs help with XYZ'...So we are it. If you look at our service agreement with Queensland Health, it looks like we have nice little groups each day and a cup of tea. In reality, we're the pen pushers, we're the advocates. We're the picking up, dropping off. We're the everything. We are their resource....Start to finish and doing the entire work to get them in and out" (F, IRSP, NGO staff)

Throughout the evaluation, consumers consistently commented that having to retell their story repetitively to various health providers can be frustrating and potentially triggering, yet important when accessing new services such as psychologists. In rural areas, task-sharing has an added benefit of reducing the number of times consumers need to retell stories, given there are fewer stakeholders involved in a consumer's journey.

## Referral processes

The referral process has been identified by NGO staff across the state as an area for improvement. As such, rural NGO staff identified exacerbated difficulties with referral processes, specifically referral pathways into MH CSS programs. The perceived requirement for consumers to be referred from a bed-based service was described by many NGO staff as a strict referral pathway and a major barrier to referring eligible consumers into the programs in these areas. Combined issues already discussed such as increased stigma, decreased mental health literacy, and fewer clinical services being available anecdotally has been linked to many people from rural areas missing out on referrals into the program. One NGO staff member described these difficulties with the change in how referrals into the MH CSS program had implications for rural locations, "Originally, this program...was open to the general public in [town], which is great. So people could walk through the door and get support in whatever area they needed, whether it be advocacy, helping them fill out a form, going to a GP, destressing, whatever it is. So now that it's Queensland Health referral only, you can imagine out here, there's only a very small amount of people who work in the mental health...So the referral pathway is clunky at best and isn't particularly managed well" (F, IRSP, NGO staff)

Another NGO staff member described difficulties experienced with clinical staff not understanding or being aware of the MH CSS programs in particular locations;

Interviewee: "It's really poor communication as well because most Queensland Health staff members don't even realise they can refer to us. So it's not just open to the mental health team. It's Queensland Health in general. So it could be coming from the social worker in the hospital. It could be ... but they don't even know.

Facilitator: They don't even know you exist, and it sounds like you don't have the relationship to even...tell them all that you exist, or to have that communication...

Interviewee: Yeah. We ring up. We go up there. We tell them what we can do, and everyone's like, "Oh my God. That's fantastic. Can you really do that? That's amazing. Fantastic." Then they'll change position and then there'll be a locum come into that role. There's a lot of shuffling of staff. There's all of that stuff. So it's just really hard and it is a bit of them and us because of our scenario now. I noticed that other organisations like [other NGOs], they just find the whole [our NGO process], having to go through Queensland Health just too difficult." (F, IRSP, NGO staff)

## Awareness and emphasis on local services/people

As is a key ingredient throughout the evaluation's findings, relationships and trust-building were found to be crucial facilitators in strong consumer/NGO staff relationships. Similar to other findings related to the rural populations discussed above, this emphasis on relationships and trust-building is even more important. Findings from the evaluation indicated that being a 'local,' understanding the rural context, and being a part of the community is very important. Whilst not all NGO staff are originally rural-based or will be rural-based permanently, it was found that when stakeholders showed genuine interest in rural culture and/or assimilated into the area, consumers were more likely to trust and build relationships. Being local or part of the rural community was found to be particularly relevant when consumers were referred to other services and/or ultimately exited from the MH CSS programs. Locals or stakeholders who were in touch with available

community services could assist consumers based on their needs and deliver a fundamentally consumer-focussed service from referral onto the program to exit back into the community.

## 6.2 Peer Workforce

Throughout the evaluation, the concept and utility of a peer workforce (or staff who identify as having lived experience of mental illness and are employed to use these experiences to support others) within the MH CSS programs, and community mental health services in general, arose as an important theme. The below summarizes the sub-themes found underneath the overarching theme of peer workforce, as they relate to the MH CSS programs and the delivery of community-based mental health services:

### Relatability

It is well accepted within the literature that mental health peer workers provide a number of essential features which aid in a consumer's recovery (Barr et al., 2020; Lewis & Foye, 2022; Stratford et al., 2019; Walsh et al., 2018). Specifically, a consumer's ability to relate to a peer worker was assessed to be a substantial facilitator in engaging with the MH CSS programs. It was found that consumers valued shared common understandings and experiences between themselves and peer workers, and that this provided comfort and confidence to the consumer in their NGO staff member's role. One participant said, "I find it a lot easier talking to someone with past experiences...Somebody who can relate to what I'm saying, and offer me, 'This is how I got through it.'" (M, 25-34yrs, IRSP, consumer). Additionally, it was assessed that consumers found that by participating in groups facilitated by peer support workers, consumers were able to relate to not only the NGO staff member but also other individuals with mental illness. This mutual understanding of shared experience helped consumers experiencing SMI not feel they were alone, while also providing a community and repository of tried-and-tested learning and techniques relating to living everyday with mental illness (Stratford et al., 2019). Another consumer described being part of the peer groups as; "It just sort of felt, it sort of felt like a family and sort of people that I could be around and trust. And other people that have had similar lived experience to what I've had." (F, 45-54yrs, multiple programs, consumer)

### Mental health normalized

Similarly, it was assessed that consumers found engaging with peer workers helped to normalise mental ill health and noted it provided an example of recovery being possible and hope. This notion of peer workers providing hope is commonly discussed in the literature, and has been seen a major outcome of embedding peer workers within the mental health workforce (Stratford et al., 2019; Walsh et al., 2018). One MH CSS consumer expressed sentiments about feeling 'normal' in the following quote: "But it's been good coming here because also they've got lived experiences and stuff. Because I know it's weird, it's like, what I have is no different from anybody else, or anybody normal, it's just different. It's nice to be able to talk to people who have the same thing and try and understand what I have because to me it's just normal stuff because I hide everything. So therefore I don't know what the deal is." (F, 45-54yrs, GBPRSP, consumer). Reflecting on how peer workers helped provide hope and made them feel recovery was even possible, this consumer said: "So it's like, they've already mastered their mental health issues, they've already gone and learned on it and then they can create all of their advice based on those two things, which most only have one side of. So it's like you trust a lot of what they say a lot more as well. It feels a lot more like its real advice rather than they're just listing the dot points that they read at school." (M, 18-24yrs, multiple programs, consumer)

## Consumer interest in becoming a peer worker

Following on from peer workers providing hope to consumers about recovery, a few consumers expressed interest in becoming peer workers themselves after interacting and benefitting from the peer workforce. Debyser et al. (2019) discusses this trajectory from consumer to peer worker, including some of the reasons for this common transition including an opportunity to ensure personal recovery and liberate themselves from being a consumer by finding a meaningful vocation of offering hope to others. Similarly, MH CSS consumers who were interested in peer work indicated that becoming a peer worker provided them with a meaningful vocation and purpose. For example, one consumer described their inclination to become a peer worker below:

**Interviewee:** I'd like to probably help people who've been through mental health and give them my story how I got through it and stuff like that. I think I could do that, you know, something like that.

**Facilitator:** What makes you want to do that?

**Interviewee:** Because people helped me through it... and I saw a lady the other day at the course and she broke down and cried and I went over and I said "Are you all right?", and she goes "No", and I said "Do you want to go outside with me?", and she came outside and I just said do the breathing, you know, breathe and then count to four or five, and she was okay... (F, F, 65+yrs, IRHP, consumer)

Most times, consumers independently decided to embark on a path towards becoming a peer worker as part of their recovery journey, and their support workers (including peer support workers) assisted them with the logistics (i.e. researching the course, applying, enrolling, etc.). Occasionally, however, consumers expressed sentiments of feeling like their support workers were 'pushing them' into becoming a peer worker. For some NGOs, consumers described a common progression from being a consumer attending the peer groups to becoming a peer worker who facilitated the groups.

## Support (including training) for peer workers

Support (including training) requirements for mental health peer workers differ widely, which can present difficulties across organisations in understanding how to best support this workforce (Burke et al., 2018; Charles et al., 2021; Nossek et al., 2021; Stewart et al., 2008). At present in Queensland, the only formal qualification required for peer work is a Certificate IV in Mental Health Peer Work through Tafe, alongside having lived experience of mental illness (Byrne, 2021). Consistent with the literature, peer workers interviewed through the evaluation indicated varying degrees of both training and support across and within the NGOs in which they were employed. Some peer workers highlighted the extensive training opportunities and support (supervision, team meetings, professional development, etc.) available to them through their NGO. For example, one peer worker said,

"There's always ongoing training. Next Monday is the start of a peer work module, I've done the four modules, it's the practical side where I'll be Zooming like this – so I've got four days basically of that to go over a lot of different things and get the chance to talk about my journey and self-care, all that sort of thing. And then also within the workplace here, you know, I've worked in a few different places and this, in particular the staff, they were all very supportive especially, you know, because we've all got our lived experience and have a good understanding of mental health issues and there's been great support around." (M, GBPRSP, NGO staff)

However, a number of peer workers described a dearth in training and support, which significantly impacted upon not only the delivery of the service (MH CSS programs) but also had the potential to impact upon the peer worker themselves. Globally, peer workers have described confusion about their roles and

acknowledged that more support (including external supervision and/or training) would be of benefit (Nossek et al., 2021; Stewart et al., 2008). Based on the National Lived Experience Workforce Guidelines, further training and support for peer workers past this Cert. IV, implemented consistently across the state, is essential to peer workers' success and safety (Byrne, 2021).

### Unhealthy dynamics related to peer work

As identified above, some of the peer workforce employed on some of the MH CSS programs do not have adequate or frequent enough training and support, which has great risks to both the peer worker and the consumers they are working with. As a result of the evaluation, both consumers and peer workers described instances where unhealthy relationships existed between peer workers and consumers. Literature supports the importance of support and training in establishing healthy boundaries between peer workers and consumers, and without this oversight, peer workers and their consumers can be at risk in various ways (Holley et al., 2015; Mowbray et al., 1998; Stewart et al., 2008). This unhealthy relationship might manifest in a dynamic where the consumer acts as a support for the peer worker, as evidenced by this consumer/peer worker interaction:

**Interviewee:** There was a situation where we were talking about my parents, and then he started talking about his parents. And then he was talking about his Mum up in heaven, gave her the finger and all that. And I was like, "Whoa, you've got more issues than me, mate...I was like, "Who's giving who counselling?"

**Facilitator:** What am I here for?

**Interviewee:** Exactly. I don't mind listening, I like getting perspective on stuff like, but it just went a bit too far. I'm like, "Whoa, I don't think you've really healed from that." (M, 25-34yrs, IRSP, consumer)

Similarly, it was expressed that sometimes peer workers might overshare on the struggles they are going through, which has an impact on their role to support a consumer: "I won't go naming names of people but sometimes people with their own problems, you know, they may not be able to attend work if they're too overwhelmed with stress or something." (M, 35-44yrs, multiple programs, consumer).

Another way an unhealthy relationship between consumer and peer worker was described is through a consumer developing an unhealthy attachment to their peer worker, due to their ability to relate on a more personal level to their lived experience. For example, this consumer recognises the start of this unhealthy attachment in the following quote: "Yeah so, that's how it's evolved and the more I've opened up to her and the more we've chatted about what we did on the weekend or likes and dislikes, things like that, the more it's become relaxed and we'll have a laugh, and I don't know. It's just evolved like that. So I get that feeling of a friendship developing and I've got to be careful of that because I'm aware that it's the patient-client thing." (F, 45-54yrs, GBPRSP, consumer). This has been described in the literature as a common risk, and can be better managed by improvements to the peer worker's supervision and training (Holley et al., 2015; Nossek et al., 2021; Stewart et al., 2008).

Finally, it was found that sometimes the GBPRSP can sometimes present an opportunity for consumers to overshare about their mental illness, creating a potentially unsafe environment. As described by one consumer, this can be quite taxing, however the peer workers in this example display skill in navigating this group dynamic and ensuring a safe space for all GBPRSP participants:

**Interviewee:** I feel like some people are very open. Which can be a little bit off-putting sometimes, but each to their own, if you can handle it, like if you have the mental capacity and trying to listen

to other people's problems, like I do, I always sit and I listen and I talk, but some people are like. I don't want to talk about this. Yeah. I don't want to open up. I don't want to hear about your trauma.

Facilitator: Yeah, and how does that kind of manage by the group facilitators? The kind of chatting about, here's all of my traumas at a [GBPRSP event] sounds like it would be a bit triggering.

Interviewee: It can, they're really good at managing. Like if they notice, usually it's fine. Not many people go into too much detail, but if someone's bringing up something really intense, like they're very good at, as opposed to just saying, shut up, stop talking about it. They're very good at like distracting, changing the conversation, talking about card games or talking about the food. They're very good at navigating it and then usually talk to that person on their own. (F, 18-24yrs, IRSP, consumer)

### 6.3 Inclusivity

Another special consideration assessed throughout the evaluation centered on the inclusivity of the MH CSS programs, specifically referring to inclusivity of diverse consumers including those identifying as Aboriginal and/or Torres Strait Islander, Culturally and Linguistically Diverse (CALD), and/or LGBTQI+. The evaluation yielded mixed findings regarding suggestions of imbedding content related to specific population groups into the MH CSS programs, for example Aboriginal and Torres Strait Islander peoples or individuals identifying as LGBTQI+. Whilst some consumers were supportive of this addition, indicating that being able to connect their culture and identities to their recovery journeys were important, others did not feel this addition would change the services they were receiving. Consumers identified that the best method for imbedding this would be through the GBPRSP offer; for example, a group for consumers who identify as LGBTQI+ and another group for individuals who identify as Aboriginal and/or Torres Strait Islander, so that a community could be developed that links consumers with similar identities who are also experiencing mental ill health. This was also supported by the more elderly consumers of the MH CSS programs; many times elderly consumers indicated the age disparity between themselves and younger consumers was a barrier towards participating in the GBPRSP. It was also expressed from consumers that when the majority of consumers in a group were of similar age, inclination to attend groups was higher as there was more common ground and relatability among consumers.

The most common sentiment from consumers and NGO staff, however, was that the MH CSS program needed to be a safe space for all individuals regardless of their various identities. Reflecting on the importance for inclusivity, one consumer said, "I like the idea of being culturally acceptable and letting people feel more included...I like the idea of like it being a safe space for everybody and not pinpointing some, because like what if this was like, how about people that are like Muslim and things like that, there's no recognition for them, is there recognition for Chinese people?" (F, 18-24yrs, IRSP, consumer)

Another finding from the evaluation indicated that consumers were supportive of the idea that their NGO staff were diverse, and that the inclusivity of the MH CSS programs' consumers were reflected in the identities of the NGO staff. For example, consumers of the TCFP were supportive of staff members having experience of incarceration and similarly consumers of the IRHP were supportive of staff members having experience of homelessness. Further, it was viewed positively that all MH CSS programs have staff of diverse backgrounds, so that consumers could connect and build rapport better with NGO staff from similar identities or backgrounds.

## 6.4 COVID-19

Throughout the evaluation consumers and staff from the NGOs were asked if they experienced any changes to the delivery of the service because of the COVID-19 pandemic. The responses could be grouped into several common themes including:

### No impact (+)

There were several consumers and staff from various HHS' that reported the COVID-19 pandemic did not impact on their accessing or delivery of the community mental health supports. One consumer noted "[i]t hasn't impacted it at all" (M, 65+yrs, IRSP, consumer) and a staff member summarized "I don't think it's impacted us at all. That's just my perspective. They still need support, they still need to go shopping or whatever, you know. Most of them isolate anyway. Most of them aren't in the community like you or me." (M, IRSP, NGO staff)

### Decreasing isolation (+)

There were a small number of consumers who responded positively to their supports being delivered online where they may have historically not engaged in support due to social anxieties and mental health concerns, services being delivered remotely allowed them to access supports in the comfort of their familiar environments. One consumer summarized receiving supports virtually "[i]t was better than what I had which was nothing" (F, 55-64yrs, GBPRSP, consumer), and another noted "It was actually quite nice. I mean, it was different. I think it gave the people that were on the course, because there were quite different types of people, the ability to actually go there because I think if they had to actually come into the class then it would have probably been harder for them to do it. Because a lot people were suffering quite a bit with their depression and stuff like that. In some way it made it easier for some people and others it didn't." (F, 45-54yrs, GBPRSP, consumer)

### Additional funding (+)

Some organisations referenced the additional funding they were provided during COVID-19 and the benefit that it had in delivering the service to consumers. NGOs reportedly used the funding to purchase devices so the consumers could access the program remotely, or other essential goods. One staff member noted "[w]e picked up some additional funding through COVID last year to be able to do that. We don't need a lot but it is really useful for things like, you know, purchasing of items, assisting a person with their housing, there's lots of bits and pieces that you don't want to have to go through somewhere else to try and find relief money, you actually just want something available immediately that you can tap into and it doesn't have to be massive but it's extremely useful to have that flexible funds." (F, multiple programs, NGO staff), and another reported how they utilised the funding to the benefit of the consumers "we just spent that money on a lot of meaningful things, like maybe just help people with 18+ cards, licences, certificates and training, like some training or education to get them sort of on their feet. So yeah, that's something that – it would be good to just have a little bit of brokerage just for the people that are really in crisis or, you know, just to help them a little bit" (F, TCFP, NGO staff)

### Consumer loss of employment (-)

Some consumers noted they had experienced loss of employment as a result of the COVID-19 pandemic. It was common for consumers to work in roles that were more likely to be impacted included essential services such as grocery stores and hospitality roles. One consumer noted "COVID came around. You don't really

need a heap of staff at a motel, so unfortunately, and also fortunate at the same time, I did lose my job there.” (M, 18-24yrs, IRSP, consumer)

### Increasing isolation (-)

Consumers and staff commonly reported that they experienced an increase in isolation due to the COVID-19 lockdowns and social isolation rules. A number of consumers are vulnerable to isolation as a result of their mental health concerns and their ability to engage with community mental health supports was at times impacted. One consumer noted they had felt more isolated “...because I can't go and see my friends and they can't come over because of the COVID.” (F, 45-54yrs, GBPRSP, consumer)

### Impact to delivery of services (-)

The GBPRSPs were most commonly impacted by the COVID-19 pandemic lockdowns as they were often located in venues that had to close, or were not able to adhere to COVID-safe practices (ie too many consumers in a room where social distancing could not be maintained). One staff noted that consumers used to attend groups “but because of COVID everything stopped” (F, 45-54yrs, IRHP, consumer) and a consumer noted in regard to their group support being delivered online “[s]o I don't know whether that was putting people off – other people off, you know, because they were giving out tablets to people to do the Zoom sessions. So whether they weren't comfortable with the technology, I don't know, it might have been a barrier for some.” (M, 45-54yrs, GBPRSP, consumer). A staff reported how the major impact to service was related to the delivery of groups “We've been able to continue the service pretty much as normal. The groups are probably different. That's probably way more affected than one on one, yeah.” (M, IRSP, NGO staff), and another staff noted “So, we couldn't really 'social distance' and stuff like that. So, we couldn't offer a group and then like, only take like, two people.” (F, 55-64yrs, GBPRSP, consumer)

### Increase in mental health concerns (-)

A small number of consumers reported that their mental health concerns increased during the COVID-19 pandemic. This was related to an increase in experiences of stress and anxiety and was reportedly linked experiences such as panic buying in the supermarkets and not being able to access support services as normal. One consumer noted her anxiety around leaving the house escalated during the pandemic, “[m]y brain just went into this overdrive...I couldn't go out because of COVID and it just has built since then.” (F, 55-64yrs, IRSP, consumer) and one staff member noted how they had to support consumers experiencing increased mental health concerns “[s]o if we've gone into a setting where everyone's has actually become a little bit snappy or, you know, watching their personal space or go into hospital and you've got to go and sign these things and everyone's sort of sitting down looking at each other thinking have they got it, you know, there is a raised anxiety in general, and probably with the staff as well, you know, they're under stress and myself included. So just trying to be aware of what's happening in the moment and really talk about it. So to answer your question, I think there has been an impact. My role is to support people so I'm supporting them around, you know, it's okay, we can still go to these things, I'll find out, you know, we'll ring ahead, you know, is your appointment going to be on. So it's just trying to slow it all down and make sure it's okay.” (M, IRSP, NGO staff)

## 7. Limitations

Although the team visited the majority of locations in which the MH CSS programs were delivered, there were a small number of locations in which a site visit was not conducted (and subsequently participants from these sites were not included in the data collected). This limitation was largely due to minimal recruitment responses from these areas, despite continued efforts. However, given the breadth and depth of participants that were recruited and interviewed during data collection, the evaluation's overall sample remained representative of the MH CSS consumers, NGO staff, HHS staff, and wider stakeholders. It is also important to note that there are clear gaps in recruiting participants (consumers, NGO staff, HHS staff, and wider stakeholders) from the TCFP in metropolitan areas and IRHP in rural and remote areas.

The evaluation sought to recruit a wide range of participants accessing the MH CSS programs, and the sample included individuals identifying as LGBTQI+ and Aboriginal and/or Torres Strait Islander. It is important to note that although recruitment processes included options for the use of translators and translated recruitment materials, specifically designed to include individuals from CALD communities, our sample did not include any participants whose primary language was not English. This is a limitation of our evaluation, and the inability to recruit and interview individuals from CALD communities does *not* suggest these groups do not need to access MH CSS services. Conversely, this lack of representation highlights a significant barrier within the MH CSS programs to reaching and supporting these populations. In a study conducted by Minas et al. (2013), authors described the significant lack of inclusion of multicultural Australians across the country's various mental health services, but also showed these populations' dearth among research samples. Further and more targeted research is required to capture the experiences of these populations accessing Australian mental health services, as their need for inclusion is arguably greater due to increased rates of mental illness among these populations (Minas et al., 2013).

More broadly, the evaluation was unable to recruit participants from each stage of the MH CSS program, particularly at the earlier stages where a consumer might have been referred but declined the referral or where a consumer was referred and attended the first few sessions of the MH CSS program but failed to adopt the program. Although efforts were specifically deployed to capture these important participant voices, logistics including NGOs not having consent to release their contact details or no longer having their up-to-date contact details presented barriers to their recruitment. As such, the lack of representation from these consumers highlights a limitation within our sampling. However, during interviews with recruited consumers, as well as probing negative experiences, interviewers used alternate scenario questioning and antithesis checking to determine the likely outcome that different or negative experiences might have had for consumers.

## 8. References

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## 9. Appendices

### A. Royal Brisbane & Women's Hospital Human Research Ethics Committee Approval



**Metro North**  
Hospital and Health Service

**Royal Brisbane & Women's Hospital**  
**Human Research Ethics Committee**

Enquiries to: Ann-Maree Gordon  
Coordinator  
Telephone: 07 3647 1007  
File Ref: HREC/2021/QRBW/73074  
Email: [RBWH-Ethics@health.qld.gov.au](mailto:RBWH-Ethics@health.qld.gov.au)

Dr Zoe Rutherford  
Queensland Centre for Mental Health Research  
The Park – Centre for Mental Health  
Locked Bag 500  
Archerfield Qld 4108

Dear Dr Rutherford,

**Re: Ref N°: HREC/2021/QRBW/73074: Evaluation of the Queensland Mental Health Community Support Services (MHCSS) Program**

Thank you for submitting the above research project for single ethical review. This project was considered by the Royal Brisbane & Women's Hospital Human Research Ethics Committee (RBWH HREC) (EC00172) at its meeting held on 08 March 2021.

I am pleased to advise that this research project meets the requirements of the National Health and Medical Research Council's (NHMRC) *National Statement on Ethical Conduct in Human Research (2007)* and that the RBWH Human Research Ethics Committee has granted ethical approval of this research project.

**This letter constitutes ethical approval only.** This project cannot proceed at any site until separate research governance authorisation has been obtained from the CEO or Delegate of the institution under whose auspices the research will be conducted at that site.

The approved documents include:

Document	Version	Date
Cover Letter		22 February 2021
Distress, Imminent Risk and Follow-up Protocol	1.0	22 February 2021
HHS Memo	1.0	22 February 2021
Indicative Interview Schedule	1.0	22 February 2021
NGO Memo	1.0	22 February 2021
Appendix 12: Appendices List	1.0	22 February 2021
Schedule – Deed Details (signed by Z H Rutherford on 16.02.2021 and Karen North on 17.02.2021)		
Curriculum Vitae of Dr Zoe H Rutherford	1.0	22 February 2021
Response to request for further information		23 March 2021
HREA	Mar ver 4	24 March 2021

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Document	Version	Date
QMHCSSE Protocol	1.1	23 March 2021
Appendix 1: NGO Gatekeeper Letter	1.1	23 March 2021
Appendix 2: Templates for Recruiting	1.1	23 March 2021
Appendix 3A: Consumer Information Sheet	1.1	23 March 2021
Appendix 3B: Consumer Consent Form	1.1	23 March 2021
Appendix 4: Demographic Survey	1.1	23 March 2021
Appendix 6A: NGO Staff Information Sheet	1.1	23 March 2021
Appendix 6B: NGO Staff Consent Form	1.1	23 March 2021
Appendix 8A: Stakeholders Information Sheet	1.1	23 March 2021
Appendix 8B: Stakeholders Consent Form	1.1	23 March 2021
Appendix 11: Data Custodian Approval for MG NGO E DC data	1.1	23 March 2021

Ongoing approval is for the duration of the project, conditional on:

1. In accordance with Section 5.5.6 (b) of the National Statement, the Principal Investigator will report to the HREC annually (Due by 30 April each year) in the specified format with a final report to be submitted on completion of the study.  
<https://www.health.qld.gov.au/metronorth/research/ethics-governance/post-approval-reporting/default.asp>
  2. The Principal Investigator will immediately report anything which might warrant review of ethical approval of the project, in the specified format, including:
    - a. Unforeseen events that might affect continued ethical acceptability of the project.
    - b. Serious Adverse Events that materially impact on the continued ethical acceptability of the project.
  3. Amendments to the research project are to be submitted to the HREC for review. Amendments should be reflected in a cover letter from the Principal Investigator, providing a description of the changes, the rationale for the changes, and their implications for the ongoing conduct of the study. Further advice on submitting amendments is available from:  
<https://metronorth.health.qld.gov.au/research/ethics-and-governance/post-approval-reporting>
  4. The Principal Investigator will notify the HREC if the project is discontinued at the participating site(s) with reasons provided.
  5. If additional sites are engaged prior to the commencement of, or during the research project, the Principal Investigator is required to notify the HREC. Notification of the withdrawn sites should also be provided to the HREC in a timely fashion accompanying a close out report for that site.
- Please advise the HREC of the date you commence the research project for the approved site(s) using the Notification of Commencement Form:  
<https://www.health.qld.gov.au/metronorth/research/ethics-governance/post-approval-reporting/default.asp>

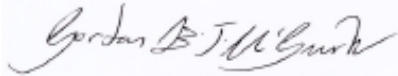
- The HREC's Terms of Reference, Standard Operating Procedures, membership and standard forms are available from: <https://www.health.qld.gov.au/metronorth/research/ethics-governance/hrec-approval/membership/default.asp>.

**The nominated participating sites for this project are:**

- Metro North Hospital and Health Service
- West Moreton Hospital and Health Service
- South West Hospital and Health Service
- Darling Downs Hospital and Health Service
- Metro South Hospital and Health Service
- Gold Coast Hospital and Health Service
- Sunshine Coast Hospital and Health Service
- Wide Bay Hospital and Health Service
- Central Queensland Hospital and Health Service
- Central West Hospital and Health Service
- Mackay Hospital and Health Service
- Townsville Hospital and Health Service
- Cairns and Hinterland Hospital and Health Service
- North West Hospital and Health Service

The Royal Brisbane & Women's Hospital Human Research Ethics Committee wishes you every success in your research.

Yours sincerely,



Dr Gordon McGurk  
Chairperson RBWH Human Research Ethics Committee  
[Metro North Hospital and Health Service](#)  
30 March 2021

This HREC is constituted and operates in accordance with the National Health and Medical Research Council's (NHMRC) *National Statement on Ethical Conduct in Human Research (2007)*. The processes used by this HREC to review multi-centre research proposals have been certified by the National Health and Medical Research Council.