FLORESCO SERVICE MODEL EVALUATION

FINAL REPORT 2018

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Executive summary

Background

A well-recognised problem in the Australian mental health system — and in other contemporary mental health systems — is the fragmentation of community-based care. This can make it difficult for people with mental illness and ongoing functional disability to get the right mix of clinical treatment and non-clinical support services at the right time. In turn, this can lead to poor outcomes for individuals, governments and communities. While there have been many attempts to integrate mental health services, relatively few evaluations of service models that integrate specialised mental health services and non-clinical support services have been published. The service model implemented at the Floresco Centre presented a unique opportunity to add to the evidence base through an evaluation of an innovative attempt to improve integration between multiple providers of clinical and non-clinical mental health and related services.

About the Floresco Centre

The Floresco Centre was established in late 2014 by a consortium of four non-government organisations (NGOs), including two mental health support providers, a disability support provider, and a tenancy advice and advocacy service. The consortium, led by Aftercare Inc., intended to operate it as a 'one-stop' mental health service hub for adult residents of Ipswich and surrounding areas. Located within the Greater Brisbane metropolitan area, to the west of Brisbane city, this service area comprises a mix of urban and rural communities, and includes large areas of relatively high socioeconomic disadvantage.

The Queensland Government funded the consortium, through Aftercare, to deliver a suite of community-based psychosocial support service types at the Floresco Centre, including personalised support, group support, mutual support and self-help, and family and carer support. As well as co-locating for delivery of these service types, the consortium worked with several other local health and community service providers to encourage the co-location at the centre of a range of clinical and non-clinical services relevant to the needs of adults with mental illness and their families and carers. It also employed a number of other strategies to support service integration at Floresco and achieve better outcomes for people with mental illness. These included:

- shared processes and systems — a single intake and assessment process, a single care plan, a shared client information system, a single practice manual of policies and procedures, and a single brand name
- collaborative governance through a Governance Committee comprising representatives of the four NGO partners, the local public mental health service, and several other local community service providers.

What we did

We conducted a three-year mixed-methods evaluation, with the aim of assessing the effectiveness of the service model while also investigating its implementation, including the barriers to, and enablers of, service integration at the Floresco Centre, and opportunities for improvement. We included both process (formative) and outcomes (summative) components in the evaluation design.

For the process component, we analysed data collected primarily through semi-structured interviews with Floresco staff and other key informants; additional data were sourced from meeting observations, documents, and Floresco clients. Four key questions guided this component of the evaluation:

Q1 Was an integrated service model implemented at the Floresco Centre as planned?

Q2 What were the barriers to effective service integration?

Q3 What were the key enablers of service integration?

Q4 How could the Floresco service model be improved to achieve better outcomes for clients?

For the outcomes component of the evaluation, we analysed Floresco client data, including scores on the Recovery Assessment Scale — Domains and Stages (RAS–DS) tool. In addition, we conducted a follow-up study of 37 clients referred to the Floresco Centre by the local public mental health service, using structured questionnaires, the RAS–DS, and data on participants' pre- and post-Floresco use of public inpatient and emergency department (ED) services. The outcomes component sought to answer two key questions:

Q5 Has the Floresco service model improved outcomes for people with mental illness?

Q6 To what extent has the service model contributed to improved system outcomes?

What we found

Was an integrated service model implemented at the Floresco Centre as planned?

Integration of a range of clinical and non-clinical mental health services has been achieved at Floresco, which — from the perspective of its clients — operates effectively as a one-stop mental health service hub. The Floresco Centre is filling a significant gap in mental health service provision in the Ipswich area and meeting a high level of need for psychosocial support and therapeutic group services. However, the integrated service model remains a work in progress, with several intended features not yet working as planned. For example:

- ongoing co-location of public mental health service staff has not proved feasible
- the shared client information system is not being used by all service providers that are co-located at the Floresco Centre, so clients still sometimes have to tell their story more than once, albeit less frequently than they otherwise might
- no general practice services are co-located at Floresco, and the availability of private mental health practitioners has been inconsistent
- the potential benefits of having Floresco operated by a consortium of NGOs that each have their own specialty have not been realised. This is because none of the mental health support workers employed at Floresco by Aftercare's consortium partners have any training in the speciality areas of their employing organisations.

What were the barriers to effective service integration?

We found that the effort to implement an integrated service model at the Floresco Centre had encountered several significant barriers, not all of which have been overcome in the more than three years since the centre was established. These barriers included:

- the challenges of bringing staff from four different NGOs together to work as one team
- barriers to integrating with the local public mental health service
- a range of barriers to systematic information-sharing

- resourcing challenges
- staffing problems
- difficulties in recruiting and retaining general practitioners (GPs) and private mental health practitioners
- difficulties in responding to the level of demand as well as the level of clinical need
- complexities related to operating as a consortium
- inconsistent leadership and governance.

What were the key enablers of service integration?

Key stakeholders consistently identified strong relationships, particularly between Floresco and the local public mental health service, as among the factors that have facilitated service integration at the Floresco Centre. Other significant enablers identified in this evaluation included:

- an enabling environment, in which the drive to innovate was supported at senior management and board level across all participating organisations, and particularly within Aftercare
- personality factors — although stakeholders recognised the potential risks of relying on the passion and drive of individuals in leadership positions to sustain the commitment to service integration
- committed staff at all levels across the consortium partners and in the mental health service
- open communication
- co-location of a number of services and supports to meet the needs of people with mental illness, all of them accessible via the one reception area, and all operating under the Floresco banner
- good reputations and high levels of credibility among the individual consortium partners
- flexibility, not only in relation to the delivery of services and supports, but also in developing and refining the service model
- positive client outcomes, which have helped reinforce the commitment to service integration and to Floresco's service model as a means of achieving it.

How could the Floresco service model be improved to achieve better outcomes for clients?

We found numerous opportunities for improvements to the Floresco service model that may help to achieve better mental health outcomes for clients. Most of these improvements would require either additional funding or better use of existing funding — or a combination of both. For example, while the current level of Queensland Government funding covers the costs of delivering the contracted psychosocial support service outputs, it does not cover the full costs involved in holding the integrated service model's components together, which have been borne by Aftercare as lead agency. Additional funding would also support the recruitment of more clinical staff, including additional intake staff, to help meet the higher-than-expected clinical mental health needs of the local population.

At the same time, the current level of funding could be used more flexibly, and potentially more effectively, if Aftercare were not locked into subcontracting arrangements with its three consortium partners. The current arrangements limit the possibilities for employing a more appropriate mix of clinical staff and mental health support workers to meet the needs of Floresco's clients. Moreover, if

the consortium NGOs were to provide their services in kind, rather than via subcontracted outputs, they would be better placed to deliver services in their speciality areas, and the potential benefits to clients of bringing together a group of NGOs with different areas of expertise could be realised.

Abandoning the subcontracting arrangements would also allow Floresco and Aftercare management staff to focus more on improving systems and processes at Floresco, rather than becoming caught up in managing overly complex staffing arrangements and negotiating compromises with the NGO partners over clinical governance issues. In particular, it seems likely that clients' mental health outcomes could be improved if Floresco staff could be trained and supported to make better use of the shared client information system. Client information needs to be entered in a consistent way, so that it can be more easily extracted and used to track and support clients' recovery, not just individually but also by cohort (e.g., according to age, gender, diagnosis, etc.). Floresco's agreed outcome measures also need to be used more routinely and effectively, to enable more focus, throughout each client's engagement, on working towards mutually agreed recovery goals, and on planning and supporting the client's exit from services.

Other suggested improvements to systems and processes at Floresco include:
- stronger clinical governance
- better waitlist management
- more clarity for clients, when they first engage, about not only what Floresco can do for them, but for how long
- a more strategic focus by the Governance Committee
- revisions to position descriptions for Floresco's service manager and team leader
- better induction for new staff into the vision and philosophy underpinning the Floresco service model
- more focus on staff retention.

Has the Floresco service model improved outcomes for people with mental illness?

The main outcome measure used in the evaluation was the RAS–DS tool, the results of which showed statistically significant improvements in self-reported mental health outcomes between baseline and follow-up among 1129 clients who engaged with Floresco between 1 July 2015 and 31 December 2017. We also observed significant increases in recovery across all four domains of the RAS–DS — functional recovery ('Doing things I value'), personal recovery ('Looking forward'), clinical recovery ('Mastering my illness') and social recovery ('Connecting and belonging') — among the 37 participants in our follow-up study.

In addition, whereas follow-up study participants reported high rates of suicidal ideation in the 12 months prior to their engagement with Floresco, these rates dropped dramatically afterwards: almost two-thirds of participants reported no suicidal ideation during the 6 months between their baseline and follow-up interviews.

Other indicators that Floresco's service model has improved outcomes for people with mental illness include the results of Aftercare's 2017 Your Experience of Service survey. The 34 Floresco clients who participated in this survey were asked about the effects that Floresco had on their overall wellbeing, their ability to manage their day-to-day lives, and their hopefulness for the future; in all cases about 80 per cent of respondents rated these effects as either excellent or very good.

Despite these positive findings, it is important to recognise that our follow-up study lacked a control group that might have enabled us to more conclusively attribute the significant self-reported mental health recovery experienced by Floresco clients (as measured by the RAS–DS) to the Floresco service model.

To what extent has the service model contributed to improved system outcomes?

Our findings have positive resource implications for public sector acute and continuing care mental health services. Several stakeholders, including staff from the local mental health service, expressed the view that the Floresco service model has the potential to lead to improved system outcomes, in terms of more effective use of scarce hospital and mental health service resources. Their belief gained some support from our follow-up study, which compared participants' use of hospital ED services and acute care inpatient beds during the six months pre- and post-intake to Floresco. We found decreases in hospital admissions, ED attendance, and median length of stay. While we found no statistically significant decline in the number of participants attending ED, or the number admitted to hospital, following intake to Floresco, our results were in a positive direction, suggesting that another study with a larger sample size would lead to more robust and potentially significant findings.

Conclusions

Our evaluation had some limitations, but has nevertheless provided valuable insights into the significant barriers that may be encountered by initiatives that seek to integrate mental health services, and has identified some important enabling factors. Implementing a new integrated model was challenging in the Australian mental health service environment where there are so many different funders and providers. However, this study shows that horizontal service integration of NGO and private practitioner services is achievable in this environment, and that meaningful progress towards the integration of these services with public mental health services can be made.

The evaluation found that Floresco clients improved in recovery during their engagement with the centre, although further research, using more robust study designs, is needed to determine whether these improvements are attributable to Floresco's integrated service model. Either way, the evaluation also identified several ways in which Floresco's integrated service model could be improved to achieve better mental health outcomes for clients.

Introduction

In the wake of deinstitutionalisation, a common problem among contemporary mental health systems is the fragmentation of community-based care. This can make it difficult for people with mental illness and ongoing functional disability to get the right mix of clinical treatment and non-clinical support services at the right time [1-4], leading to poor outcomes for individuals, governments and communities [1-3, 5]. Although this problem is well-known, and many attempts to integrate mental health services have been made, there have been relatively few published evaluations of service models that integrate specialised mental health services and non-clinical support services [4]. More evidence is needed regarding the implementation and effectiveness of integrated mental health service models, to inform service development and planning.

The need for improved service integration in response to the problems created by the separation of clinical and non-clinical services is a recurring theme in mental health plans in many countries [5-9]. In Australia, this separation arises because the mental health service system comprises a complex mix of government agencies, private (for-profit) providers, and not-for-profit non-government organisations (NGOs), where responsibility for funding different levels and types of mental health care is dispersed across different tiers of government [1, 3, 4]. 'Service integration' in this context is understood to refer to collaborative attempts by two or more service providers to improve outcomes for individuals with mental illness by breaking down barriers between services (horizontal integration), without necessarily merging into a single organisation (vertical integration) [9]. It may involve one or more of a broad range of strategies — such as formal agreements, joint service planning and provision, single cross-agency care plans, cross-training of staff, shared case records, integrated funding, and service co-location [4] — and can be viewed as a continuum, rather than something that is either achieved or not [10, 11].

Despite ongoing calls for better mental health service integration, evidence on the effectiveness of models that integrate the services of clinical and non-clinical providers is weak, as is the evidence on how best to implement and/or strengthen integration within complex, multi-sectoral mental health systems. Most evaluations have focused on the outcomes of integration efforts; for example, a 2014 systematic review of attempts to coordinate the activities of clinical and non-clinical mental health service providers [4] identified a range of positive clinical and non-clinical outcomes for clients as well as some benefits for services. Similarly, a 2017 review of evaluations of integrated youth health care services, including the Australian *headspace* initiative [11], identified promising results in terms of symptomatic and functional improvements for between half and two-thirds of young service users. However, both reviews found that studies were often of poor quality [4, 11], at least partly because of the multiple difficulties of evaluating integration initiatives [11]. Both also noted that the various integration mechanisms employed in these initiatives were inadequately described; there was little detail about how they worked or what was involved in implementing them [4, 11]. A 2017 pre-post evaluation of an integrated program to better support people with severe and persistent mental illness who are homeless or 'at risk' of homelessness [12] illustrates these problems. It linked positive outcomes for clients (clinical and non-clinical) and cost benefits for government with the strategy of embedding housing and recovery workers employed by a mental health NGO within public mental health teams; however, it provided no information on how this strategy was implemented or what challenges were involved.

Barriers to mental health service integration have been considered in some evaluations. For example, a 2009 qualitative evaluation of Jigsaw, an Australian integrated young persons' mental health program [13], highlighted several major challenges, particularly those involved in bringing together different organisational and professional cultures and maintaining the quality of relationships between partners. The Jigsaw program also had difficulty in recruiting general practitioners (GPs) [13], a problem shared by many Australian *headspace* centres, where workforce issues often present challenges for the 'seamless' provision of co-located services for young people [14]. Key challenges for the English Care Programme Approach to integrating care for people with mental illness included patchy implementation, a lack of shared information systems, and care coordinators' lack of power to exert authority across networks of diverse providers [15]. In the implementation of Integrated Service Networks under the Quebec Mental Health Reform, most barriers related to organisational characteristics such as high staff turnover, concerns about losing autonomy, and leadership problems [9]. Other identified barriers include funding and technology constraints, excessive workloads, 'turf wars' among service providers, difficulties in maintaining stakeholder commitment, and barriers to information sharing, including concerns about client confidentiality [4].

Several evaluations have identified factors that facilitate mental health service integration. Strong leadership across participating services has been identified as an important enabler [4, 9, 16], as has co-location [4, 16], which can in turn promote another key enabler, namely effective information-sharing [4, 15, 16]. Perhaps most importantly, several studies have emphasised the importance of attending to issues of culture and philosophy, to ensure mutual respect and trust, and shared understandings about the purpose of integration [4, 15, 16].

The service model implemented at the Floresco Centre in Ipswich, Queensland, presented a unique opportunity to add to the evidence base through an evaluation of an innovative attempt to improve integration between multiple providers within the mental health service system. The evaluation aimed to assess the effectiveness of the service model while also investigating its implementation, including the barriers to, and enablers of, service integration at the Floresco Centre, and opportunities for improvement.

Methods

Evaluation setting

The Floresco Centre was established in late 2014 by a consortium of four NGOs (two mental health support providers, a disability support provider, and a tenancy advice and advocacy service) with the intention of operating it as a 'one-stop' mental health service hub for adults. The Queensland Government funded the consortium, through Aftercare Inc. (the lead agency), to deliver a suite of community-based psychosocial support service types, including personalised support, group support, mutual support and self-help, and family and carer support. The Floresco Centre serves residents of Ipswich — a city within the Greater Brisbane metropolitan area, to the west of Brisbane city — and surrounding areas. This service area comprises a mix of urban and rural communities, and includes large areas of relatively high socioeconomic disadvantage [17]. Mental health support services such as those the consortium was funded to deliver had not previously been available there, except to specific groups of people with mental illness (e.g., people with mental illness being released from correctional facilities).

Figure 1 illustrates the program logic (theory of change) that underpinned the Floresco Centre's service model, as well as the key steps involved in establishing it. These included:
- a memorandum of understanding (MOU) between the consortium members, outlining how they would collaborate to establish Floresco as an integrated mental health service
- subcontracts between Aftercare, the funding recipient, and its three NGO partners for the delivery of the four service types
- an MOU between Aftercare and the West Moreton Hospital and Health Service, designed to facilitate collaboration between the Floresco Centre and the local public mental health service (MHS).

Figure 1 also shows the strategies intended to support service integration at Floresco and achieve better outcomes for people with mental illness.
- Co-location: As well as co-locating for delivery of the four funded service types, the consortium worked with several other local health and community service providers to encourage the co-location at the Floresco Centre of a range of clinical and non-clinical services relevant to the needs of adults with mental illness and their families and carers — for example, MHS Acute Care Team (ACT), GP, psychology, mental health social work, drug and alcohol, employment, and housing services.
- Shared processes and systems: These included a single intake and assessment process, so that clients would have to tell their story only once; a single care plan; a shared client information system, so that all providers involved in an individual's care could access and input current information on that person's recovery journey; a single practice manual of policies and procedures; and a single brand name and logo for use throughout the centre, to minimise confusion for clients.
- Collaborative governance: The Floresco Governance Committee comprised representatives from the four NGO partners and the MHS, and several other local community service providers were also invited to participate as partners.

With the Queensland Government funding, Aftercare employed a service manager, part-time clinical team leader, intake officer, and receptionist/administrative assistant, while the three partner NGOs each employed two mental health support workers. Floresco's psychosocial support services are delivered free of charge, as are the clinical services delivered by private GPs or allied health practitioners. These providers agree, as part of their agreement with the Floresco consortium, not to charge clients for their services; instead, Aftercare (as lead agency) bills the Australian Government on their behalf, under the Medicare Benefits Scheme (MBS). Aftercare retains a proportion of MBS payments to cover its costs (administrative services, practitioner rooms, etc.) and to provide an income stream from which to fund the delivery of additional services to those funded by the Queensland and Australian Governments. Other co-located services are also delivered free of charge, as they too are funded by the Queensland and/or Australian Governments. Figure 2 describes how the service model was intended to work in practice, showing potential client pathways through the Floresco Centre's range of individual and group services.
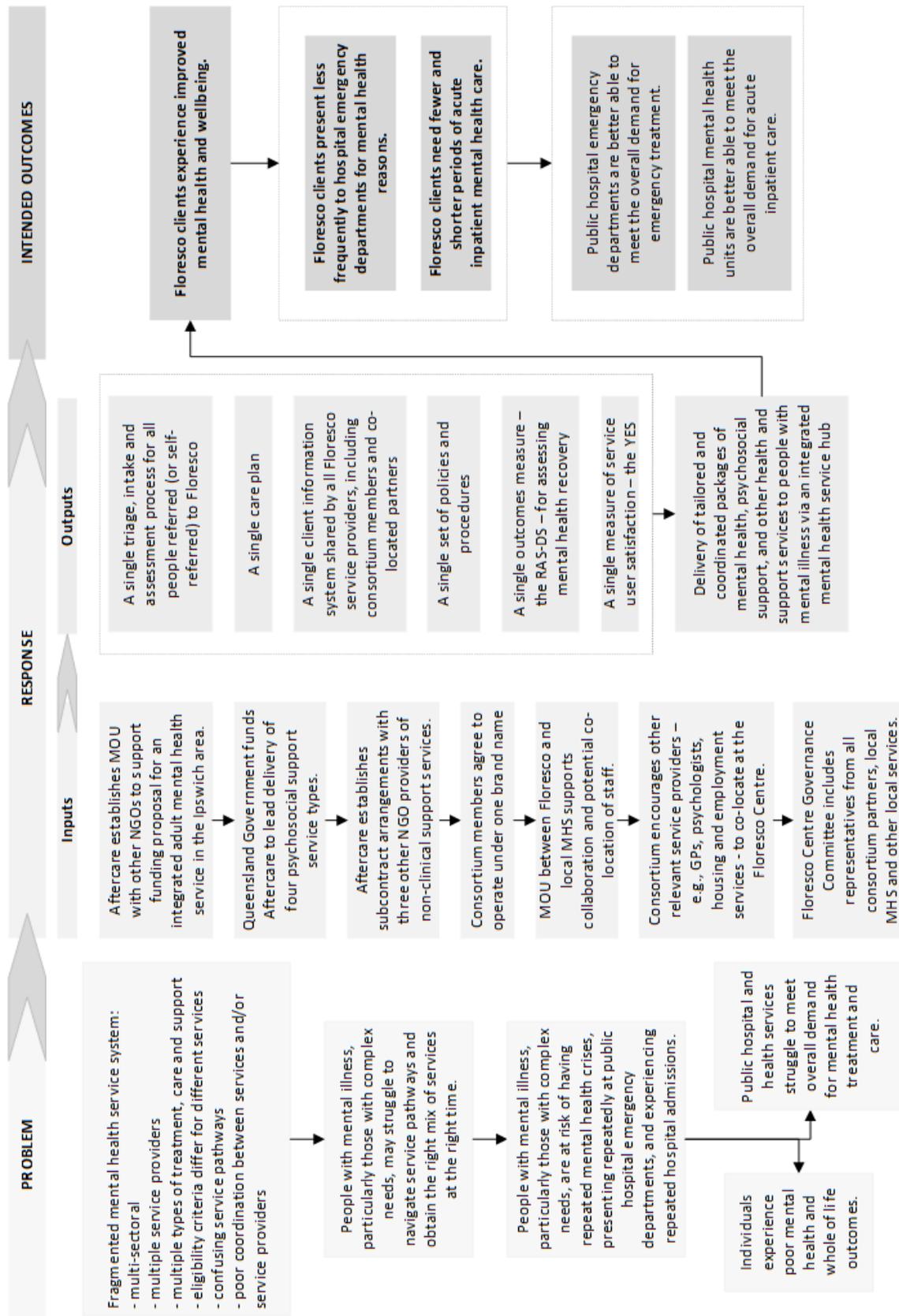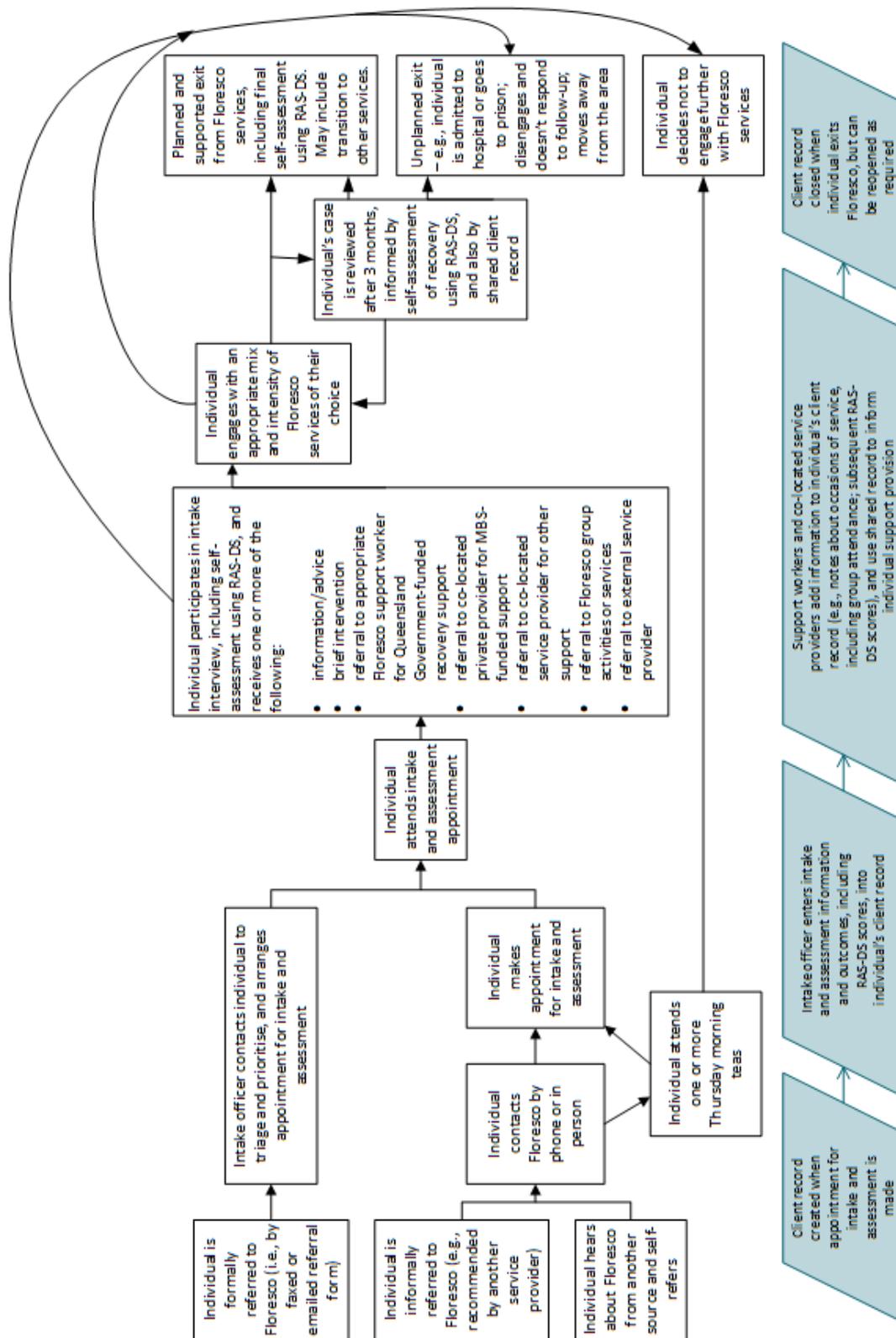
Figure 1: Floresco Centre program logic diagram

PROBLEM

Fragmented mental health service system:
- multi-sectoral
- multiple service providers
- multiple types of treatment, care and support
- eligibility criteria differ for different services
- confusing service pathways
- poor coordination between services and/or service providers

People with mental illness, particularly those with complex needs, may struggle to navigate service pathways and obtain the right mix of services at the right time.

People with mental illness, particularly those with complex needs, are at risk of having repeated mental health crises, presenting repeatedly at public hospital emergency departments, and experiencing repeated hospital admissions.

Public hospital and health services struggle to meet overall demand for mental health treatment and care.

Individuals experience poor mental health and whole of life outcomes.

RESPONSE

Inputs

Aftercare establishes MOU with other NGOs to support funding proposal for an integrated adult mental health service in the Ipswich area.

Queensland Government funds Aftercare to lead delivery of four psychosocial support service types.

Aftercare establishes subcontract arrangements with three other NGO providers of non-clinical support services.

Consortium members agree to operate under one brand name

MOU between Floresco and local MHS supports collaboration and potential co-location of staff.

Consortium encourages other relevant service providers – e.g., GPs, psychologists, housing and employment services – to co-locate at the Floresco Centre.

Floresco Centre Governance Committee includes representatives from all consortium partners, local MHS and other local services.

Outputs

A single triage, intake and assessment process for all people referred (or self-referred) to Floresco

A single care plan

A single client information system shared by all Floresco service providers, including consortium members and co-located partners

A single set of policies and procedures

A single outcomes measure – the RAS-DS – for assessing mental health recovery

A single measure of service user satisfaction – the YES

Delivery of tailored and coordinated packages of mental health, psychosocial support, and other health and support services to people with mental illness via an integrated mental health service hub

INTENDED OUTCOMES

Floresco clients experience improved mental health and wellbeing.

Floresco clients present less frequently to hospital emergency departments for mental health reasons.

Floresco clients need fewer and shorter periods of acute inpatient mental health care.

Public hospital emergency departments are better able to meet the overall demand for emergency treatment.

Public hospital mental health units are better able to meet the overall demand for acute inpatient care.

Figure 2: Planned Floresco Centre service model and client pathways

Individual is formally referred to Floresco (i.e., by faxed or emailed referral form)

Individual is informally referred to Floresco (e.g., recommended by another service provider)

Individual hears about Floresco from another source and self-refers

Intake officer contacts individual to triage and prioritise, and arranges appointment for intake and assessment

Individual makes appointment for intake and assessment

Individual contacts Floresco by phone or in person

Individual attends one or more Thursday morning teas

Individual attends intake and assessment appointment

Individual participates in intake interview, including self-assessment using RAS-DS, and receives one or more of the following:

- information/advice
- brief intervention
- referral to appropriate Floresco support worker for Queensland Government-funded recovery support
- referral to co-located private provider for MBS-funded support
- referral to co-located service provider for other support
- referral to Floresco group activities or services
- referral to external service provider

Individual engages with an appropriate mix and intensity of Floresco services of their choice

Individual's case is reviewed after 3 months, informed by self-assessment of recovery using RAS-DS, and also by shared client record

Planned and supported exit from Floresco services, including final self-assessment using RAS-DS. May include transition to other services.

Unplanned exit – e.g., individual is admitted to hospital or goes to prison; disengages and doesn't respond to follow-up; moves away from the area

Individual decides not to engage further with Floresco services

Client record created when appointment for intake and assessment is made

Intake officer enters intake and assessment information and outcomes, including RAS-DS scores, into individual's client record

Support workers and co-located service providers add information to individual's client record (e.g., notes about occasions of service, including group attendance; subsequent RAS-DS scores), and use shared record to inform individual support provision

Client record closed when individual exits Floresco, but can be reopened as required

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Design

The evaluation commenced in mid-2015 and continued through to March 2018. Informed by the program logic (Figure 1), it used a mixed methods approach with both a process (formative) and an outcomes (summative) component. Figure 3 illustrates the evaluation design and shows the key questions addressed by each component.

The evaluation received ethical clearance from the Gold Coast Hospital and Health Service Human Research Ethics Committee and The University of Queensland Medical Research Ethics Committee.

Process evaluation

We collected data for the process evaluation from several sources, as shown in Figure 3.

Key informants

During the period August to November 2017, we conducted semi-structured interviews with key stakeholders in the Floresco Centre, whom we identified by several means, including document reviews, attendance at Governance Committee meetings, and snowball methods. We initially approached these people in person, by telephone or by email, to seek their informal agreement to be interviewed. In all cases this contact was followed up by email to arrange the interview date and time, advise participants that (with their permission) the interview would be recorded, and provide copies of the participant information and consent form (Appendix A) and the question guide (Appendix B). The interviews took 30–60 minutes, and were conducted by DB, who also checked the transcriptions for accuracy after they had been professionally transcribed.

Governance Committee

Members of the Governance Committee were among the key informants we interviewed. In addition, during the period from mid-2015 to March 2018, we observed and took notes at Governance Committee meetings, with the informed consent of members, and collected meeting papers from these and previous meetings.

Follow-up study participants

During structured interviews conducted for the follow-up study (see below), participants often made additional comments to explain or expand on their responses to questions. We noted these comments and collated them for analysis.

Self-selected Floresco clients

From Floresco, we obtained the de-identified raw data from client focus groups conducted, independently of the evaluation, on four Thursdays during 2017: 12 January, 13 April, 6 July and 28 September. All current clients were invited to the focus groups, which aimed to gather participants' feedback on things that were working well or could be improved at Floresco. Participation was voluntary. A manager from one of Aftercare's consortium partners (not a Floresco staff member) facilitated the groups and collected the data.

YES survey respondents

From Aftercare we obtained the raw data provided by non-identified Floresco clients who responded to the organisation's annual Your Experience of Service (YES) survey, conducted in April 2017 by an independent contractor. These clients responded to a Floresco-specific version of the standard YES instrument [18], including two items about Floresco's effectiveness as a 'one-stop shop' and how easy it was to access the right mix of services (Appendix C).

Figure 3: Evaluation questions and methods

Evaluation questions	Design	Participants	Data collection	Analysis
Q1 Was an integrated service model implemented at the Floresco Centre as planned? **Q2** What were the barriers to effective service integration? **Q3** What were the key enablers of service integration? **Q4** How could the Floresco service model be improved to achieve better outcomes for clients?	Process evaluation	Key informants (Qs 1–4)	Semi-structured interviews	Themes & sub-themes
		Governance Committee (Qs 1 & 2)	Meeting observations Meeting papers	
		Follow-up study participants (Qs 1 & 4)	Structured interviews — additional comments	
		Self-selected Floresco clients (Q4)	Floresco client focus groups data*	
		Floresco clients who participated in Aftercare's 2017 YES survey (Q1)	Aftercare YES survey data*	
			Contracts & MOUs Other documents	
Q5 Has the Floresco service model improved outcomes for people with mental illness? **Q6** To what extent has the service model contributed to improved system outcomes?	Outcomes evaluation Overall outcomes study Follow-up study	All Floresco clients 1 July 2015 to 30 Sep 2017 (Q5)	Floresco client data extracts* Floresco client RAS–DS scores*	Descriptive statistics
		Floresco clients who participated in Aftercare's 2017 YES survey (Q5)	Aftercare YES survey data*	Themes
		Key informants (Qs 5 & 6)	Semi-structured interviews	
		Consumers referred to Floresco by MHS 1 Oct 2016 to 30 Sep 2017 (Qs 5 & 6)	Structured interviews RAS–DS scores Floresco client data extracts* MHS data extracts*	

*not collected by research team

Documents

In addition to the Governance Committee meeting papers, we obtained documents pertaining to the establishment of the Floresco Centre and the development and implementation of its service model. These included the initial funding proposal, the funding contract and subcontracts, MOUs, the practice manual, and service documentation.

Outcomes evaluation

The outcomes evaluation also used data from multiple sources. As shown in Figure 3, it included both a study of overall outcomes and a more detailed follow-up study of outcomes for clients who were referred to the Floresco Centre by the local MHS.

Floresco clients

Floresco clients are adults (18 years or older) with mental illness and/or family members or carers of people with mental illness. On engagement with Floresco, they sign a statement acknowledging that aggregated, non-identifying information about them may be provided to external researchers undertaking research on or evaluation of the Floresco Centre. Accordingly, from Floresco's client information system, we obtained extracts of de-identified data on all clients during the period 1 July 2015 to 31 December 2017. These extracts included demographic data, mental health diagnoses, suicidality, factors affecting mental health (e.g., homelessness, social isolation, history of domestic violence), referral date and source, service usage, and Recovery Assessment Scale — Domains and Stages (RAS–DS) scores. The RAS–DS (Appendix D) is a measure of self-reported mental health recovery developed in Australia from the Recovery Assessment Scale. It has been shown to generate valid and reliable scores reflecting mental health recovery and to be useful for facilitating collaborative recovery planning in recovery-oriented mental health services [19, 20]. The 38 items in the RAS–DS are grouped into four domains: functional recovery ('Doing things I value'), personal recovery ('Looking forward'), clinical recovery ('Mastering my illness') and social recovery ('Connecting and belonging'). Each item is self-rated on a four-point scale (1=untrue to 4=completely true). Higher scores indicate higher levels of recovery. Either raw scores or statistically adjusted measures (percentage scores) can be used to analyse RAS–DS results; the latter approach becomes necessary when data are missing [21]. Floresco clients complete the RAS—DS as part of their intake and assessment, at case reviews, and, where possible, on exit. To ensure the most complete set of records were used for analysis, only those that included demographic, service use and outcomes data were analysed.

YES survey respondents

The overall outcomes study also used the 2017 YES telephone survey data obtained from Aftercare.

Key informants

Some of the qualitative data from the semi-structured interviews with key informants contributed to the outcomes evaluation. In particular, the interviews sought participants' views about the contribution of the Floresco service model to improved system outcomes (see Appendix B).

Follow-up study participants

Participants in the follow-up study were a subset of Floresco clients who had been referred to the Floresco Centre by the local MHS but were not residing in or transitioning out of an extended treatment facility. We focused on this group for several reasons.

A key objective of the Floresco service model is to help reduce the pressure on the local MHS, particularly by reducing clients' use of hospital Emergency Department (ED) services and acute care inpatient beds. Focusing on clients referred by MHS allowed us to assess Floresco's effectiveness against this objective by investigating their use of ED and inpatient services before and after their engagement with Floresco.

- The local MHS is the main source of referrals to the Floresco Centre.
- Patients from extended treatment facilities could be expected to have different characteristics from people with mental illness who normally reside in the community.

We undertook recruitment and initial data collection for the follow-up study during the period October 2016 to September 2017 inclusive. Follow-up interviews were conducted after six months, during the period April 2017 to March 2018 inclusive. For follow up interviews, participants were deemed unable to be contacted after multiple unsuccessful attempts to reach them, both via contact details obtained at the initial interview and by checking their engagement status and contact details with Floresco.

We engaged Floresco staff in planning and undertaking recruitment, liaising regularly with them to ascertain when eligible individuals were scheduled for intake, and arranging for one researcher (ISP or DB) to be at the centre at these times. Following their intake appointments, these clients were invited to meet the researcher, who explained the purpose of the study, answered any questions, and guided them through the participant information and consent form (Appendix E). Baseline interviews were either conducted immediately or scheduled for as soon as possible afterwards. If a researcher could not be on site, the intake officer sought eligible clients' permission for us to contact them directly about the evaluation. With their agreement, ISP or DB telephoned them and made appointments to go through the informed consent process in person and complete the baseline interview as soon as possible.

Both baseline and follow-up interviews were fully structured, and included completion of the RAS–DS by participants. We used the online survey software *Checkbox* to design the baseline and follow-up questions, which incorporated skip logic, and to enable responses to be recorded directly via an electronic tablet. The baseline interview had up to 56 questions, while the follow-up interviews had up to 53. In addition to demographic items, they included questions about participants' mental health diagnoses; accommodation and living arrangements; involvement in work, education and other activities; and use of health and community services (Appendices F and G). Most interviews took about 30 minutes to complete, and most were conducted in a private space at the Floresco Centre. When this was not feasible, we met the participant at a library or café convenient to them. At the completion of each interview participants received a $20 multi-store gift card and an information sheet listing local mental health services and online resources.

With the consent of participants, we also obtained extracts of data from their mental health records with both Floresco and the MHS. From the former we obtained data collected during their intake and assessment interviews, and on their use of Floresco services during the six-month study period. The MHS supplied data on their use of hospital emergency department services and acute care beds over the period from six months before their baseline interview to the date of their follow-up interview six months later.

Data analysis

Thematic content analysis of the qualitative data was undertaken progressively throughout the evaluation. The analysis of documents relating to the establishment of Floresco, together with meeting papers and notes taken during committee meetings, was undertaken by DB, and aided the development of the question guide for the stakeholder interviews. It also informed the interpretation of participants' responses during interviews and the inclusion of probing questions as required. Coding and analysis of the interview data was also done by DB, using a framework that was progressively refined as themes and sub-themes emerged from the transcripts.

The focus group data and comments made by follow-up study participants were coded and analysed separately from the other qualitative data, as a different set of themes emerged from the initial review. This work was done by ISP, who also undertook the analysis of the YES data relevant to the process evaluation, in conjunction with the analysis of the other YES data for the overall outcomes study.

The outcomes study data, on both the overall and the follow up study groups were analysed using Stata/SE 11.0. Demographic characteristics, housing status, mental health diagnoses, additional factors affecting mental health at intake, rates of service use, consultations with health professionals and outcomes data (RAS-DS scores, as percentages) were explored descriptively. When calculating median values (e.g., number of consultations), only respondents who reported 1 or more were included. Two-tailed t-tests were used to determine whether improvements in RAS-DS outcomes were significant between baseline and follow-up, McNemar's test was used to determine whether differences in hospital and emergency department admissions were significant pre- vs post-Floresco, and a critical value of $p < 0.05$ indicated statistical significance.

Results

Process evaluation

Participant characteristics

We sought one-to-one interviews with a total of 25 Floresco stakeholders, 5 of whom either declined to be interviewed or did not respond to repeated telephone and email messages. Several of the interview participants had held multiple roles at, or in relation to, the Floresco Centre, so between them the 20 participants included:

- 4 current or former Aftercare senior or middle management staff who had been involved in the development and implementation of the Floresco service model, or had line management responsibilities for the Floresco Centre
- 4 current or former Aftercare staff who had held roles as Floresco's Service Manager, Team Leader and/or Intake Officer
- 3 people who were or had been employed by one of Aftercare's three consortium partners, as mental health support workers at Floresco
- 4 managers from Aftercare's consortium partners, who were or had been line managers of Floresco's mental health support workers
- 2 private practitioners who delivered MBS-funded mental health services at Floresco
- 5 MHS staff, including a senior manager, a clinical team leader, and 3 clinicians
- 10 people who were, or had been, members of the Floresco Governance Committee.

Of the 43 follow-up study participants, 28 offered additional comments during the structured interviews. They included 1 person who did not complete a follow-up interview.

Characteristics of the participants in the four client feedback focus groups held in 2017 were not recorded by Floresco. Participants varied in number between three and nine, and may have included clients who were carers or family members of people with mental illness. Some clients may have participated in more than one focus group.

The 87 Floresco clients who were invited to participate in Aftercare's annual YES survey in 2017 were all those who were receiving one-to-one support from a mental health support worker at the time. Of these, 34 (39%) responded to the survey, including 24 females and 10 males. All but 3 of them had been receiving support from Floresco for more than one month; most (19) had been supported for one to three months. Other demographic characteristics for the YES survey respondents are provided in Appendix H.

Findings

Question 1: Was an integrated service model implemented at the Floresco Centre as planned?

Interviews with key informants revealed some variation in their views of what constituted service integration, but there was qualified agreement that an integrated service model had been implemented at the Floresco Centre. As one of the Aftercare senior managers put it, *It's a work in progress*. Other informants agreed that, in several ways, the service model was not, or not yet, as integrated as intended.

- Co-location of MHS staff occurred only for a brief period. While it remains a long-term goal for both the consortium and the MHS, it is not sustainable within the latter's current resources.
- A shared client information system has been implemented, and is being used by the mental health support workers and private practitioners, but most of the co-located services — including MHS staff when they worked at Floresco —do not use it. Clients still sometimes have to tell their story more than once, albeit less frequently than they otherwise might.
- It has proved difficult to maintain GP services at Floresco. One GP worked there for a few months during 2016, but no replacement has yet been found.
- Fewer private mental health practitioners have co-located at Floresco than was envisaged, and their availability has been inconsistent. During the period when interviews were conducted, three MBS-funded practitioners were delivering services at Floresco, but within a few months there were none. As a result, the income stream that was intended to fund the provision of additional mental health services at Floresco has been smaller and less steady than expected.
- The benefits of having a consortium of NGOs that each have their own specialty have not been realised, because the mental health support workers employed by the disability provider and the advocacy service have no training in the speciality areas of their employing organisations. So, for example, if a Floresco client needs tenancy advice and advocacy, they cannot access such services at Floresco; they have to be referred to the advocacy service, which is located separately. Moreover, they will probably have to tell their story again, because although the Floresco support workers employed by the advocacy service use the shared information system, the advocacy service itself does not.

Despite these findings, the 2017 YES survey results and the comments made by focus group and follow-up study participants indicated that from the client's perspective, Floresco was operating much as Aftercare and its consortium partners had intended. For example, in the YES survey, in response to the statement *Staff worked as a team in your care and treatment (for example, you got consistent information and didn't have to repeat yourself to different staff)*, 29 out of 34 respondents answered 'always' (27) or 'usually' (2). Other relevant YES survey results are presented in Figure 4 (overleaf).

Furthermore, key informants were in no doubt that, at least in part because it operates as a one-stop shop for a range of services, the Floresco Centre is filling a significant gap in mental health services in the Ipswich area and is meeting a high level of need for psychosocial support and therapeutic group services.

> *I think 100 per cent it has filled a need. I mean, not only can that be seen by the number of active clients we have and the number of referrals we receive — where were they going before and where would they go without us? But I think we're a bit like a little basket underneath that can catch the people that don't qualify for acute services and who don't qualify for long-term services* (Floresco staff member).

Figure 4: 2017 YES survey results — client ratings of Floresco's performance over the previous three months (n=34)
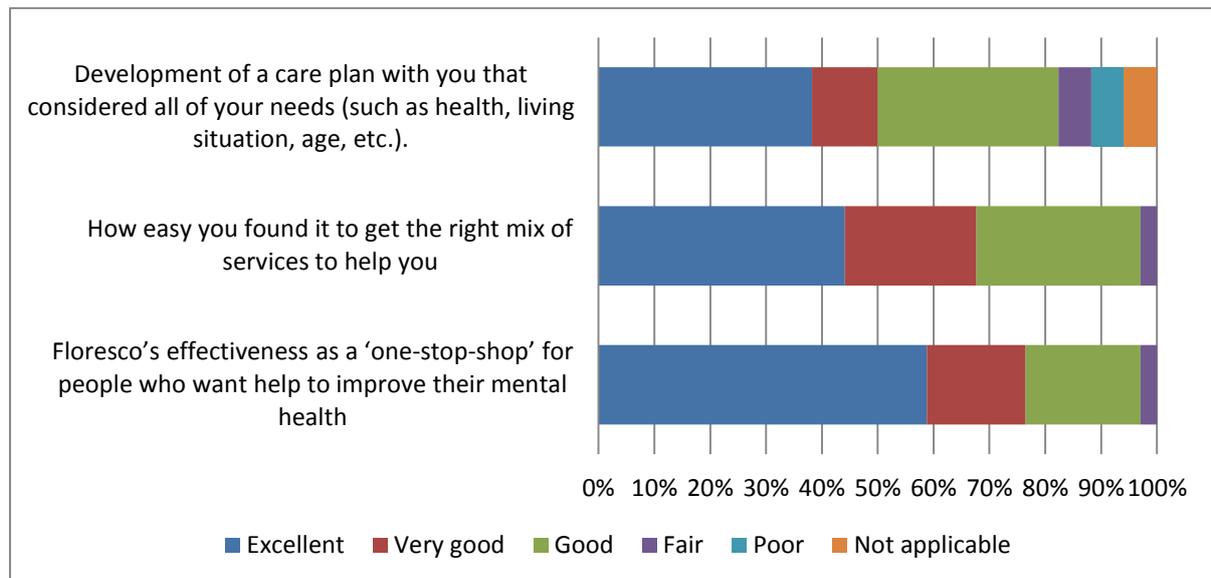
Compared to other organisations I'm aware of, quite significant. They've included not just therapeutic work, but things like craft, art, finding your voice, developing a new story, rage, yoga, exercise physiology. Also, employment and also just the general support… I think they've done a much better job than other agencies (private practitioner).

Usually they can help in some way or they can point you in another direction. … So they were even a good point of reference for well, we do this or we could do that short term, and then we could refer on. … But a lot of the other services I have been in contact with are not as helpful and they are very specific about what they do. Whereas I think with Floresco they understand that things have to be a little bit more flexible. There are a lot of services out there that are very rigid and that doesn't really work, does it, when it comes to people with complex needs (MHS staff member).

It has filled a need for therapeutic groups. … I think the groups that we've offered have really built a lot and added a lot to what is available. We do still get many, many referrals from … other NGOs who want their clients to access our groups, because they are not available elsewhere (Floresco staff member).

When I look at their diagnosis and their secondary issues and all of that, it reflects to me — I've always said there's a lot of depression and anxiety and domestic violence and crisis situations and emotional crisis and I think to myself, that's really good, because that's the stuff that we shouldn't be dealing with, but the GPs can't deal with, so it's really filled that gap. Whereas I look at things like — they're not swamped with people with schizophrenia or bipolar … and that's our core group (MHS staff member).

*If you ask anyone in this organisation who — as we do work with people in crisis —
it's invaluable. Absolutely invaluable. … We found here that it was just brilliant to be
able to say, look, pop down to Floresco. It's just that middle ground, that's sometimes
so undervalued in terms of intervention, in a timely way. We found the response to
the people who were referred there was brilliant and I strongly believe there is a place
for this model* (NGO partner representative).

*Question 2: What were the barriers
to effective service integration?*

Together, the interviews and the Governance Committee
meeting observations and papers revealed that there had
been multiple, sometimes inter-related, barriers to the
implementation of an integrated service model at the Floresco Centre. These included:

- the challenges of bringing four different NGOs together to work as one team
- barriers to integrating with the MHS
- a range of barriers to systematic information-sharing
- resourcing challenges
- staffing problems
- difficulties in recruiting and retaining GPs and private mental health practitioners
- difficulties in responding to the level of demand as well as the level of clinical need
- complexities related to operating as a consortium
- inconsistent leadership and governance.

These challenges are explained in more detail in Table 1. Not all of the identified barriers had been
fully overcome by the time the interviews were conducted, nearly three years after the Floresco
Centre opened:

*We were very hopeful and very optimistic that we could overcome a lot of hurdles
that have just been too difficult* (MHS staff member).

*Thinking differently and operating differently will take years … We have to start and
work with all of the barriers and all of the difficulties around confidentiality and
information sharing and one client information management system … These things
all sound easy, but to actually put them into practice is never easy, and it takes time*
(Aftercare manager).

Table 1: Barriers to mental health service integration at the Floresco Centre

Barriers/challenges	Key informants mentioned…	Examples
Bringing four different NGOs together to work as one team	- Differences in organisational culture (values, philosophy, tolerance of risk) - Differences in organisational policies, procedures and practices - Having to negotiate over seemingly minor issues - Challenges — for Aftercare, NGO partners, and staff themselves — related to staff supervision	*I think in any kind of new model organisations don't want to lose their identity and their sense of their expertise* (Floresco staff member). *It was a big challenge, I think, to try and put together something that accommodated good practice from a range of perspectives* (Floresco staff member, regarding development of Floresco's practice manual). *Organisations like to manage their organisational risk … people think about the deficit straightaway. What's going to go wrong and how can I control this? The only way you can control it is to separate and silo the services which we don't want to do* (Aftercare manager). *Just an example of how we had to navigate through the partners … because for Aftercare and some of the other partners, that's very important to them* [but] *we don't do duress alarms … so for little things like that it's been a real negotiation between the partners about how we move forward* (NGO partner representative). [One NGO partner was] *strongly against our clinical team leader and our service manager providing supervision to* [its] *staff. They also wanted staff to report* [crises] *directly to their own managers or supervisors. Then* [their] *supervisors would report it to our managers … It was slowing the process down and delaying those crisis response procedures* (Floresco staff member). *It has been quite challenging to maintain — to create and maintain that sense of team, when all the majority of the working life is not in this premises. I think we cannot, realistically, expect an individual employee to keep that thought in their mind* (NGO partner representative). *I was very confused for a long time as to who I was working for* (Floresco support worker).
Barriers to integrating with the MHS	- The fact that this initiative was driven by Aftercare, rather than mandated by government - Systemic constraints on the MHS's ability to participate	*It's the NGO sector attempting to pull the levers, which they don't — the sector doesn't have that power and influence* (Aftercare manager). *The major challenges have been I think around the freedom that* [the MHS] *has to participate in these types of models. They've got a whole range of restrictions — that system has, so not the individuals. The leadership was on side, but their system barriers for them to, I suppose, fully participate in these types of models, I think that's been one of the major, a major sort of challenge, because you need* [the MHS] *at the table* (Aftercare manager). *If it just has the association and the backing of the* [MHS], *is it integrated or is it just the spirit of integration? … Talking about integrated services, the integration is in two parts. One, you've got the integration with the* [MHS] … *Then you've got the integration of NGOs* (NGO partner representative).

Barriers/challenges	Key informants mentioned…	Examples
Barriers to systematic information sharing	- System barriers preventing NGOs from accessing the MHS information system - Practical difficulties preventing MHS staff from using Floresco's information system - Differing views among the partner NGOs about the importance of record-keeping - Co-located services not using the shared client information system - Difficulty of ensuring that users of the shared client information system enter data correctly and consistently	*Shared information is major. Different organisations recording information on different systems. At one point Aftercare were hoping that our staff would do a double — like a duplication. That's just not going to happen, it was just too difficult* (MHS staff member). [The MHS] *really were the only ones that had the major problem around the one client information management system … all of the difficulties around confidentiality …* (Aftercare manager). *We still haven't overcome that, the system barrier* (Floresco staff member). *Where we've fallen down is with the telling of the story over and over again. It's still sometimes necessary because we don't share databases* (Floresco staff member). *We set up a system that we had all the intent that it was going to be an integrated record, but the problem has been executive support around that and also allocating resources to make sure it's being used correctly. People … just pumped in whatever they thought needed to be done but no one actually knew the implications of what they were entering and how that looked* [in terms of extracting and reporting] *data and activity … That's been painful* (Aftercare manager).
Resourcing challenges	- Insufficient NGO funding to support necessary components of the service model - Insufficient NGO funding to enable employment of more appropriately qualified, skilled and/or experienced staff to respond to clinical need - Insufficient MHS resources to enable co-location of staff at Floresco	*The funding and the resources behind it needed to be more intense. For example, I think the funding for a clinical team leader, that person — it wasn't sufficient funding* [for a full-time position] (Floresco staff member). *I think one of the biggest challenges … is the complexity of the clients that are coming to Floresco* [is] *much, much higher than what we originally thought. … What they're needing Floresco to provide to them, where there are gaps in the community, is more than what we thought* (Aftercare manager). *We are not getting enough funding to justify, say, employing social workers, or people with experience, that would leave them very situated to deal with the work we do. … Some of the best staff we've had haven't had those qualifications, but the salaries that they're on aren't enough to justify the work they're doing. With or without qualifications* (Floresco staff member). *I still think it needs — I suppose it needs more funding to be able to do what it does, based from an NGO perspective. I think the* [MHS] *needs in some way to be supported to participate in this way, and to me I think the biggest problem around the private system, engaging them, is that — particularly GPs, but even some allied health professionals — do not just want to work under MBS, they want to charge a* [fee] (Aftercare manager). *I would love to have two clinicians to send down* [to Floresco] *every day but I don't have the resources* (MHS staff member).

Barriers/challenges	Key informants mentioned…	Examples
Staffing problems	- High staff turnover, particularly among support workers - Difficulties in recruiting suitable NGO staff, both support workers and managers - Long delays in filling support worker positions - Difficulties maintaining commitment to the integration vision in the context of management changes - Mental health workforce recruitment difficulties in the Ipswich area	*We've gone through two service managers.* [X is] *probably the third team leader. I can't even count how many support workers we've gone through* (Floresco staff member). *It was not the role that I expected to walk into. I had a completely different vision of what was going to be expected of me. … We are not support workers, we are case managers* (Floresco support worker). *Looking generally at it, most cases it's workload. It's capacity to do the work we do. Because it is intense, heavy, heavy that we work that we do on occasion. We deal constantly with homelessness, suicide, death, drug and alcohol. Many, many things that are so emotionally draining and such high pressure work. I don't think it's acknowledged by the* [partner] *organisations, the level of work, and by the position descriptions of the support workers. So they're currently funded as support workers. But in my mind, they're doing short-term case management. ... So the money isn't worth the pressure that it has on people a lot of the time* (Floresco staff member). *We have been on many occasions understaffed for a long time because the* [partner] *organisations don't see the pressure that we're under here. … So they don't understand the urgency of recruiting when a position is vacant* (Floresco staff member). *There's been challenges generally recruiting staff to the service, so management as well as support staff, who really understand that model, that integrated model, to know what it is that is missing, or is needed within that model. Then that has had an impact on how we work with our partners, and how we recruit other staff* (Aftercare manager). *There was quite a marked difference in the approach of the two service managers. Different goals… Before, it appeared as though there was quite a sound model and that there was a close eye on how the model was progressing. I don't know that we could say that there is that at the moment* (NGO partner representative). *So recruiting the right people to do the job, whether they were working for us as non-government organisations, or getting private practitioners, such as particularly GPs* [was] *like pulling teeth* (Aftercare manager).

Barriers/challenges	Key informants mentioned…	Examples
Recruiting and retaining GPs and private mental health practitioners	• Constraints on charging a fee • Lack of incentives and support for private practitioners	*We haven't been able to recruit private practitioners to the level that we thought we would, which has then impacted the amount of clinical support that is provided* (Aftercare manager). *Because we bulk bill, there's not much left over … if you're a new worker coming in, and trying to make a living, you wouldn't come here, you'd go somewhere else* (private practitioner). *They're not getting private practitioners because a private practitioner probably would make more money on their own than actually working under a Floresco model* (private practitioner). *GPs and private practitioners, you know, why come to this particular location, why work in this particular context? Certainly there are people who have an interest in that context, a personal interest, or a personal passion, but finding those people who would perhaps want to work in … what is very much the pointy end to the mental health service system, I think is a real challenge* (Aftercare manager). *I don't think that there's been the supports in place. I pay for all of my own clinical supervision* (private practitioner).
Responding to demand	• Higher-than-expected demand for services • Insufficient resources to meet demand	*I think that we were all blown away when* [Floresco] *opened the doors and … just got absolutely inundated* (MHS staff member). *The idea of a one-stop shop is brilliant, but you've got to be able to adequately resource that to respond and see people through their journey. At the moment … there's fairly long waiting lists, and that's difficult, because people still are referred every day, and usually when they're referred there's crucial issues going on in their lives that need to be responded to in a timely manner. … The backlog is becoming bigger, and staff are feeling pressured* (private practitioner).
Responding to clinical need	• Higher level of clinical need than expected • Inability to meet demand for private practitioners • Insufficient capability among support workers to respond to clinical need	*Originally, we had very much set it up as a support worker kind of model, and what we're seeing now, and I think the evidence of that is starting to come through in the last 6 to 12 months, is we need to balance that support work model with a fair bit of clinical support, probably more than we initially thought. Although we always thought it would have a clinical component, I think that balance isn't there as it should be* (Aftercare manager). *The idea was for it to be a bit of a one-stop shop but then we're finding, because the waitlist* [for private practitioners] *is so long, we're referring out for counselling support or other things just because we don't have the capacity to be able to offer that at the time* (Floresco staff member). *We're needing to look at, okay, how else do we bring in that clinical support if it's not going to be through private practitioners, because it's needed* (Aftercare manager). *At the moment we're talking about actually changing what the position type is… So we're looking at getting some clinicians in rather than more support workers. We're having to do a bit of a business plan around that* (NGO partner representative).

Barriers/challenges	Key informants mentioned…	Examples
Operating as a consortium	- Additional and more complex staff management problems for Aftercare - Ongoing clinical governance problems - Lack of benefits for clients - Unequal partnerships - Tension between the need to collaborate in the Floresco service model and the pressure to compete in the context of the incoming National Disability Insurance Scheme (NDIS)	*We have partner organisations offsite who recruit people without necessarily taking into consideration the workplace culture here and then those staff kind of come over here and then there has been issues, just in terms of workplace culture, office morale, that sort of thing, because of recruitment decisions that* [the partner] *organisations don't necessarily have to* [deal with] (Floresco support worker). *It served a purpose at the very start for all of the organisations to be involved, and to have buy-in to the service, but I'm not sure that it's the best way. … I'm trying not to sound too negative, because I think that there's been some real positives with it, but I think there are some very real challenges with the model* (Aftercare manager). *It's not the most effective use of money, for any of us. I think that possibly if you brought that money in and then had in-kind co-located services rather than subcontracted co-located services, that would be a better way to be managing that* (Aftercare manager). *From a clinical governance perspective … we still have some real challenges* (Aftercare manager). *It's overly complex in terms of having a range of mental health NGOs who do similar sorts of things, and have similar sorts of capabilities. … One agency probably could have done the work of at least two of them, and you might have had partnership with one of them, maybe* (Aftercare manager). *Look, it can work, it's worked, but the pressure it puts on the management structure … I think it's a big ask* (Aftercare manager). *As consortium partners we probably haven't helped to achieve service integration beyond our own agency being a strong participant. … Aftercare were the driver, without a doubt, of bringing everyone else in …from a perspective as an agency, … it was definitely about 'are we achieving our outcomes?' because you get quite concerned in that kind of model. … Our energies went probably into that rather than into the bigger picture model* (NGO partner representative). *NDIS is creating a competitive market place where we would… before, we were in together, we shared our resources, we shared our funding. Now we're at a stage where we're working with more people that are going to be eligible for NDIS and the partners and us are trying to figure out how we're going to survive in this new market. So that naturally causes competitiveness* (Aftercare manager). *We are in a different climate now than when the Floresco model started. Because we've got — there are huge pressures on NGOs to find their way in NDIS land. That could have a bigger effect on the Floresco model than anything else… So we've had the big push — collaborate, collaborate, collaborate. Then it's like, oh hello. Well, you all need to vie for … you know, you'll need to fight for your funding* (NGO partner representative).

Barriers/challenges	Key informants mentioned…	Examples
Inconsistent leadership and governance	• Over-reliance on the commitment of key personalities • Difficulties maintaining the commitment to collaboration in the face of several management staff changes, particularly within Aftercare • Inconsistent commitment to the Governance Committee among consortium partners • Uncertainty about an appropriate governance model • Lack of strategic focus by the Governance Committee	*I think it was developed with maybe — which is very easy for us to do — but personalities help drive services and you can never really stop that* (NGO partner representative). *Of course, having lost* [X], *who was a big, big motivator…* [and] *had a way of getting things done… It shouldn't rely on one person. It shouldn't, and we'll say that theoretically through everything we do. But it does. When it comes down to it, the person had the idea and the person had the motivator…* (MHS staff member). *Executive endorsement and leadership and drive down to keep this happening has been lacking.* [X] *was a great visionary but couldn't be here every day. I don't think that the management of this — from a senior management point of view's gone very well. There should have been much more commitment, much more energy given to the model and what we were trying to achieve. So, I think the wrong managers were put in here* (Aftercare manager). *At the start … there was a really energetic, cohesive group and we were always there and we knew* [what we were going to do]. *Then I think there's a couple of organisations who drip different people in and out all the time and you just haven't got that consistency. …There's a couple of people who contribute loads, and then there's a couple of people who just don't even say anything* (Governance Committee member). *I think there's varying levels of seniority at that steering committee as well. I think some people just send… When I go to the next steering committee I don't even know who is going to be there* (Governance Committee member). *Service integration governance is — I think that is something that is still quite new as well. How do you, you know, it's not a parcel or a piece of work that's easy to find to kind of piggyback off* (NGO partner representative). *I think we should have been thinking about things like permanency of funding and the direction. I don't know that we got all of that in the steering committee* (Governance Committee member).

To the extent that the barriers to service integration at the Floresco Centre have been overcome, key informants agreed that this was largely due to the strength of the relationships, at management level, between the four consortium partners, and between Floresco and the MHS. These relationships were long standing in most cases, and seem to have been strengthened as a result of the collaborative effort to implement an integrated service model at Floresco. Thus a stakeholder from the MHS observed that the mutual respect and understanding that had been achieved through the collaboration on Floresco had provided a platform for further collaborative work by the partner NGOs, other NGOs in the area, and the MHS.

Both Floresco and MHS staff commented on the value of the efforts made by the former to build and maintain strong relationships with the latter, particularly in helping to work around the problem of not being able to share client information systematically. From the start, Floresco intake staff established a routine of attending MHS ACT meetings every week, which MHS staff recognised as:

> *actually really good of them because sometimes our team meeting is so lengthy and it's busy and they're just kind of sitting on the sidelines waiting to speak and we've not always got something to discuss; sometimes we've got a lot to discuss with them. And they've persevered and they come up every time and it definitely helps because it's really good to have that face to face contact and discussion rather than always just picking up the phone and people are busy. So that's a really important thing* (MHS staff member).

These regular meetings are used to share information about particular referrals or mutual clients that have been observed by either the MHS or Floresco to be struggling and perhaps in need of follow-up by one or the other service.

Other facilitators of service integration mentioned by participants in the semi-structured interviews included the following.

- An enabling environment, in which the drive to innovate was supported at senior management and board level. This was particularly important in the case of Aftercare, as lead agency in the consortium.

- Personality factors: participants frequently mentioned the passion and drive of individuals in leadership positions who were particularly talented at building relationships across organisations and sectors. At the same time, they acknowledged the risks of relying on one or two key people: *There were key personalities who were so committed to this and wanted it to work and hung in there with it. What's happened recently is we've had a major change of personnel and it'll be interesting to see what that does to the model* (MHS staff member).

- Committed staff at all levels across the consortium partners and in the MHS. *Everyone had hope for this place. Even when there was conflict and a difference of opinion in the way things should be delivered, or managed … they are willing to compromise and to communicate around it. Which I think is a real strength. It is the reason we have gotten as far as we have* (Floresco staff member).

- Open communication: *So that's the biggest way to overcome our barriers is to have those conversations and not be scared. …We need to have those debates. It might get challenging but when you focus on the consumer you know your intention's good* (Aftercare manager).

- Co-location of a number of services and supports to meet the needs of people with mental illness, all of them accessible via the one reception area, and all operating under the Floresco banner. The latter has helped create a common sense of team identity and purpose among Floresco staff, regardless of which consortium partner employs them.

- Good reputations and high levels of credibility among the individual consortium partners, which have helped achieve buy-in from other organisations as co-located service providers.

- Flexibility, not only in relation to the delivery of services and supports, but also *when the model wasn't working in one way, the willingness of the steering committee and Aftercare to turn around and say, right let's try this or let's … try something different* (MHS staff member). This flexibility in developing and refining the service model, together with the ability to be creative in solving problems, was supported by the funding arrangement with the Queensland Government, which had simply funded the delivery of service outputs rather than prescribing their delivery via a specific service model.

- Positive outcomes: as one Aftercare manager explained, the fact that *people have been able to see some outcomes with the clients that they're working with, or the clients that they're referring* has helped reinforce their commitment to service integration and to Floresco's service model as a means of achieving it.

Question 4: How could the Floresco service model be improved to achieve better outcomes for clients?

Many of the improvements to the service model suggested by interview participants could be inferred from the findings reported above. Some of them — such as the delivery of more therapeutic group programs and group activities, the re-establishment of GP services, and an increase in the number of co-located MBS-funded private practitioners — were quite specific and echoed the comments of participants in Floresco's client feedback focus groups and in the follow-up study; several of the latter, in particular, expressed frustration over the long wait for MBS-funded psychological services. Most of the suggested improvements — such as more staff, including more clinical staff and, in particular, a second intake officer — would require additional funding, or at least a change to the current funding arrangements. However, several related to Floresco's systems and processes.

In particular, better use needs to be made of the shared client information system, which one key informant described as the 'lumpiest' aspect of the service model. This is not just about finding a systematic way to share information with the MHS, although this was on most interview participants' wish lists. The more immediate priority is *getting people to think about, you know, making sure that my notes go into the single care plan, that everybody else can see this, that it's actually building a scaffolding around this individual* (Aftercare manager).

Related issues are that client information needs to be entered in a consistent way, so that it can be more easily extracted and used to track clients' recovery progress, not just individually but also by cohort (e.g., according to age, gender, diagnosis, etc.), and that outcome measures need to be used

more routinely and effectively. During 2015, considerable effort went into identifying and gaining Governance Committee agreement on a set of routine recovery-oriented outcome measures, including:

- the RAS–DS (Appendix D) for use with clients experiencing mental illness
- a modified version of the CarerQol-7D+VAS (Appendix I) for use with carers and family members of people with mental illness
- the Flourishing Scale [22] for evaluating the effectiveness of group programs.

Yet there is no evidence that the latter two measures have been used more than occasionally, and while the RAS–DS is routinely used during intake and assessment, its use in case reviews has been erratic, apparently because the necessary systems have not been in place.

> *I feel like in some — over the last couple of years we've created a dependence in the community rather than recovery. The systems weren't in place to really review people's recovery plans, for example. Where are we at with our goals? How are we moving along? How are we tracking? That stuff hasn't — we need intake reviews, we need just general implementation of the National Mental Health Standards* (Aftercare manager).

As a result, clients have sometimes remained engaged with Floresco for several years:

> *So, people that came in on the first day and are still here almost three years later, that shouldn't have happened. …We need to have a welcoming place that people can come, but also that they leave, and they go back to their lives. I don't want people to feel like this has to be their life. Because we're not providing anything different to anyone else then* (Aftercare manager).

Other suggested improvements in systems and processes include:

- stronger clinical governance
- better waitlist management, including ways to avoid having carers and family members of people with mental illness waiting for intake and assessment at times when the carer support worker has a low caseload
- more clarity for clients, when they first engage, about not only what Floresco can do for them, but for how long — together with more focus, throughout their engagement, on working towards mutually agreed recovery goals, and on planning and supporting the client's exit from services
- revisions to the terms of reference for the Governance Committee, particularly to ensure it has a more strategic focus
- revisions to position descriptions for Floresco's service manager and team leader, including reviews of the skill sets required for these positions
- better induction for new staff into the vision and philosophy underpinning the Floresco service model
- staff retention strategies
- more clarity for staff in relation to supervision
- involvement of Floresco management in the recruitment of all support workers by the consortium partners

- better use of the speciality expertise of Aftercare's consortium partners, such that staff they employ as Floresco support workers are trained in those speciality areas
- subcontracts between Aftercare and its consortium partners that specify each party's responsibilities in relation to service integration.

The last four suggestions assume the continuation of the current subcontracting arrangements between Aftercare and its three consortium partners. However, several participants — most of them from Aftercare — had doubts about the ongoing value of these arrangements, and some were explicitly in favour of abandoning them.

> *I don't think it's sustainable with the subcontracted arrangement, on reflection. As someone who negotiated those subcontracts, and was very much on board with them, I have come full circle … because I don't think it's the most effective use of money given what we know is the client base now…* [and] *I think a lot of time gets spent on working through challenges. If that money was just with one organisation, you'd just work through it yourself, you'd make the changes yourself, rather than having to go back and forth* (Aftercare manager).

> *I can see the integrated model continuing but maybe not the consortium. Maybe even just having it, say hypothetically, completely Aftercare. …and using that money to then just recruit Aftercare support workers and then have the private practitioners on MBS and then having co-located services that are separate to mental health support work. So your housing and your alcohol and drug…* (Floresco staff member).

> *There were certain areas of expertise that Aftercare didn't have, that we could purchase* [by having] *a consortium model. The bit that's probably never recognised in consortium models is around how resource intensive running consortia is. If you don't have an organisation with enough capability to actually do that, invest some of its own dollars, it's an expensive exercise* (Aftercare manager).

Outcomes evaluation

Participant characteristics

The data extract from the Floresco Centre for the period 1 July 2015 to 31 December 2017 included information on a total of 2580 clients. Of these records, 1129 included a complete set of demographic, service use and outcomes data, including results for at least one RAS–DS self-assessment; these records were included in the analysis. During the recruitment period for the follow-up study, October 2016 to September 2017, 93 Floresco clients were identified as eligible (see Figure 5). Of these, 43 completed baseline interviews; follow-up interviews were conducted with 37 (86%) approximately six months later (mean=6.3 months; SD: 0.39 months).

Figure 5: Follow-up study recruitment flowchart
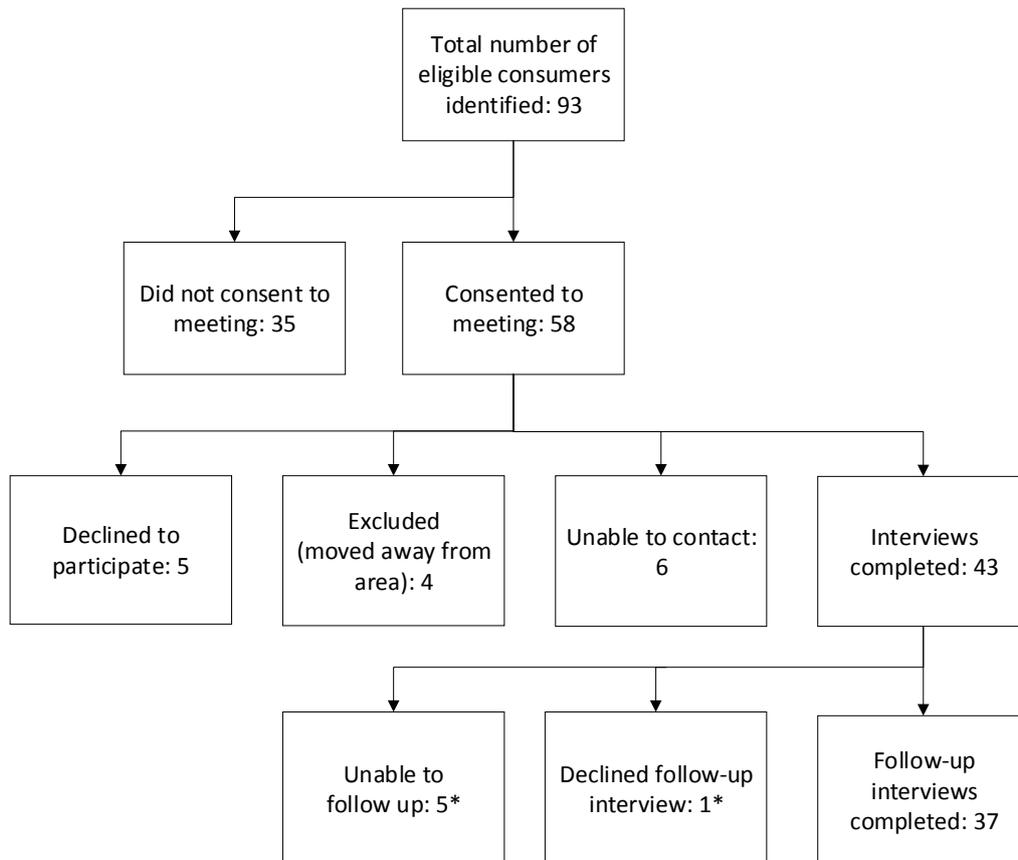
* None of these participants were using Floresco services at the six-month follow-up date.

Baseline data are presented in Table 2. In most respects, the characteristics of the follow-up study participants were similar to those of the whole Floresco client cohort. However, the average number of diagnoses per client was higher in the follow-up study group, as were the rate of psychosis, suicide risk and the prevalence of additional factors affecting mental health at intake to Floresco.

Characteristics of the 34 Floresco clients who participated in Aftercare's 2017 YES survey are shown in Appendix H.

Table 2: Baseline data for outcomes study participants

	All Floresco clients (n=1129)	Follow-up study participants (n=43)
Age: Mean (range)*	41 years (18–85)	40 years (19–62)
Sex: % (n)		
Female	60.6% (684)	58.1% (25)
Male	39.4% (445)	41.9% (18)
English as first language: % (n)	-	95.3% (41)
Aboriginal or Torres Strait Islander: % (n)	-	9.3% (4)
Government benefits as main income source: % (n)	-	74.4% (32)
Currently doing any paid work: % (n)	-	23.3% (10)
Highest educational qualification: % (n)		
University qualification (including post-graduate)	-	11.6% (5)
Other post-school qualification	-	62.8% (27)
Year 12 or equivalent	-	7.0% (3)
Year 11 or equivalent	-	2.3% (1)
Year 10 or equivalent	-	9.3% (4)
Year 9 or equivalent	-	7.0% (3)
Referral source: % (n)		
GP or other non-government health care provider	42.4% (479)	0
Self/family/friend	17.0% (192)	0
Other community service	10.5% (119)	0
Public mental health service	9.9% (112)	100% (43)
Missing	20.1% (227)	0
Mental health diagnosis^$		
Mood disorders: % (n)	68.1% (470)	79.1% (34)
Anxiety disorders: % (n)	54.5% (376)	65.1% (28)
Psychosis: % (n)	8.8% (61)	23.3% (10)
Other: % (n)	21.3% (147)	20.9% (9)
Average number of diagnoses per client	1.5	1.9
Suicide risk$: % (n)		
Lifetime history of suicide attempt	5.6% (63)	-
Current suicidal ideation within 12 months	5.1% (58)	72.1 (31)
History of self-harm	2.4% (27)	-
Current deliberate self-harm within 12 months	1.0% (11)	30.2% (13)
None of the above	89.4% (1009)	-
Additional factors affecting mental health at intake$: % (n)		
Social isolation	9.4% (106)	69.8% (30)
Financial strain	-	60.5% (26)
Physical health concern	9.2% (104)	37.2% (16)
History of sexual or physical assault or abuse	5.6% (63)	41.9% (18)
Homeless or at risk of homelessness	2.0% (23)	48.8% (21)
Unemployment/employment issues	-	51.2% (25)
Relationship problems	-	18.6% (8)

Note: missing data were recorded as a category in the table for mutually exclusive variables where more than 10% of the sample had missing data.

* The age variable for all Floresco clients had 3 missing values.

^ For the all Floresco clients group, mental health diagnosis was available for 690 clients (61.1%); other diagnosis category includes eating disorders, substance abuse, personality disorders, trichotillomania, sleep disorder, irritability and anger, adult onset ADHD, trauma and stress.

$ Categories are not mutually exclusive.

Findings

Question 5: Has the Floresco service model improved outcomes for people with mental illness?

At baseline, the follow-up study participants reported high rates of suicidal ideation in the previous year (see Table 3). These rates dropped dramatically after intake: almost two-thirds of participants reported no suicidal ideation during the six months between interviews. Use of GP services also decreased; however, this may be attributable to the difference in timeframes. Use of community services remained fairly stable.

Table 3: Suicide risk and use of services in the 12 months prior to Floresco intake and the 6 months between initial and follow-up interviews, for clients who completed both interviews (n=37)*

	12 months prior to Floresco intake	**6 months between interviews**
Suicide risk: % (n)		
Suicidal ideation	67.6% (25)	32.4% (12)
Self-harm	24.3% (9)	10.8% (4)
Suicide attempt	29.7% (11)	8.11% (3)
None of the above	29.7% (11)	64.9% (24)
GP service use: % (n)		
Saw a GP	100% (37)	97.3% (36)
Average no. of consultations (range)	12 (0-50)	6 (0-20)
Average no. of consultations for mental health reasons (range)	8 (0-40)	3 (0-15)
Community services use^: % (n)		
Employment or financial counselling service	35.1% (13)	4.7% (2)
Emergency/crisis/domestic violence support service	24.3% (9)	18.6% (8)
Alcohol or other drugs service	10.8% (4)	8.1% (3)
Housing/homelessness support service	8.1% (3)	11.6% (5)
Child or family support service	5.4% (2)	10.8% (4)

* As information on the 6 months between interviews was not available for clients who did not complete a follow up interview (n=6), only data on those who completed both interviews were included.

^ Categories are not mutually exclusive.

The main outcome measure used for the evaluation was the RAS–DS tool. Table 4 shows results for:

- all Floresco clients at intake
- all Floresco clients who completed two (or more) questionnaires
- follow-up study participants who completed both baseline and follow-up interviews.

Baseline results for all three groups were very similar: mean overall scores ranged from 63.3 to 65.4 per cent and differences in individual measures between groups ranged from 2.1 to 2.7 per cent. For the Floresco clients who completed two (or more) questionnaires, increases in self-reported mental health recovery can be seen across all four domains, ranging from +2.0% to +9.5% (Table 4, middle section). For this cohort, there was a significant difference between overall baseline (M=63.3, SD=15.6) and follow-up (M=69.2, SD=16.1) RAS–DS results (t(107)=4.25, p<0.001). Similar results were seen for the follow-up study group, where increases in self-reported mental health recovery occurred across all four domains of the RAS–DS, and ranged from +4.6 to +13.3 per cent (Table 4, lower section). Again we found a significant difference between overall baseline (M=65.4, SD=13.1) and follow-up (M=73.8, SD=13.4) scores (t(36)=2.48, p=0.018).

Table 4: RAS–DS results

RAS–DS domain	Mean score (SD)		
	Baseline	Follow-up	Differences
All Floresco clients at intake (n=1129)			
Doing things I value	69.6% (16.2)	-	-
Looking forward	64.2% (16.0)	-	-
Mastering my illness	58.6% (16.7)	-	-
Connecting and belonging	66.4% (17.5)	-	-
Overall	64.7% (14.0)	-	-
All Floresco clients who completed the RAS–DS on two occasions (n=108)*			
Doing things I value	70.4% (18.3)	72.4% (17.3)	+ 2.0% (15.3)
Looking forward	62.9% (16.3)	69.9% (17.9)	+ 7.0% (16.8)
Mastering my illness	56.1% (17.7)	65.6% (18.6)	+ 9.5% (18.9)
Connecting and belonging	63.8% (18.4)	68.8% (18.4)	+ 5.0% (15.6)
Overall	63.3% (15.6)	69.2% (16.1)	+ 5.9% (14.3)
Follow-up study participants who completed both baseline and follow-up interviews (n=37)^			
Doing things I value	72.0% (14.8)	76.6% (14.9)	+ 4.6% (20.5)
Looking forward	65.6% (15.0)	73.0% (14.3)	+ 7.4% (21.6)
Mastering my illness	57.9% (17.1)	71.2% (14.4)	+ 13.3% (25.9)
Connecting and belonging	66.2% (17.5)	74.2% (17.3)	+ 8.0% (25.4)
Overall	65.4% (13.1)	73.8% (13.4)	+ 8.3% (20.4)

Note: higher scores indicate higher levels of recovery.

* Average period between baseline and follow-up was 5.1 months (dates when the RAS-DS tool was completed were available for 78 of the 108 clients (72.2%)).

^ Average period between baseline and follow-up was 6.3 months.

Several participants in the semi-structured interviews expressed the view that the Floresco service model was contributing to improved mental health outcomes. For example, one of the private practitioners commented that they could:

> see the outcomes in clients I've tracked. Even in the sense that we get referred, highly suicidal ones who won't go to hospital. Highly suicidal, they've just attempted suicide last week and they won't go to hospital. Because of the support and the clinical work we've done here, we've been able to, I guess, keep them alive. Who knows whether it was us or whether something else? But all we're saying is that they came highly suicidal and they're better.

The same informant also offered the following comment on the benefits of having a team of clinical and non-clinical staff collaborating to achieve better outcomes for clients:

> I tend to think the support they get is having an outcome … they find accommodation for people, they help them with Centrelink, some will take them to the GP when they're stressed, they do home visits, they might do a follow-up for me, encourage

people to come back — on the whole the support workers have helped me do my work better.

As an MHS staff member observed, many people who are seen by the ACT do not meet the threshold for ongoing case management, *and it's like well, where do you send them? So now those people might not be falling through the cracks as much because there's that onward referral out from the public mental health system to* [the Floresco Centre].

The 34 Floresco clients who participated in Aftercare's 2017 YES survey reported positively on the differences that Floresco had made in their lives. The survey (Appendix C) asked about the effects that Floresco had on their overall wellbeing, their ability to manage their day-to-day lives, and their hopefulness for the future; as shown Figure 6 below, in all cases about 80 per cent of respondents rated these effects as either excellent or very good. A majority of respondents also rated their overall experience of service at Floresco as either excellent (59%) or very good (26%). The results for all items of the survey are included in Appendix H.

Figure 6: 2017 YES survey results — client ratings of Floresco's effectiveness in improving their mental health and wellbeing
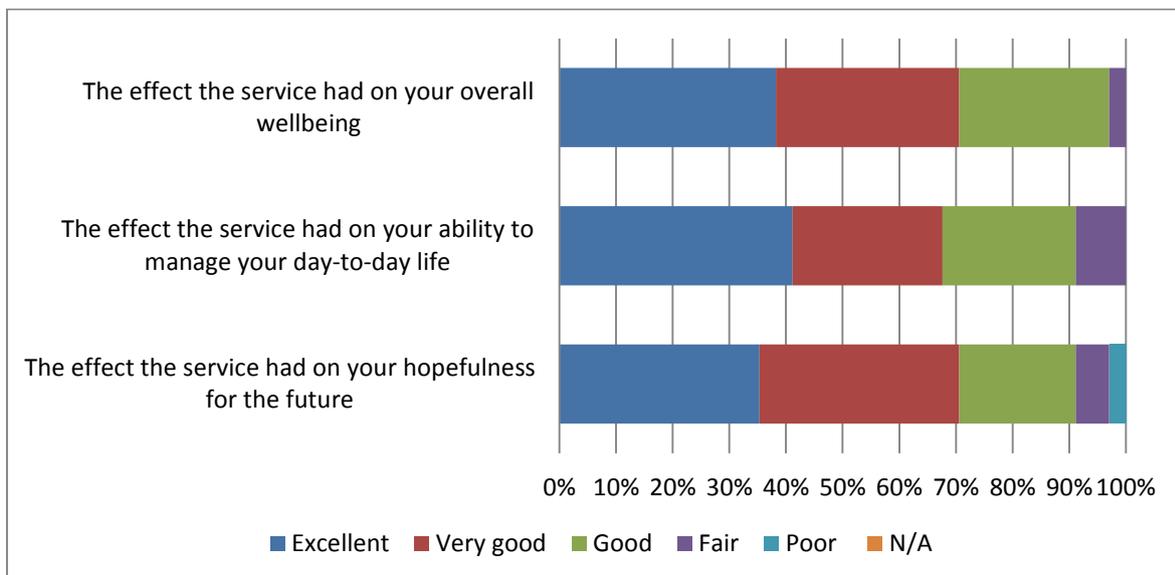
Question 6: To what extent has the service model contributed to improved system outcomes?

Use of hospital ED services and acute care beds by follow-up study participants in the six months pre- and post-intake to Floresco can be seen in Table 5. Decreases in hospital admissions and ED attendance were recorded, along with decreases in the median length of stay. The total number of occupied bed days for the cohort declined from 129 to 21, while the total duration of ED attendances declined by more than 50 per cent. However, only a few of the participants were admitted to hospital or attended ED. Due to the small sample size, the decline in the number of participants admitted to hospital post-intake was not statistically significant according to McNemar's test (chi2(1)=4.57; p=0.057); nor was the decline in the number of participants attending ED post-intake (chi2(1)=4.50; p=0.070).

Table 5: Use of public hospital ED and inpatient services by follow-up study participants (n=43) pre- and post-intake to Floresco

Public hospital service use	6 months prior to Floresco intake	6 months between interviews
Hospital admission		
Admitted for mental health reasons: % (n)	20.9% (9)	7.0% (3)
Total number of admissions for cohort (n)	12	10
Total number of occupied bed days for cohort (n)	129	21
Median number of admissions (range)	1 (1-3)	1 (1-8)
Median length of stay per admission in days (range)	8 (1-46)	3 (1-17)
Emergency department attendance		
Attended for mental health reasons: % (n)	34.8% (15)	6.3% (7)
Total number of attendances for cohort (n)	34	20
Total duration of attendances for cohort, in minutes	2834	1211
Median number of attendances (range)	1 (1–6)	2 (1–7)
Median length of stay per attendance, in minutes (range)	187 (50-360)	147 (47-320)

Despite the small sample size, the findings presented in Table 5 lend some support to the belief among participants in the semi-structured interviews that the Floresco service model has the potential to lead to improved system outcomes, in terms of more effective use of scarce hospital and MHS resources. For example, one MHS staff member commented that they knew of several Floresco clients who, based on past experience:

> would have presented [to ED] *so many more times for assessments because 'there is something but I don't know what I need'. Just needing to talk to a professional, but they didn't necessarily need hospitalisation*.

Another MHS staff member referred to Floresco's contribution to easing the pressure on the Acute Care and Continuing Care teams:

> *From an Acute Care perspective, it's taken a lot of pressure off us to actually really just focus on managing crisis, managing acuity and doing that, and then, once we can stabilise it, then that takes a lot of pressure off our — maybe people that might have gone to case management, they don't need to go there, they can go to Floresco and get some follow-up*.

Discussion

In an area with high levels of unmet need for mental health and psychosocial support services, the Floresco Centre has been a valuable addition to the mental health service system — the more so because its service model provides clients with seamless access to a wide range of services. These services aim to both meet clients' mental health needs and address factors that impact on their mental health, such as housing instability and unemployment. They include not only the psychosocial support services the Queensland Government funded the Floresco consortium to provide, but also MBS-funded clinical services delivered by psychologists and mental health social workers.

Despite the considerable challenges identified in this study, Floresco's service model appears to have contributed to positive mental health outcomes among clients who have significant mental health and functional difficulties but do not require inpatient care and do not meet the eligibility threshold for continuing community-based care through the MHS. Our study found that clients appreciated the way Floresco operated as a one-stop shop for a variety of mental health services and supports, were satisfied with the services they received, and improved in recovery during their engagement with Floresco. While clients referred by the MHS reduced their number of ED presentations and hospital admissions following their engagement with Floresco, the results from McNemar's test were non-significant. They may nevertheless have positive resource implications for public sector acute and continuing care mental health services, because the p values were trending towards significance; doing another study with a greater sample size would lead to more robust and potentially significant findings.

While it is still a work in progress, service integration between multiple NGO service providers and private mental health practitioners has largely been achieved at Floresco, as evidenced by their co-location, their implementation of a shared client information system, and their adoption of a single set of processes, outcome measures and practice standards. However, despite the development of a strong collaborative relationship between Floresco and the local MHS, intersectoral integration has not yet been achieved. This is due mainly to public health system barriers that currently prevent NGOs accessing client data via the MHS information system, together with resource constraints that limit the possibilities for MHS staff to co-locate at Floresco and use its shared client information system.

As found in previous evaluation studies, committed leadership and strong relationships were key enablers of service integration at the Floresco Centre; in this case they have been particularly important because the drive to innovate has come from outside government — that is, from the funded NGOs, rather than the funding body. That said, much of the leadership has been provided by a few passionate individuals whose departures from key positions have exacerbated the challenge of maintaining a shared vision and understanding of Floresco's integrated service model across the four consortium partners.

Another important enabler of service integration identified in previous studies, co-location of services, has been combined in Floresco's case with the adoption of a single brand name; this has helped to develop a strong sense of team identity at the Floresco Centre, despite the fact that staff

are employed by four different NGOs. And while co-location of MHS ACT staff at Floresco has not yet been possible in an ongoing way, Floresco staff have worked hard to nevertheless gain some of the benefits of co-location by regularly attending the ACT's weekly meetings. This frequent face-to-face contact with ACT staff over three years has helped to build mutual respect and understanding, and contributed to effective information-sharing between Floresco and the MHS, even in the absence of a shared information system.

Several of the significant challenges involved in implementing an integrated service model at Floresco have arisen as a result of the consortium approach, which has complicated issues in relation to clinical governance and the recruitment and management of support workers, and may have contributed to high staff turnover and lengthy delays in filling vacant positions. These problems have added to the challenge of bringing different organisational cultures together, which were noted in the evaluation of the Jigsaw program [13]. Like Jigsaw and many *headspace* centres, Floresco has had difficulty recruiting and retaining GPs [13, 14]; it has also had limited success in recruiting MBS-funded private mental health practitioners. As a result, Floresco has not only struggled to meet the high level of clinical needs among its clients, but has also been unable to secure a supplementary funding stream that might have made it possible to recruit and retain an additional intake officer and/or better qualified support staff, and thus reduce the length of its waiting list.

Barriers to service integration identified in other studies but not in this one include difficulties maintaining stakeholder commitment [4] and concerns about losing autonomy [9]. Maintaining stakeholder commitment may have been easier in Floresco's case because of the leadership provided by key personalities, particularly in the first two years, and because of the strong relationships that already existed between the consortium partners and the MHS, prior to the establishment of the Floresco Centre. Another enabling factor that mitigated the difficulties of maintaining commitment to service integration among stakeholders was their perception that Floresco's service model was contributing to positive mental health outcomes for clients.

None of the key informants mentioned any concerns about losing autonomy, but such concerns may have contributed to some of the challenges involved in bringing four NGOs together to work as one team; certainly it seems that Aftercare's NGO partners had some concerns about losing control of the staff that they placed at Floresco. However, it seems more likely that, because their involvement in the Floresco Centre was limited to only a few staff in each case — it did not involve the whole organisation or impact on its culture or systems — the three partner NGOs never perceived any threats to their autonomy.

'Turf wars' among service providers, which have caused problems for other mental health service integration initiatives [4], were also not evident at Floresco. However, there are some signs that they may emerge as a problem with the advent of the NDIS, under which collaborative partnerships such as those in operation at Floresco may be undermined by the pressure to compete.

We found numerous opportunities for improvements to the Floresco service model that may help to achieve even better mental health outcomes for clients. In particular, the model has been inadequately funded to meet the higher-than-expected clinical mental health needs of the local population and to cover the costs involved in holding its components together. That said, the current level of funding could be used more flexibly, and potentially more effectively, if Aftercare were not locked into subcontracting arrangements with its consortium partners. These arrangements limit the

possibilities for employing a more appropriate mix of clinical staff and mental health support workers. Moreover, if the consortium NGOs were to provide their services in kind, rather than via subcontracted outputs, they would be better placed to deliver services in their speciality areas, and the potential benefits to clients of bringing together a group of NGOs with different areas of expertise could be realised. Abandoning the subcontracting arrangements would also allow Floresco and Aftercare management staff to focus more on improving systems and processes at Floresco, rather than becoming caught up in managing overly complex staffing arrangements and negotiating compromises with the NGO partners over clinical governance issues. In particular, it seems likely that clients' mental health outcomes could be improved if Floresco staff could be trained and supported to make better use of the shared client information system.

Limitations of the study

The outcomes component of the evaluation had several limitations, including the lack of a control group that might have enabled us to more conclusively attribute the significant self-reported mental health recovery experienced by Floresco clients (as measured by the RAS–DS) to the Floresco service model. Our research design, as originally planned, included a comparison study, but recruitment of sufficient participants for this proved not to be feasible within the available timeframe.

Other limitations relate to the completeness of the data extract we were able to obtain from Floresco's client information system. To combat these problems, we analysed data on much smaller numbers of clients than have actually used Floresco's services, as explained in the methods section above. More complete data on all Floresco clients would have enabled a more robust evaluation. However, the availability of a more complete data set would be dependent on all users of the shared client information system —including not only Floresco staff, but also GPs, private practitioners and staff of co-located services —being trained to enter data in a consistent manner, and having shared understandings of the multiple benefits of collecting high quality client data. Moreover, while it is disappointing that subsequent RAS–DS results were available for only 9.6 per cent of the 1129 Floresco clients who completed the RAS–DS at intake, it is not surprising in the light of findings from other mental health service evaluations. For example, for the evaluation of Australia's Access to Allied Psychological Services program, overall outcomes data was available for only 13 per cent of the program's clients [23].

Conclusions

This evaluation shows that implementing a new integrated model is challenging in the Australian mental health service environment where there are so many different funders and providers. However, it also shows that horizontal service integration of NGO and private practitioner services is achievable in this environment, and that meaningful progress towards the integration of these services with public mental health services can be made. Key success factors are an enabling environment, committed and consistent leadership, a high level of stakeholder buy-in, strong relationships characterised by open communication, and adequate funding.

Previous reviews have noted that most published evaluations of efforts to integrate mental health services have provided little detail on their integration mechanisms and strategies, or how the service models work in practice. To maximise the learnings that can be drawn from it, this evaluation has provided detailed information on how the Floresco service model works and the steps involved in implementing it.

Despite the significant role of government-funded NGO providers within the Australian mental health system, there is little published research relevant to the Australian context that provides evidence of their effectiveness in improving outcomes for people affected by mental illness. This evaluation contributes to the evidence base, indicating that Floresco clients improved in recovery during their engagement with the centre. However, further research, using more robust study designs, is needed to determine whether these improvements are attributable to Floresco's integrated service model.

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Appendices

PARTICIPANT INFORMATION SHEET

(Floresco staff, governance group members, and partner service providers)

Project title

Floresco Centre service model evaluation

Purpose of study

You are being asked to take part in a research study that will evaluate the mental health service model implemented at the Floresco Centre in Ipswich. The project will assess the effectiveness of Floresco's integrated service model in improving outcomes for people who experience mental illness and their families and carers. In addition, it aims to identify barriers to the integration of community-based mental health services, the key enablers of effective integration, and the possibilities for improving Floresco's service model and/or its implementation. The study will contribute to knowledge about how best to deliver services for people with mental illness.

Dr Diana Beere is conducting this research in partnership with Sandra Diminic and Meredith Harris from the School of Public Health, The University of Queensland.

Your participation

You have been selected to participate in this study because of your role as a member of the Floresco Centre staff, its Governance Committee or sub-committees, or as a partner provider. You will be asked to participate in one or more of the following:

- a one-to-one interview, either in person at Floresco or your preferred location, or by telephone
- a face-to-face group interview, at Floresco, and/or
- completion of a questionnaire in your preferred format (paper-based, electronic, or online).

The interview(s) and/or questionnaire will ask about your previous experiences of integrated mental health service models; your understanding about integration; your knowledge and experience of Floresco's integrated service model; your opinions on its strengths, weaknesses and effectiveness; your views on the key challenges/barriers to mental health service integration and the key success factors; and suggestions about how Floresco's service model could be improved.

If the researchers feel the service model appears to have changed over time, you may also be invited to participate in a follow-up interview or questionnaire to explore your understanding and views about how the Floresco service model has changed.

It is important that you understand that your involvement in the research is voluntary and there is no penalty for not participating. Your participation or decision not to participate and the data you provide for this study will not affect your employment, and will not be communicated to your employer.

You have the right to have your questions about the procedures answered; if you have any questions, you should ask the researcher before the study begins. If you decide to discontinue participation at any time you may do so without providing any explanation. You have the right to ask that any data you have supplied to that point be withdrawn and destroyed.

All information you provide will be treated in a confidential manner and will be kept securely at The University of Queensland. Your name will be replaced with a unique code to protect your identity.

Benefits and risks

We cannot guarantee any direct benefits to participating. We hope that the research will provide information to guide the future delivery of Floresco services. You may enjoy the opportunity to discuss and reflect on the challenges involved in implementing an integrated mental health service model, what has or has not worked, and how integration might be improved. In addition, Floresco service users and other people with mental health problems will benefit in the longer term as a result of improvements in our knowledge about how best to deliver mental health services.

There are no specific risks associated with participation in this research. However, if you find you are becoming uncomfortable you can discontinue your participation at any time without prejudice.

For further information

Dr Diana Beere will be glad to answer your questions about this study at any time. You may contact her on 07 3271 8706 or diana.beere@qcmhr.uq.edu.au. If you want to find out the final results of this study, you should contact Diana. The results will also be published at an aggregated level in a final report and academic papers (you will not be individually identifiable).

This study has been reviewed by the Gold Coast Hospital and Health Service Human Research Ethics Committee, and adheres to the Guidelines of the ethical review process of The University of Queensland and the National Statement on Ethical Conduct in Human Research. While you are free to discuss your participation in this study with project staff (contactable on 07 3271 8706), if you would like to speak to someone who is not involved in the study, you may contact either:

- the Ethics Coordinator at The University of Queensland (07 3365 3924), or
- the HREC Coordinator at Gold Coast Health (07 5687 3879 or GCHEthics@health.qld.gov.au).

PARTICIPANT CONSENT FORM

(Floresco staff, governance group members, and partner service providers)

Project title

Floresco Centre service model evaluation

Statement

- I have read the Participant Information Sheet for this project, and have been given a copy to keep.
- I have been given an opportunity to ask questions about the research.
- I understand that my involvement is voluntary and there is no penalty for not participating.
- I understand that I may withdraw from the research study at any time without explanation, and may ask to have any data I have already supplied destroyed.
- I agree to participate in the research study and for data provided by me to be stored and used for the research as described in the Participant Information Sheet.

Name: _____

Signature: _____ _   **Today's date:** _____/_____/_____

Floresco Centre service model evaluation: Questions for semi-structured stakeholder interviews

Standard questions

What is (or was) your connection to the Floresco Centre?

For how long have you been (or were you) connected with the Floresco Centre?

How would you rate your knowledge about Queensland's mental health service system? (e.g., on a scale of 1 to 10, with 1 being 'very limited' and 10 being 'very comprehensive')

A common criticism about Queensland's mental health system is that better service integration is needed. What does 'better service integration' mean to you?

What is your understanding of the motivations behind the establishment of the Floresco Centre?

To the best of your knowledge, has the integrated mental health service model been implemented at the Floresco Centre as planned?

Does it operate as intended?

Is it consistent with what was envisaged?

If not, in what ways does it differ?

To what extent, in your view, has the Floresco Centre filled a need for mental health consumers? Can you explain the basis for that judgement?

What have been the main barriers, from your perspective, to implementing an integrated service model at the Floresco Centre?

Have these barriers been overcome, and if so, how has this been achieved?

To the extent that service integration has been achieved at the Floresco Centre, what do you think have been the key factors that have enabled this?

In your view, is Floresco's integrated service model sustainable over time? Why, or why not?

How, in your opinion, could the Floresco service model be improved to achieve better mental health and whole-of-life outcomes for consumers?

Based on what you know of the history of Floresco's development, as well as how it operates now, what do you think are the key learnings about service integration?

Thinking particularly about the aim of improving service integration, is there anything that we haven't already discussed that you would suggest should be done differently next time?

Other than what we've already discussed, is there any advice that you would give to other organisations wanting to establish an integrated mental health service?

Your Experience of Service

FLORESCO

Your feedback is important. This survey aims to help mental health services and consumers work together to improve services. It was developed with mental health consumers and is based on the recovery principles of the 'National Standards for Mental Health Services 2010'. If you want to know more about the survey please ask for an information sheet.

Completion of the YES survey is voluntary. All the information collected is anonymous, and none of it will be used to identify you. It would be helpful if you could answer all questions, but please leave any question blank if you don't want to answer it.

	Never	Rarely	Sometimes	Usually	Always	Not applicable
Please put a cross in just one box for each question, like this…				X		

The following questions ask *how often* we did the following things.

Thinking about the care you have received from this service within the last 3 months or less, what was your experience in the following areas?	Never	Rarely	Sometimes	Usually	Always	Not applicable
1. You felt welcome at this service.						
2. Staff showed respect for how you were feeling.						
3. You felt safe using this service.						
4. Your privacy was respected.						
5. Staff showed hopefulness for your future.						
6. Your individuality and values were respected (your culture, faith, gender identity, etc.).						
7. Staff made an effort to see you when you wanted.						
8. You believe that you would receive fair treatment if you made a complaint.						
9. Your opinions about the involvement of family or friends in your care were respected.						

10. The facilities and environment met your needs (cleanliness, private space, reception area, furniture, common areas, etc.).						

The next questions ask *how often* we did the following things.

Thinking about the care you have received from this service within the last 3 months or less, what was your experience in the following areas?	Never	Rarely	Sometimes	Usually	Always	Not applicable
11. You were listened to in all aspects of your care and treatment.						
12. Staff worked as a team in your care and treatment (for example, you got consistent information and didn't have to repeat yourself to different staff).						
13. You had opportunities to discuss your progress with the staff caring for you.						
14. There were activities you could do that suited you.						
15. You had opportunities for your family and carers to be involved in your treatment and care if you wanted.						

The next questions ask *how well* we did the following things.

Thinking about the care you have received from this service within the last 3 months or less, what was your experience in the following areas?	Poor	Fair	Good	Very Good	Excellent	Not applicable
16. Information given to you about this service (such as how the service works, which staff will be working with you, how to make a complaint, etc.).						
17. Explanation of your rights and responsibilities.						
18. Access to peer support (such as information about peer workers, referral to consumer programs, advocates, etc.).						
19. Development of a care plan with you that considered all of your needs (such as health, living situation, age, etc.).						
20. Convenience of the location for you (such as close to family and friends, transport, parking, community services you use, etc.).						

The next questions ask you to *rate us* on the following things.

As a result of your experience with the service in the last 3 months or less, please rate the following:	Poor	Fair	Good	Very Good	Excellent
21. The effect the service had on your hopefulness for the future					
22. The effect the service had on your ability to manage your day-to-day life					
23. The effect the service had on your overall wellbeing					
24. Overall, how would you rate your experience of care with this service in the last 3 months?					
Thinking about all the Floresco services you have used within the last 3 months or less, please rate the following:	Poor	Fair	Good	Very Good	Excellent
25. How easy you found it to get the right mix of services to help you					
26. Floresco's effectiveness as a 'one-stop-shop' for people who want help to improve their mental health					

Please tell us a bit more about your experience of this service.

27. My experience would have been better if…

28. The best things about this service were…

The remaining questions help us to know whether we are missing out on feedback from some groups of people. They also tell us if some groups of people have a better or worse experience than others. Knowing this will help us focus our efforts to improve services.

No information collected in this section will be used to identify you.

What is your gender?

☐ **Male**   ☐ **Female**   ☐ **Other**

What is the main language you speak at home?

☐ **English**   **Other** [   ]

Are you of Aboriginal or Torres Strait Islander origin?

☐ **No**

☐ **Yes—Aboriginal**

☐ **Yes—Torres Strait Islander**

☐ **Yes—both Aboriginal and Torres Strait Islander**

What is your age?

☐ **18 to 24 years**   ☐ **25 to 34 years**

☐ **35 to 44 years**   ☐ **45 to 54 years**

☐ **55 to 64 years**

How long have you been receiving care from this service on this occasion?

☐ **Less than 24 hours**

☐ **1 day to 2 weeks**   ☐ **3 to 4 weeks**

☐ **1 to 3 months**   ☐ **4 to 6 months**

☐ **More than 6 months**

At any point during the last 3 months were you receiving involuntary treatment (such as an involuntary patient or on a community treatment order) under Mental Health Legislation?

☐ **Yes, involuntary patient / on a community treatment order**

☐ **No, I was always a voluntary patient**

Did someone help you complete this survey?

☐ **No**

☐ **Yes—family member or friend**

☐ **Yes—language or cultural interpreter**

☐ **Yes—consumer worker or peer worker**

☐ **Yes—another staff member from the service**

☐ **Yes—someone else**

Please place your completed survey in the locked YES survey return box at the Floresco Centre. Alternatively, you may post it to:

Floresco Centre
Level 1, 3 Wharf Street
Ipswich QLD 4305

For further information, please contact the Floresco Centre:
phone: 07 3280 5670   email: floresco@aftercare.com.au

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Name: ....

Recovery Assessment Scale – Domains and Stages (RAS-DS)

Instructions

Below is a list of statements that describe how people sometimes feel about themselves and their lives.

Please *read each one carefully* and *circle the number* to the right that *best describes you at the moment*.

Circle *only one number for each statement* and *do not skip any items*.

FUNCTIONAL RECOVERY				
	UNTRUE	A bit TRUE	Mostly TRUE	Completely TRUE
It is important to have fun.	1	2	3	4
It is important to have healthy habits.	1	2	3	4
I do things that are meaningful to me.	1	2	3	4
I continue to have new interests.	1	2	3	4
I do things that are valuable and helpful to others.	1	2	3	4
I do things that give me a feeling of great pleasure.	1	2	3	4
PERSONAL RECOVERY				
	UNTRUE	A bit TRUE	Mostly TRUE	Completely TRUE
I can handle it if I become unwell again.	1	2	3	4
I can help myself become better.	1	2	3	4
I have the desire to succeed.	1	2	3	4
I have goals in life that I want to reach.	1	2	3	4
I believe that I can reach my current personal goals.	1	2	3	4
I can handle what happens in my life.	1	2	3	4
I like myself.	1	2	3	4
I have a purpose in life.	1	2	3	4
If people really knew me they would like me.	1	2	3	4
If I keep trying, I will continue to get better.	1	2	3	4
I have an idea of who I want to become.	1	2	3	4
Something good will eventually happen.	1	2	3	4
I am the person most responsible for my own improvement.	1	2	3	4
I am hopeful about my own future.	1	2	3	4
I know when to ask for help.	1	2	3	4

PERSONAL RECOVERY (continued)				
	UNTRUE	A bit TRUE	Mostly TRUE	Completely TRUE
I ask for help, when I need it.	1	2	3	4
I know what helps me get better.	1	2	3	4
I can learn from my mistakes.	1	2	3	4
CLINICAL RECOVERY				
	UNTRUE	A bit TRUE	Mostly TRUE	Completely TRUE
I can identify the early warning signs of becoming unwell.	1	2	3	4
I have my own plan for how to stay or become well.	1	2	3	4
There are things that I can do that help me deal with unwanted symptoms.	1	2	3	4
I know that there are mental health services that help me.	1	2	3	4
Although my symptoms may get worse, I know I can handle it.	1	2	3	4
My symptoms interfere less and less with my life.	1	2	3	4
My symptoms seem to be a problem for shorter periods of time each time they occur.	1	2	3	4
SOCIAL RECOVERY				
	UNTRUE	A bit TRUE	Mostly TRUE	Completely TRUE
I have people that I can count on.	1	2	3	4
Even when I don't believe in myself, other people do.	1	2	3	4
It is important to have a variety of friends.	1	2	3	4
I have friends who have also experienced mental illness.	1	2	3	4
I have friends without mental illness.	1	2	3	4
I have friends that can depend on me.	1	2	3	4
I feel OK about my family situation.	1	2	3	4

PARTICIPANT INFORMATION SHEET
(Floresco mental health service users)

Project title

Evaluation of community-based mental health support services

Purpose of study

You are invited to take part in a research study that will evaluate short- to medium-term mental health and wellbeing outcomes among people with mental illness who use non-government, community-based mental health support services. The study aims to compare outcomes from these support services in two different areas: Ipswich and Logan. The results will contribute to knowledge about how best to deliver services for people with mental illness.

Dr Diana Beere is conducting this study in partnership with Sandra Diminic and Meredith Harris from the School of Public Health, The University of Queensland.

Your participation

You will be asked to participate in an initial face-to-face interview with a researcher. The interview will be conducted at the Floresco Centre, and will take approximately 30–45 minutes. You will then be invited back at intervals of 3–6 months to participate in one or more follow-up interviews.

The interviews will include questions about your:
- personal characteristics, such as age and gender
- accommodation and living arrangements
- involvement in work, education and other activities
- recent contact with health and community services.

At each interview, you will also be asked to complete a short questionnaire about your mental health recovery.

In addition, you will be asked to permit the researchers to access routine information held by:
- Queensland Health, about your use of hospital, emergency department and community mental health services over the last 12 months, and from now until the end of the study period
- the Floresco Centre, about you, your mental health and recovery, and your use of Floresco services between your referral to the centre and the end of the study period.

The research team will treat all the information you provide, and any information about you that is obtained from either Queensland Health or the Floresco Centre, as confidential. To protect your identity, a unique code will replace your name in the research records, and these records will be kept securely at The University of Queensland.

Your rights

It is important that you understand that your involvement in the study is voluntary and there is no penalty for not participating. You have the right to:

- ask questions about the process
- receive answers to your questions
- stop participating at any time, and to do so without explaining why
- ask the research team to destroy, without using it, any information about you that was obtained before you stopped participating. This includes information obtained from you, Queensland Health and the Floresco Centre.

If you have any questions, please ask the researcher before the study begins.

Benefits and risks

You will receive a $20 gift voucher at each interview, as thanks for your time and to cover any costs you incur to attend. In the longer term, you and other people who experience mental illness may also benefit from improvements in knowledge about how best to deliver community-based mental health services.

No specific risks are associated with participation in this study. However, if you find you are becoming uncomfortable, you can stop participating at any time without any impact on your care.

For further information

Dr Diana Beere will be glad to answer your questions about this study at any time. You may contact her on 07 3271 8706 or diana.beere@qcmhr.uq.edu.au.

You may also contact Diana if you want to find out the final results of this study. The results will be published at an aggregated level in a final report and academic papers (you will not be individually identifiable).

This study has been reviewed by the Gold Coast Hospital and Health Service Human Research Ethics Committee, and adheres to the Guidelines of the ethical review process of The University of Queensland and the National Statement on Ethical Conduct in Human Research. While you are free to discuss your participation in this study with the research team (contactable on 07 3271 8706), if you would like to speak to someone who is not involved in the study, you may contact either:

- the Ethics Coordinator at The University of Queensland (07 3365 3924), or
- the HREC Coordinator at Gold Coast Health (07 5687 3879 or GCHEthics@health.qld.gov.au).

PARTICIPANT CONSENT FORM (Floresco mental health service users)

Project title: Evaluation of community-based mental health support services

Statement

- I have read the Participant Information Sheet for this project, and have been given a copy to keep.
- I have had an opportunity to ask questions about the study.
- I understand that my participation is voluntary, and that there is no penalty for not participating.
- I understand that I may withdraw from the study at any time without explanation, and may ask the research team to destroy, without using it, any information that I have already supplied or that has already been obtained from my Queensland Health and/or Floresco Centre records.
- I agree to participate in the study and for information about me to be stored and used for the study, as described in the Participant Information Sheet.

Consent for release of Queensland Health data

I give permission for the research team to obtain from Queensland Health the following information about me, for the period from 12 months before today's date (i.e., _____) until 31 January 2018:

- number of presentations for mental health treatment at Queensland public hospital emergency departments (including date and duration of each attendance)
- number of inpatient admissions to Queensland public hospitals for mental health treatment and care (including admission and discharge dates, length of stay, and primary and secondary diagnoses)
- number of attendances at community-based public mental health services (including date of each attendance).

    YES ☐   **NO** ☐

Consent for release of Floresco Centre

I give permission for the research team to obtain from the Floresco Centre the following information about me:

- data collected at my intake interview, including my age, gender, suburb, referral source, diagnosis, suicidality, and additional factors affecting my wellbeing (such as homelessness or family violence)
- my use of Floresco Centre services during the period between my referral and 31 January 2018
- my recovery questionnaire (RAS–DS) scores at intake, 3-month review/s, and/or exit from Floresco
- any other mental health or wellbeing outcomes identified at the time of my exit from Floresco.

    YES ☐   **NO** ☐

Name: _____   **Date of birth:** _____/_____/_____

Signature: _____ _   **Today's date:** _____/_____/_____

Floresco Evaluation

Paper interview reference guide: Baseline interviews

Notes:

- If there is no arrow next to an answer then go to the next question
- If there is an arrow next to an answer then go to the question indicated
- If the question does not say "multiple responses possible" then only one response should be recorded

1. Today's date _____

2. Interview number

- ○ Floresco 1
- ○ Floresco 2

To ensure your responses remain confidential, I'm only going to record an ID code for you, rather than your name.

<ID code is a combination of numbers, letters from the participant's name and their date of birth>

3. Participant ID code _____

»» I'd like to start by asking for some basic demographic information about you, please.

4. What is your age, in years? _____

If declined, use 99.

5. What gender do you identify as: male, female, or other? Or would you prefer not to say?

○ Male   ○ Other

○ Female   ○ Prefer not to say

6. Are you of Aboriginal or Torres Strait Islander origin?

- ○ No
- ○ Yes, Aboriginal
- ○ Yes, Torres Strait Islander
- ○ Yes, both Aboriginal & Torres Strait Islander
- ○ Declined

7. What is your first language?

○ English   ○ Declined

○ Other: _____

8. What is the highest year of primary or secondary school you completed?

○ Year 12 or equivalent	○ Year 8 or below
○ Year 11 or equivalent	○ Never attended school
○ Year 10 or equivalent	○ Declined
○ Year 9 or equivalent	

9. Have you completed a trade certificate, diploma, degree or any other educational qualification?

○ Yes -> go to Q11

○ No -> go to Q12

○ Declined -> go to Q12

10. What is the highest level qualification you have completed?

○ Trade certificate or apprenticeship
○ Technician's cert./Advanced cert.
○ TAFE certification
○ Associate diploma

○ Undergraduate diploma
○ Bachelor degree
○ Postgraduate qualification
○ Declined

11. What is currently your main source of income?

For this question 'currently' means now and over the last 2-4 weeks.

○ Salary or wages -> go to Q13
○ Self-employed -> go to Q13
○ Government benefits -> go to Q12
○ Superannuation/investments -> go to Q13
○ No income -> go to Q13
○ Declined -> go to Q13
○ Other: _____-> go to Q13

12. What is the main type of government benefit you're currently receiving?

i.e. the benefit that currently provides the largest amount of regular income

○ ABSTUDY or AUSTUDY
○ Carer payment
○ Disability support pension
○ Newstart
○ Parenting payment
○ Sickness allowance
○ Special benefit
○ Declined
○ Other: _____

»» Now I have a few questions about your physical and mental health.

13. In general, thinking about the last 6 months, would you describe your <u>physical</u> health as excellent, very good, good, fair or poor?

- ○ Excellent
- ○ Very good
- ○ Good
- ○ Fair
- ○ Poor
- ○ Declined

14. If you know your primary mental health diagnosis, please tell me what it is.

One only; no prompts

- ○ Adjustment disorder
- ○ Anxiety disorder
- ○ Bipolar disorder
- ○ Borderline personality disorder
- ○ Other personality disorder
- ○ Depression
- ○ Eating disorder
- ○ Obsessive compulsive disorder
- ○ Perinatal depression

- ○ PTSD
- ○ Schizoaffective disorder
- ○ Schizophrenia
- ○ Other psychosis (inc drug-induced)
- ○ Stress
- ○ Substance misuse
- ○ Declined
- ○ Don't know / can't recall
- ○ Other:_____

15. If you have one or more <u>secondary</u> mental health diagnoses, please tell me what they are.

No prompts. Multiple responses possible.

- ○ Adjustment disorder
- ○ Anxiety disorder
- ○ Bipolar disorder
- ○ Borderline personality disorder
- ○ Other personality disorder
- ○ Depression
- ○ Eating disorder
- ○ Obsessive compulsive disorder
- ○ Perinatal depression

- ○ PTSD
- ○ Schizoaffective disorder
- ○ Schizophrenia
- ○ Other psychosis (inc drug-induced)
- ○ Stress
- ○ Substance misuse
- ○ Declined
- ○ Don't know / can't recall
- ○ Other:_____

»» The next question is about suicide and self-harm.

16. In the last 12 months, have you done any of the following things?

Multiple responses possible

- ☐ Thought seriously about killing yourself
- ☐ Made a plan to kill yourself
- ☐ Attempted to kill yourself
- ☐ Deliberately done something to harm or hurt yourself, without intending to kill yourself
- ☐ None of these
- ☐ Declined

»» Now I'd like to ask you about hospital admissions for mental health reasons.

17. In the last 12 months have you been admitted to hospital for mental health reasons?

- ○ Yes -> go to Q24
- ○ No -> go to Q29
- ○ Declined -> go to Q29

18. How many times during the last 12 months were you admitted...

If declined, use 99.

If don't know/can't recall, ask for an estimate.

If unable to estimate, use 100.

- to a mental health unit (specifically for people with mental illness)? _____

- for mental health reasons to some other type of hospital ward? _____

- as an involuntary mental health patient? _____

19. During the last 12 months, what was the <u>total</u> number of nights you spent in hospital for mental health reasons? It's OK if you can't remember exactly; an estimate is fine. _____

If declined, use 99.

»» The next questions are about any visits you might have made to a hospital emergency department for mental health-related reasons.

20. During the last 12 months, have you ever been to a hospital emergency department to get help with a mental health problem?

- ○ Yes -> go to Q21
- ○ No -> go to Q22
- ○ Not sure / can't recall -> go to Q22
- ○ Declined -> go to Q22

21. How many times during the last 12 months did you go to a hospital emergency department for help with a mental health problem?

If you can't remember, please just give me an estimate._____

If declined, use 99.

»» Now I'd like to ask you about your housing situation.

22. What kind of housing do you live in at present?

For example, do you live in:

- ○ public (social) rental housing -> go to Q24
- ○ private rental housing -> go to Q24
- ○ your own home, or one that you're currently buying -> go to Q24
- ○ a boarding house -> go to Q24

Or are you:

- ○ renting a room or boarding privately -> go to Q24
- ○ couch-surfing or in other temporary accommodation -> go to Q25
- ○ homeless -> go to Q23
- ○ other?-> go to Q24

23. Please tell me how long you've been homeless.

If the participant is moving in and out of homelessness, about how long has the current period of homelessness been? Read out response options if necessary.

- ○ Less than 1 week -> go to Q27
- ○ More than 1 week but less than 1 month -> go to Q27
- ○ 1 to 2 months -> go to Q27
- ○ 3 months or longer -> go to Q27
- ○ Declined -> go to Q27

24. Were there any times during the last 12 months when you were homeless or had no stable accommodation?

- ○ No -> go to Q26
- ○ Yes -> go to Q28
- ○ Declined -> go to Q26

25. How long have you been couch surfing / had no stable accommodation?

Estimated length of the participant's current period of housing instability

Read out response options from drop down list if necessary.

- ○ Less than 1 week -> go to Q27
- ○ More than 1 week but less than 1 month -> go to Q27
- ○ 1 to 2 months -> go to Q27
- ○ 3 months or longer -> go to Q27
- ○ Declined -> go to Q27

26. Who do you currently live with?

- ○ Living alone
- ○ Living with partner and/or family members
- ○ Sharing with friends/housemates
- ○ Declined
- ○ Other:_____

27. Thinking about the last 12 months, how many times have you moved house or changed accommodation during that period?

- ○ None -> go to Q29
- ○ 1 -> go to Q29
- ○ 2 -> go to Q29
- ○ 3 or more -> go to Q29
- ○ Declined -> go to Q29

28. For about how long during the last 12 months were you homeless or living in some kind of temporary accommodation?

If there was more than one period when you were living like that, please estimate the total length of time.

Read out response options if necessary.

- ○ Less than 1 week -> go to Q26
- ○ More than 1 week, but less than 1 month -> go to Q26
- ○ 1 to 2 months -> go to Q26
- ○ 3 months or longer -> go to Q26
- ○ Declined-> go to Q26

»» The next few questions are about your employment situation.

29. Are you currently doing any paid work?

For this question, 'currently' means now and over the last 2-4 weeks.

- ○ Yes -> go to Q30
- ○ No -> go to Q32
- ○ Declined -> go to Q32

30. What sort of paid work do you do?

See response options.

Use probing Qs to help identify whether the participant works in a 'mainstream' job for wages/salary, is self-employed, or is paid to do work made available via:

- a 'make work' scheme (e.g., work for the dole)
- a supported employment initiative for people with specific disadvantages/disabilities/needs (e.g., mental health clubhouse programs, The Big Issue, Endeavour Foundation workshops)
- a social enterprise or similar initiative that provides employment opportunities and training/experience to people who are currently marginalised by the competitive jobs market. If unsure, use 'Other' and enter job title and/or employer's name.

○ 'Real' / mainstream job for wage/salary

○ Self-employed

○ Work for the dole or similar

○ Mental health clubhouse or similar

○ Social enterprise or similar

○ Declined

○ Other: _____

31. How many hours of paid work do you normally do each week?

If the number of hours varies from week to week, please estimate an average number, based on the last 4 weeks.

If declined, use 99.

_____

32. Are you actively looking for any paid work at present? This includes looking for:

- **more paid work (additional hours or an additional job)**
- **paid work with better pay or conditions**
- **a different type of paid work**
- **paid work with a different employer**
- **paid work in a different location.**

○ No
○ Yes, looking for paid work
○ Yes, looking for MORE paid work
○ Yes, looking for DIFFERENT paid work
○ Yes, looking for work with BETTER PAY/CONDITIONS
○ Yes, looking for paid work with a DIFFERENT EMPLOYER
○ Yes, looking for paid work in a DIFFERENT LOCATION
○ Declined
○ Other: _____

»» Now I'd like to ask you briefly about unpaid work.

Unpaid work can include things like looking after children or other family members, or doing domestic work for your household (if you live with other people), as well as various kinds of voluntary work.

33. Are you currently doing any unpaid work?

For this question, 'currently' means now and over the last 2 to 4 weeks.

- ○ Yes -> go to Q34
- ○ No -> go to Q36
- ○ Declined -> go to Q36

34. What type/s of unpaid work are you currently doing?

Multiple responses possible

- ☐ Domestic work for your household
- ☐ Voluntary work in the community
- ☐ Caring for family member/s with disability, long-term illness or old age
- ☐ Looking after one or more children <15 yrs old
- ☐ Declined
- ☐ Other unpaid work: _____

35. How many hours each week do you normally spend doing unpaid work?

If the number of hours varies from week to week, please estimate an average number, based on the last 4 weeks.

If declined, use 99.

_____

»» Next I have one or two questions about study.

36. Are you currently studying for an education or training qualification?

For this question, 'currently studying' means enrolled at present and actively participating in learning activities (lectures, practical exercises, assessment tasks, etc), whether face-to-face or online.

'Currently studying' would also apply if the interview takes place during a semester break (or similar) and the participant is part-way through a study program that they will be continuing in the next semester.

- ○ No -> go to Q38
- ○ Yes, studying part-time -> go to Q37
- ○ Yes, studying full-time -> go to Q37
- ○ Declined -> go to Q38

37. **Where are you studying?**

Enter the type of study institution, if it can be identified. Use 'other' to specify either a type of institution not listed or (if the type is unknown) the name of the institution.

- ○ TAFE or technical college
- ○ University
- ○ Business college
- ○ Other: _____
- ○ Declined

»» The next questions are about <u>mental health treatment services</u> you've used during the last 12 months.

38. Other than as a hospital inpatient or at a hospital emergency department, have you had any <u>specialised</u> mental health treatment during the last 12 months?

This would be treatment/therapy you've received from a mental health professional such as a mental health nurse, psychiatrist, psychologist or psychotherapist.

- ○ No -> go to Q47
- ○ Yes -> go to Q39
- ○ Can't recall -> go to Q47
- ○ Declined -> go to Q47

39. Can you remember where you got that treatment, or from whom?

For example, did you go to any of the following?

Read list. Multiple responses are possible, including 'Other'. However, the latter should not be required, so use further Qs to clarify this response, if selected.

If respondent lists multiple responses, make sure to refer back to this question and follow directions to each corresponding follow-up question before moving on to the next section (Q66).

- ☐ Community mental health service -> go to Q40
- ☐ Medicare-funded mental health practitioner -> go to Q41
- ☐ Other mental health practitioner (not Medicare-funded) -> go to Q42
- ☐ Don't know / can't recall -> go to Q47
- ☐ Declined -> go to Q47
- ☐ Other: _____ -> go to Q46

40. You said you went to a <u>community mental health service</u> for treatment during the last 12 months. Can you recall how many times you went there?

It's OK if you can't remember exactly; please just give me an approximate number.

If declined, use 99.

_____ -> go to Q43

41. You mentioned that you've been to one or more <u>Medicare-funded</u> mental health practitioners for treatment during the last 12 months. Could you tell me how many times you did that?

If you can't recall exactly, an approximate number is fine.

If declined, use 99.

_____ -> go to Q44

42. You said that during the last 12 months you went to one or more specialised mental health practitioners whose services were <u>not funded through Medicare.</u>

Can you recall how many times you did that?

An approximate number is fine if you can't remember exactly.

If declined, use 99.

_____ -> go to Q45

43. Are you still going to the community mental health service?

If participant is unsure, ask whether they have an appointment for another visit. Use 'Other' to note any remaining uncertainty.

○ No ○ Yes ○ Declined ○ Other: _____ -> go to Q47

44. Are you still going to a Medicare-funded mental health practitioner for treatment?

If participant is unsure, ask whether they have made another appointment. Use 'Other' to note any remaining uncertainty.

○ No ○ Yes ○ Declined ○ Other: _____ -> go to Q47

45. Are you still seeing a mental health practitioner who isn't funded through Medicare?

If participant is unsure, ask whether they have an appointment for another visit. Use 'Other' to note any remaining uncertainty.

○ No ○ Yes ○ Declined ○ Other: _____ -> go to Q47

46. You said earlier that you had been to <u>another type of specialised mental health provider</u> for treatment. Are you still going there for treatment?

May need to refer back to responses to Q53.

If participant is unsure about whether they are still going to this provider, ask whether they have made another appointment. Use 'Other' to explain any further uncertainty.

○ No ○ Yes ○ Declined ○ Other: _____ -> go to Q47

»» The next questions are about visits to general practitioners (GPs).

I only want to ask about GP visits you've made in relation to your own health, so please ignore any times when you might have taken someone else to see a doctor.

47. Do you have:
- **a regular GP**
- **a regular GP practice — a group of doctors in one location, where you usually go when you need to see a GP, or**
- **two or more GPs to whom you usually go, depending on the health issue at the time?**

'Regular' means the participant prefers/tries to go to this GP/practice, although it might not always be possible.

- ○ No regular GP or GP practice
- ○ Yes, regular GP
- ○ Yes, regular GP practice
- ○ Yes, more than one regular GP/practice
- ○ Declined

48. Thinking about the last 12 months, did you visit a GP — either your regular GP or another GP — for reasons related to your <u>own</u> health during that period?

- ○ No -> go to Q52
- ○ Yes -> go to Q49
- ○ Can't recall / Not sure -> go to Q52
- ○ Declined -> go to Q52

49. Can you recall the general reasons for any of your visit/s to a GP during the last 12 months?

You don't need to give me any details, just whether your visits to a GP were for:

- ○ Mainly physical health reasons
- ○ Mainly mental health reasons
- ○ Both physical and mental health reasons
- ○ Can't recall any reasons
- ○ Declined
- ○ Other reasons: _____

50. Could you tell me how many times you've visited a GP during the last 12 months?

If you can't remember exactly, that's OK; please give me an approximate number.

If declined, use 99.

_____ -> if 99 or 0, go to Q52

51. Could you tell me how many — or roughly how many — of those GP visits during the last 12 months were for mental health reasons, or included some discussion about your mental health?

An example of the latter would be if the participant went to the doctor for a physical health reason, but the doctor also checked on his/her mental health.

If declined, use 99.

_____

»» I just have a few questions now about community services that you might be using.

52. Please tell me whether you are currently using any of the following types of community support services.

For this question, 'currently' means now and over the last 2 to 4 weeks. Read the list slowly to the participant, pausing for a response to each type of service. Multiple responses are possible.

- ☐ Alcohol or other drug service -> go to Q53 and then **skip** to Q56
- ☐ Child or family support service -> go to Q53 and then **skip** to Q56
- ☐ Disability support service -> go to Q53 and then **skip** to Q56
- ☐ Domestic violence service -> go to Q53 and then **skip** to Q56
- ☐ Emergency/crisis support service -> go to Q53 and then **skip** to Q56
- ☐ Employment support service -> go to Q53 and then **skip** to Q56
- ☐ Financial counselling service -> go to Q53 and then **skip** to Q56
- ☐ Other counselling service -> go to Q53 and then **skip** to Q56
- ☐ Homelessness support service -> go to Q53 and then **skip** to Q56
- ☐ Housing service -> go to Q53 and then **skip** to Q56
- ☐ Mental health support service -> go to Q53
- ☐ Not currently using any services -> go to Q56 and end interview
- ☐ Declined to answer -> go to Q56 and end interview
- ☐ Other service: _____ -> go to Q53 and then **skip** to Q56

53. On a scale of 1 to 5, where 1 is 'not at all well' and 5 is 'extremely well', how well are these support services currently meeting your overall mental health recovery and support needs?

Not at all well		Moderately well		Extremely well	Declined
1	2	3	4	5	99

54. You've told me you're currently using a mental health support service — or possibly more than one. So just to clarify, how many mental health support services are you using at the moment?

'At the moment' means the participant is still engaged with the service, and expects to keep using it, at least for the time being.

- ○ 1
- ○ 2
- ○ 3
- ○ More than 3
- ○ Declined to answer

55. And does that include the Floresco Centre?

    ○   No   ○   Yes   ○   Declined to answer

56. Use this area to make any additional comments or notes on participant's responses to one or more questions.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Thank you very much for answering these questions.

I'd just like you to do one more thing. It should only take a couple of minutes.

- Ask participant to complete the RAS-DS.
- Give the participant a gift card as thanks.
- Make sure you get them to sign the receipt for the gift card.
- Check participant's willingness to participate in another interview in about 6 months time.
- If yes to the above, let them know we'll be in touch (by phone/email) to organise a date and time for the next interview.

Floresco Evaluation

Paper interview reference guide: Follow-up interviews

Notes:

- If there is no arrow next to an answer then go to the next question
- If there is an arrow next to an answer then go to the question indicated
- If the question does not say "multiple responses possible" then only one response should be recorded

1. Today's date _____

2. Interview number

- ○ Floresco 1
- ○ Floresco 2

As for the last interview, I'm recording only your ID code, not your name, to ensure your responses remain confidential.

<ID code is a combination of numbers, letters from the participant's name and their date of birth>

3. Participant ID code _____

»» I'd like to start by re-visiting a few of the demographic questions from the first interview, to see whether anything has changed since then.

4. What is currently your main source of income?

For this question, 'currently' means now and over the last 2-4 weeks.

- ○ Salary or wages -> go to Q6
- ○ Self-employed -> go to Q66
- ○ Government benefits -> go to Q5
- ○ Superannuation/investments -> go to Q6
- ○ No income -> go to Q6
- ○ Declined -> go to Q6
- ○ Other: -> go to Q6

5. What is the main type of government benefit you're currently receiving?

i.e. the benefit that currently provides the largest amount of regular income

- ○ ABSTUDY or AUSTUDY
- ○ Carer payment
- ○ Disability support pension
- ○ Newstart
- ○ Parenting payment
- ○ Sickness allowance
- ○ Special benefit
- ○ Declined
- ○ Other: _____

»» Now I have a few questions about your physical and mental health.

6. In general, thinking about the period since the last interview, would you describe your <u>physical</u> health as excellent, very good, good, fair or poor?

- ○ Excellent
- ○ Very good
- ○ Good
- ○ Fair
- ○ Poor
- ○ Declined

7. In general, thinking about the period since the last interview, would you describe your <u>mental health</u> as excellent, very good, good, fair or poor?

- ○ Excellent
- ○ Very good
- ○ Good
- ○ Fair
- ○ Poor
- ○ Declined

»» The next question is about suicide and self-harm.

8. Since the last interview, have you done any of the following things?

Multiple responses possible

- ☐ Thought seriously about killing yourself
- ☐ Made a plan to kill yourself
- ☐ Attempted to kill yourself
- ☐ Deliberately done something to harm or hurt yourself, without intending to kill yourself
- ☐ None of these
- ☐ Declined

»» Now I'd like to ask you about hospital admissions for mental health reasons.

9. Since the last interview, have you been admitted to hospital for mental health reasons?

- ○ Yes -> go to Q10
- ○ No -> go to Q12
- ○ Declined-> go to Q12

10. During that period, how many times were you admitted...

If declined, use 99.

If don't know/can't recall, ask for an estimate.

If unable to estimate, use 100.

to a mental health unit (specifically for people with mental illness)? _____

to some other type of hospital ward? _____

as an involuntary patient? _____

11. During that period, what was the <u>total</u> number of nights you spent in hospital for mental health reasons? It's OK if you can't remember exactly; an estimate is fine.

If declined, use 99.

_____

»» The next questions are about any visits you might have made to a hospital emergency department for mental health-related reasons

12. During the period since the last interview, have you been to a hospital emergency department to get help with a mental health problem?

- ○ Yes -> go to Q13
- ○ No -> go to Q14
- ○ Not sure/can't recall -> go to Q14
- ○ Declined-> go to Q14

13. How many times during that period did you go to a hospital emergency department for help with a mental health problem?

If you can't remember, please just give me an estimate.

If declined, use 99.

_____

»» Now I'd like to ask you about your housing situation.

14. What kind of housing do you live in at present?

For example, do you live in:

- ○ public (social) rental housing -> go to Q17
- ○ private rental housing -> go to Q17
- ○ your own home, or one that you're currently buying -> go to Q17
- ○ a boarding house -> go to Q17

Or are you:

- ○ renting a room or boarding privately -> go to Q17
- ○ couch-surfing or in other temporary accommodation -> go to Q16
- ○ homeless -> go to Q15
- ○ other?-> go to Q17

15. Please tell me how long you've been homeless.

If the participant is moving in and out of homelessness, about how long has the current period of homelessness been? Read out response options if necessary.

- ○ Less than 1 week -> go to Q18
- ○ More than 1 week but less than 1 month -> go to Q18
- ○ 1 to 2 months -> go to Q18
- ○ 3 months or longer -> go to Q18
- ○ Declined -> go to Q18

16. How long have you been couch surfing / had no stable accommodation?

Estimated length of the participant's current period of housing instability

Read out response options from drop down list if necessary.

- ○ Less than 1 week -> go to Q18
- ○ More than 1 week but less than 1 month -> go to Q18
- ○ 1 to 2 months -> go to Q18
- ○ 3 months or longer -> go to Q18
- ○ Declined -> go to Q18

17. Who do you currently live with?

- ○ Living alone -> go to Q19
- ○ Living with partner and/or family members -> go to Q19
- ○ Sharing with friends/housemates -> go to Q19
- ○ Declined -> go to Q19
- ○ Other: _____ -> go to Q19

18. Thinking about the period since the last interview, how many times have you moved house or changed accommodation during that period?

- ○ None -> go to Q21
- ○ 1 -> go to Q21
- ○ 2 -> go to Q21
- ○ 3 or more -> go to Q21
- ○ Declined -> go to Q21

19. Were there any times since the last interview, when you were homeless or had no stable accommodation?

- ○ No -> go to Q18
- ○ Yes -> go to Q20
- ○ Declined -> go to Q18

20. For about how long since the last interview were you homeless or living in some kind of temporary accommodation?

If there was more than one period when you were living like that, please estimate the total length of time. Read out response options if necessary.

- ○ Less than 1 week -> go to Q18
- ○ More than 1 week, but less than 1 -> go to Q18
- ○ 1 to 2 months -> go to Q18
- ○ 3 months or longer -> go to Q18
- ○ Declined -> go to Q18

»» The next few questions are about your employment situation.

21. Are you currently doing any paid work?

For this question, 'currently' means now and over the last 2-4 weeks.

- ○ Yes -> go to Q22
- ○ No -> go to Q24
- ○ Declined -> go to Q24

22. What sort of paid work do you do?

See response options.

Use probing Qs to help identify whether the participant works in a 'mainstream' job for wages/salary, is self-employed, or is paid to do work made available via:

- a 'make work' scheme (e.g., work for the dole)
- a supported employment initiative for people with specific disadvantages/disabilities/needs (e.g., mental health clubhouse programs, The Big Issue, Endeavour Foundation workshops)
- a social enterprise or similar initiative that provides employment opportunities and training/experience to people who are currently marginalised by the competitive jobs market. If unsure, use 'Other' and enter job title and/or employer's name.

- ○ 'Real' / mainstream job for wage/salary
- ○ Self-employed
- ○ Work for the dole or similar
- ○ Mental health clubhouse or similar
- ○ Social enterprise or similar
- ○ Declined
- ○ Other:_____

23. How many hours of paid work do you normally do each week?

If the number of hours varies from week to week, please estimate an average number, based on the last 4 weeks.

If declined, use 99.

_____

24. Are you actively looking for any paid work at present?

This includes looking for:

- more paid work (additional hours or an additional job)
- paid work with better pay or conditions
- a different type of paid work
- paid work with a different employer
- paid work in a different location.

○ No
○ Yes, looking for paid work
○ Yes, looking for MORE paid work
○ Yes, looking for DIFFERENT paid work
○ Yes, looking for work with BETTER PAY/CONDITIONS
○ Yes, looking for paid work with a DIFFERENT EMPLOYER
○ Yes, looking for paid work in a DIFFERENT LOCATION
○ Declined
○ Other: _____

»» Now I'd like to ask you briefly about unpaid work.

Unpaid work can include things like looking after children or other family members, or doing domestic work for your household (if you live with other people), as well as various kinds of voluntary work.

25. Are you currently doing any unpaid work?

For this question, 'currently' means now and over the last 2 to 4 weeks.

○ Yes -> go to Q26
○ No -> go to Q28
○ Declined -> go to Q28

26. What type/s of unpaid work are you currently doing?

Multiple responses possible

☐ Domestic work for your household
☐ Voluntary work in the community
☐ Caring for family member/s with disability, long-term illness or old age
☐ Looking after one or more children <15 yrs old
☐ Declined
☐ Other unpaid work:

27. How many hours each week do you normally spend doing unpaid work?

If the number of hours varies from week to week, please estimate an average number, based on the last 4 weeks. If declined, use 99.

_____

»» Next I have one or two questions about study.

28. **Are you currently studying for an education or training qualification?**

For this question, 'currently studying' means enrolled at present and actively participating in learning activities (lectures, practical exercises, assessment tasks, etc), whether face-to-face or online.

'Currently studying' would also apply if the interview takes place during a semester break (or similar) and the participant is part-way through a study program that they will be continuing in the next semester.

- ○ No -> go to Q30
- ○ Yes, studying part-time -> go to Q29
- ○ Yes, studying full-time -> go to Q29
- ○ Declined -> go to Q30

29. **Where are you studying?**

Enter the type of study institution, if it can be identified.

Use 'other' to specify either a type of institution not listed or (if the type is unknown) the name of the institution.

- ○ TAFE or technical college
- ○ University
- ○ Business college
- ○ Other: _____
- ○ Declined

»» The next questions are about <u>mental health treatment services</u> you've used since the last interview.

30. Other than as a hospital inpatient or at a hospital emergency department, have you had any <u>specialised</u> mental health treatment since the last interview?

This would be treatment/therapy you've received from a mental health professional such as a mental health nurse, psychiatrist, psychologist or psychotherapist.

- ○ No -> go to Q39
- ○ Yes -> go to Q31
- ○ Can't recall -> go to Q39
- ○ Declined -> go to Q39

31. Can you remember where you got that treatment, or from whom?

For example, did you go to any of the following? Read list, multiple responses possible, including 'Other'. However, the latter should not be required, so use further Qs to clarify this response, if selected.

If respondent lists multiple responses, make sure to refer back to this question and follow directions to each corresponding follow up question before moving on to the next section (Q39).

- ☐ Community mental health service -> go to Q32
- ☐ Medicare-funded mental health practitioner -> go to Q33
- ☐ Other mental health practitioner (not Medicare-funded) -> go to Q34
- ☐ Don't know / can't recall-> go to Q39
- ☐ Declined-> go to Q39
- ☐ Other: _____-> go to Q38

32. You said you went to a <u>community mental health service</u> for treatment since the last interview.

Can you recall how many times you went there? It's OK if you can't remember exactly; please just give me an approximate number. If declined, use 99.

_____-> go to Q35

33. You mentioned that you've been to one or more <u>Medicare-funded</u> mental health practitioners for treatment since the last interview.

Could you tell me how many times you did that? If you can't recall exactly, an approximate number is fine. If declined, use 99.

_____-> go to Q36

34. You said that since the last interview you went to one or more specialised mental health practitioners whose services were <u>not funded through Medicare.</u>

Can you recall how many times you did that? An approximate number is fine if you can't remember exactly. If declined, use 99.

_____-> go to Q37

35. Are you still going to the community mental health service?

If participant is unsure, ask whether they have an appointment for another visit. Use 'Other' to note any remaining uncertainty.

○ No ○ Yes ○ Declined ○ Other: _____ -> go to Q39

36. Are you still going to a Medicare-funded mental health practitioner for treatment?

If participant is unsure, ask whether they have made another appointment. Use 'Other' to note any remaining uncertainty.

○ No ○ Yes ○ Declined ○ Other: _____ -> go to Q39

37. Are you still seeing a mental health practitioner who isn't funded through Medicare?

If participant is unsure, ask whether they have an appointment for another visit. Use 'Other' to note any remaining uncertainty.

○ No ○ Yes ○ Declined ○ Other: _____ -> go to Q39

38. You said earlier that you had been to <u>another type of specialised mental health provider</u> for treatment. Are you still going there for treatment?

May need to refer back to responses to Q31.

If participant is unsure about whether they are still going to this provider, ask whether they have made another appointment. Use 'Other' to explain any further uncertainty.

○ No ○ Yes ○ Declined ○ Other: _____

»» The next questions are about visits to general practitioners (GPs)

I only want to ask about GP visits you've made in relation to your own health, so please ignore any times when you might have taken someone else to see a doctor.

39. You've answered this question before, but I'd like to check on any changes since then. So please tell me whether you have:

- **a regular GP**
- **a regular GP practice -- a group of doctors in one location, where you usually go when you need to see a GP, or**
- **two or more GPs to whom you usually go, depending on the health issue at the time?**

'Regular' means the participant prefers/tries to go to this GP/practice, although it might not always be possible.

○ No regular GP or GP practice
○ Yes, regular GP
○ Yes, regular GP practice
○ Yes, more than one regular GP/practice
○ Declined

40. Thinking about the period since the last interview, did you visit a GP - either your regular GP or another GP - for reasons related to your <u>own</u> health during that period?

○ No -> go to Q44
○ Yes -> go to Q41
○ Can't recall/ Not sure -> go to Q44
○ Declined -> go to Q44

41. Can you recall the general reasons for any of your visit/s to a GP since the last interview?

You don't need to give me any details, just whether your visits to a GP were for:

- ○ Mainly physical health reasons
- ○ Mainly mental health reasons
- ○ Both physical and mental health reasons
- ○ Can't recall any reasons
- ○ Declined
- ○ Other reasons: _____

42. Could you tell me how many times you've visited a GP since the last interview?

If you can't remember exactly, that's OK; please give me an approximate number.

If declined, use 99.

_____ -> if 99 or 0 go to Q44

43. Could you tell me how many -- or roughly how many -- of those GP visits since the last interview were for mental health reasons, or included some discussion about your mental health?

An example of the latter would be if the participant went to the doctor for a physical health reason, but the doctor also checked on his/her mental health. If declined, use 99.

_____

»»I just have a few questions now about community services you might have used since the last interview.

44. Please tell me whether you've used any of the following types of community support services at <u>any time since the last interview.</u>

Read the list slowly to the participant, pausing for a response to each type of service. Multiple responses are possible. The question covers the whole period since the last interview (including services that the participant has used during that time, but may not still be using.

- ☐ Alcohol or other drug service
- ☐ Child or family support service
- ☐ Disability support service
- ☐ Domestic violence service
- ☐ Emergency/crisis support service
- ☐ Employment support service
- ☐ Financial counselling service
- ☐ Other counselling service
- ☐ Homelessness support service
- ☐ Housing service
- ☐ Mental health support service
- ☐ Not currently using any services -> go to Q50
- ☐ Declined to answer -> go to Q50
- ☐ Other service: _____

45. And which of these support services are you <u>still using at the moment?</u>

The question is about the support services the participant has used since the last interview AND is still engaged with at the time of this interview. Read the list slowly, pausing for a response to each service type, and skip those types that you're confident the participant hasn't used since the last interview (as indicated by the previous question). Multiple responses are possible.

- ☐ Alcohol or other drug service -> do Q46 and then **skip** to Q50
- ☐ Child or family support service -> do Q46 and then **skip** to Q50
- ☐ Disability support service -> do Q46 and then **skip** to Q50
- ☐ Domestic violence service -> do Q46 and then **skip** to Q50
- ☐ Emergency/crisis support service -> do Q46 and then **skip** to Q50
- ☐ Employment support service -> do Q46 and then **skip** to Q50
- ☐ Financial counselling service -> do Q46 and then **skip** to Q50
- ☐ Other counselling service -> do Q46 and then **skip** to Q50
- ☐ Homelessness support service -> do Q46 and then **skip** to Q50
- ☐ Housing service -> do Q46 and then **skip** to Q50
- ☐ Mental health support service -> go to Q46 onwards (complete all questions in this section)
- ☐ Not currently using any services -> go to Q50
- ☐ Declined to answer -> go to Q50
- ☐ Other service: _____ -> do Q46 and then **skip** to Q50

46. On a scale of 1 to 5, where 1 is 'not at all well' and 5 is 'extremely well', how well are these support services currently meeting your overall mental health recovery and support needs?

Not at all well		Moderately well		Extremely well	Declined
1	2	3	4	5	

47. You've told me you're currently using a mental health support service - or possibly more than one. So just to clarify, how many mental health support services are you using at the moment?

'At the moment' means the participant is still engaged with the service, and expects to keep using it, at least for the time being.

- ○ 1
- ○ 2
- ○ 3
- ○ More than 3
- ○ Declined to answer

48. And does that include the Floresco Centre?

- ○ No
- ○ Yes
- ○ Declined to answer

49. Could you please tell me, just briefly, why you're not still using the Floresco Centre for mental health support?

The reason may be a positive one, but if participants seem reluctant to answer, remind them that their responses will remain confidential and will not be able to be linked to them personally. Use 99 if participant declines to answer.

_____

_____

50. Are there any issues that are currently affecting your mental health recovery in a negative way, and that you're <u>not</u> getting <u>some kind of support</u> to deal with?

This might be support from health or community services, or from family or friends, or perhaps a combination of these.

- ○ No -> go to Q53
- ○ Yes -> go to Q51
- ○ Not sure -> go to Q53
- ○ Declined -> go to Q53

51. Could you please tell me, just briefly, what kind/s of issues these are?

You don't need to tell me the details; just a general description is fine.

For example, are you referring to a housing or employment issue, or perhaps a relationship issue?

_____

_____

_____

52. Please tell me the reason/s why are you not getting any kind of help to deal with this/these issues.

Try to avoid prompting. You might need to listen to the whole answer and then fit it into one or more of the options. Multiple responses are possible.

- ☐ Can manage OK on my own
- ☐ On a waiting list for support services
- ☐ Haven't tried to get any help
- ☐ Don't know how/where to get the right kind of help
- ☐ Tried to get support, but not eligible
- ☐ No appropriate support services available
- ☐ Support services are too difficult to access
- ☐ No family
- ☐ No family able and/or willing to help
- ☐ No friends
- ☐ No friends able and/or willing to help
- ☐ Declined to answer
- ☐ Other reason

53. Use this area to make any additional comments or notes on participant's responses to one or more questions

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Thank you very much for answering these questions.

I'd just like you to do one more thing. It should only take a couple of minutes.

- Ask participant to complete the RAS-DS
- Give the participant a gift card as thanks
- Make sure you get them to sign the receipt for the gift card.

2017 YES survey results for Floresco clients

Aftercare conducts an annual survey about clients' experience of service across all of their service sites, using the Your Experience of Service (YES) survey instrument. The standard version of this instrument comprises 35 items within four categories: experience, outcomes, open-ended and demographics. The 17 'experience' items ask how often a person has experienced specific service characteristics over the past three months, and are rated on a scale of 1 = Never to 5 = Always. Nine 'outcomes' items ask clients to rate aspects of the service's performance over the previous three months on a scale of 1 = Poor to 5 = Excellent. The remainder of the standard instrument comprises 2 open-ended and 7 demographic items.[1]

Aftercare's 2017 survey targeted clients of its clinical, community and residential services across Queensland and New South Wales. It involved 645 telephone interviews with trained interviewers. A total of 34 Floresco clients participated; they comprised 39 per cent of the 87 Floresco clients who were contacted and invited to participate in the survey because they were receiving one-to-one support from a mental health support worker at the time. These clients responded to a Floresco-specific version of the YES, which deletes two 'experience' items that are not relevant to Floresco, but includes two additional 'outcomes' items. These items ask respondents to use the same 1–5 scale to rate:

- Floresco's effectiveness as a 'one-stop shop' for people who want help to improve their mental health
- how easy they found it to get the right mix of services to help them.

Of the 34 respondents to the Floresco-specific version of the YES, 24 were female, 4 were of Aboriginal and/or Torres Strait Islander origin, and all reported the main language spoken at home as English. Table 1 shows the respondents' demographic characteristics, together with those of the 1129 Floresco clients whose records were analysed for the Floresco service model evaluation.

Overall, responses to the Floresco-specific version of the YES survey were very positive, with a majority of the 34 respondents rating their overall experience of service at Floresco as either excellent (59%) or very good (26%). Figure 1 presents the results of the 'experience' items, while Figure 2 shows those for the 'outcomes' items.

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[1] For more information about the YES survey instrument, see https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/national-mental-health-committees/mental-health-information-strategy-standing-commit/your-experience-of-service-survey-instrument

Table 1: Demographic characteristics of Floresco clients (n=1129) and the subset of clients who responded to Aftercare's 2017 YES survey (n=34)

Characteristic	All Floresco clients (n=1129)	Floresco YES survey respondents (n=34)
Gender		
Female	60.6% (684)	70.6% (24)
Male	39.4% (445)	29.4% (10)
Main language spoken at home		
English	-	100.0% (34)
Are you of Aboriginal or Torres Strait Islander origin?		
Yes	-	11.8% (4)
No	-	85.3% (29)
Declined	-	2.9% (1)
Age group		
18-24	10.1% (114)	-
25-34	25.2% (285)	23.5% (8)
35-44	26.7% (301)	23.5% (8)
45-54	20.5% (231)	35.3% (12)
55-64	14.4% (163)	17.6% (6)
65+	3.1% (35)	-
How long have you been receiving care from this service on this occasion?		
Less than 24 hours	-	0.0% (0)
1 day - 2 wks	-	5.9% (2)
3-4 weeks	-	2.9% (1)
1-3 months	-	55.9% (19)
4-6 months	-	17.6% (6)
More than 6 months	-	17.6% (6)

'Experience' items results for Floresco clients (n=34)

- You had opportunities for your family and carers to be involved in your treatment and care if you wanted.
- There were activities you could do that suited you.
- You had opportunities to discuss your progress with the staff caring for you.
- Staff worked as a team in your care and treatment (for example, you got consistent information and didn't have to repeat yourself to different staff).
- You were listened to in all aspects of your care and treatment.
- The facilities and environment met your needs (cleanliness, private space, reception area, furniture, common areas, etc.).
- Your opinions about the involvement of family or friends in your care were respected.
- You believe that you would receive fair treatment if you made a complaint.
- Staff made an effort to see you when you wanted.
- Your individuality and values were respected (your culture, faith, gender identity, etc.).
- Staff showed hopefulness for your future.
- Your privacy was respected.
- You felt safe using this service.
- Staff showed respect for how you were feeling.
- You felt welcome at this service.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

■ Always ■ Usually ■ Sometimes ■ Rarely ■ Never ■ Not applicable

Figure 2: Results of 'outcomes' items of Aftercare's 2017 YES survey for Floresco clients

'Outcomes' items results for Floresco clients (n=34)
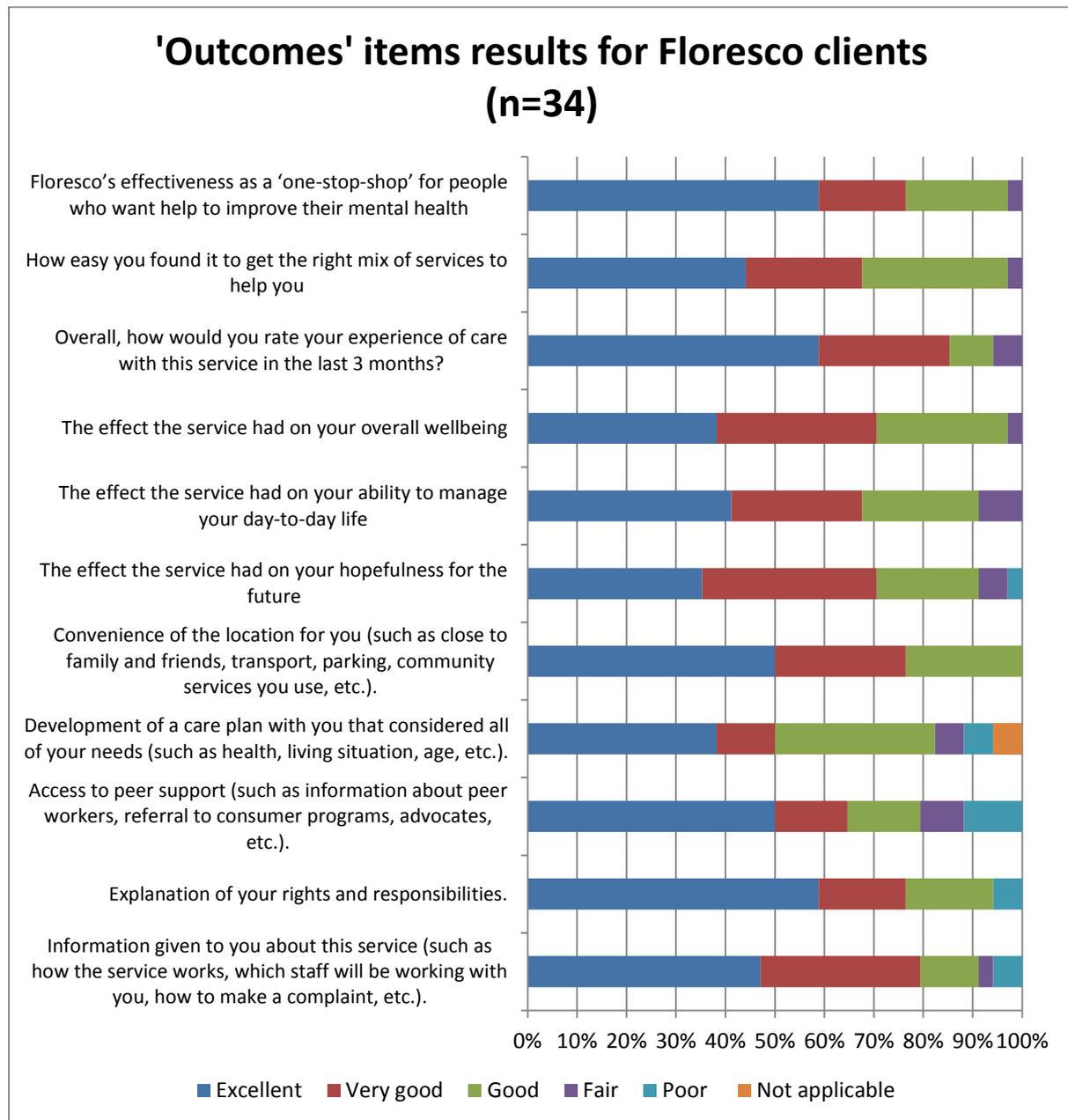
Carer outcome measure

FLORESCO

For each of the statements below, please use an **X** to indicate which wording best fits your current care-giving situation.

	no	**some**	**a lot of**	
a) I have	☐	☐	☐	sense of satisfaction as a result of carrying out my care tasks.
b) I have	☐	☐	☐	issues with my relationship with the person I care for *(e.g., he/she is very demanding, he/she behaves differently, we have communication difficulties)*.
c) I have	☐	☐	☐	issues with my own mental health *(e.g., stress, fear, gloominess, depression, concern about the future)*.
d) I have	☐	☐	☐	difficulties combining my care tasks with my daily activities *(e.g., household activities, work, study, family and leisure activities)*.
e) I have	☐	☐	☐	financial difficulties because of my care tasks.
f) I have	☐	☐	☐	support with carrying out my care tasks, when I need it *(e.g., from family, friends, neighbours, acquaintances)*.
g) I have	☐	☐	☐	issues with my own physical health *(e.g., more often sick, tiredness, physical stress)*.

Please mark the scale below with an **X** to indicate how happy you currently feel.

Completely unhappy   **Completely happy**

```
|----|----|----|----|----|----|----|----|----|
1    2    3    4    5    6    7    8    9    10
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Carers' Quality of Life-7D + Visual Analogue Scale
(CarerQol-7D+VAS) — revised for Floresco 4Jan2016