EVALUATION

Queensland Mental Health Community Support Services (MH CSS) programs, 2022

QUEENSLAND CENTRE FOR MENTAL HEALTH RESEARCH

Introduction

The Mental Health and Other Drugs Branch (MHAODB) commissioned Queensland Centre for Mental Health Research (QCMHR) to conduct an independent evaluation of the Queensland Mental Health Community Support Services (MH CSS) programs. MH CSS programs are non-clinical, holistic recovery-focused psychosocial wraparound support services delivered either one-to-one, peer-to-peer, or within a group, based on an individual's recovery needs.

Individual Recovery Support Program (IRSP)	An individualised program offering non-clinical, recovery-oriented psychosocial wraparound support tailored to meet the specific recovery needs and goals of an individual.
Group Based Peer Recovery Support Program (GBPRSP)	Provides individuals linked from the IRSP access to group-based peer-led activities, facilitated by peer workers. The GBPRSP aims to empower and support individuals through group content related to common interest and shared/similar life experiences.
The Individual Recovery Support -Transition from Correctional Facilities Program (TCFP)	This service offers support specifically tailored to individuals about to be released from a Queensland adult correctional facility who have been referred by a Prison Mental Health Service.
Individual at Risk of Homelessness Program (IRHP)	This program offers support specifically tailored to individuals residing in a boarding house, crisis accommodation, or hostel.

QCMHR conducted an in-depth evaluation of four key MH CSS programs being delivered by Non-Government Organisations (NGOs) across Hospital and Health Services (HHSs). The evaluation focused on understanding program effectiveness from high-level processes to individual consumer outcomes. The evaluation team interviewed a total of 47 NGO staff, 70 consumers, 18 HHS staff, and 2 additional stakeholder representatives.

Identified success factors

Through the evaluation, it was found that **relationships**, **a shared purpose,** and **regular communication** are key to the HHSs and NGOs working together effectively to refer into, and oversee, the programs.

The wide variability seen in program delivery was attributed to differences in staff training, skills, and experience; and the complexity of consumers' needs and their capacity to engage in the programs. See overleaf for key recommendations to ensure consumers have consistent access and experiences in MH CSS programs across Queensland.

Key consumer outcomes

- Reduction in mental health issues
- Improved relationships
- Increased confidence
- Increased quality of life
- In some instances a return to work (sometimes as a peer worker)
- Some HHSs reported reductions in re-presentation in hospital Emergency Departments

KEY FINDINGS

- The four evaluated MH CSS programs are vital in supporting the recovery of people with severe mental illness in the community, who would otherwise not be supported.
- Without the MH CSS programs, community mental health treatment teams would be further stretched, spending valuable time and resources on aspects of care for people with severe mental illness, more suited to a workforce skilled in the delivery of psychosocial supports.
- Many consumers of the MH CSS programs told the evaluation team that they had not received any psychosocial support prior to involvement in these programs. As such, these consumers credited the programs to being the reason they were "still here"; be that living in the community (many independently), or indeed alive.
- NGOs are delivering the programs flexibly and with agility to best support consumers, using local knowledge and community links.
- It was found that MH CSS programs are not being delivered consistently for consumers across the state. Both across and between the NGO-delivered MH CSS programs, there is great variability in how the programs are governed, referred to, accessed, delivered, and exited.

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KEY RECOMMENDATIONS

Program governance and relationships

1. Stakeholders should work together with a **shared purpose** to develop effective processes and relationships to ensure the programmes' sustainability and standards. This can be facilitated through **regular opportunities for communication and collaboration** between HHS and NGO, and NGO to NGO. e.g. co-location of NGO staff in clinical teams, regular governance meetings, consumer review meetings, sharing success/good news stories.
2. Develop a **community of practice**, facilitated by the MHAODB, for NGOs and HHSs to share best practice and training resources across the services.

Referrals

1. **Clarify the inclusion/exclusion criteria** for the MH CSS programs to support all stakeholders being clear, including NDIS eligibility nuances.
2. Standardise and streamline the **referral and risk assessment template** from HHS to NGO, leveraging examples of existing best practice.
3. Consider **extending the referral criteria to include General Practitioners and private clinicians'** ability to refer into the MH CSS programs.
4. Review current practice to ensure HHSs are providing **warm handovers** of consumers to NGOs, and that there is **timely first contact** from an NGO staff, as close to the HHS referral date as possible (a few days or within a week of discharge from HHS service) followed by **a timely in-person first meeting** that includes a member of the HHS referral team and the NGO staff performing intake.

There were several additional findings and recommendations specific to MH CSS programs (e.g. GBPRSP/ IRHP/TCFP), details of which can be found in the main report.

Training and Education of HHS and NGO staff

1. Review and refresh knowledge and understanding of the **purpose and function of psychosocial support** with all staff involved in referral and delivery of MH CSS programs.
2. Embed **regular NGO delivered psychosocial support education/training for referring teams** as part of comprehensive care and continuum of service that augments clinical mental health support.
3. Set and manage **clear expectations of the MH CSS program to the consumer**, as established by the HHS staff and maintained by both HHS staff and NGO staff.
4. Across the MH CSS programs in co-collaboration with stakeholders, **review the skills, experience and training required** by recovery support staff at all levels, including peer workers.

Person-centeredness of MH CSS program delivery

1. Support **flexible delivery** of the MH CSS program sessions, including location/method, as guided by the consumer.
2. Strengthen processes to **better match the right NGO support worker to a particular consumer's needs** (e.g. peer worker).
3. Identify **opportunities to enhance supports** around the consumer to meet their specific needs, including the length of the program.

Recovery-oriented practice

1. The **Individual Recovery Plans (IRPs)** should be **implemented within the first few sessions** with a consumer, follow a recovery-oriented framework, and be guided by the consumer's goals and needs.
2. IRPs should be **regularly reviewed and updated**.
3. Consumers should play a **collaborative** role in the management of the IRP.
4. **Exit planning** should be **undertaken formally** across the various MH CSS programs.
5. IRPs should **incorporate outcomes measures** as part of regular reviews (i.e. 3 months, 6 months, 9 months, and 12 months at exit).

Funding considerations

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

Data collection

1. Include **additional variables** into the MH NGOE NBEDS data collection process to **enable more functional monitoring and evaluation of programmes**, including the number of consumers referred to the MH CSS programs and additional demographic data.
2. Consider collection of **individual level data** for better monitoring and evalution. Include re-admission and re-referral for consumers enrolled in MH CSS programs.
3. **Standardise a set of outcome measures** across the MH CSS programs to allow NGOs, HHSs and the MHAODB to regularly assess programs' performance and identify areas for development, improvement, and support.
4. **Standardised outcome measures** should be **evidenced in the literature** as valid and reliable measure(s) of mental health outcomes; **collected regularly** throughout a consumer's journey on a program (i.e., at 3 months, 6 months, 9 months, and 12 months at exit) to monitor program efficacy and facilitate IRP processes; and **supplemental** to any data already captured by the HHS.

SUMMARY

The evaluation found the four MH CSS programs demonstrated many successes.
Most consumers had nothing but praise for the support they received through the programs.

It was found that relationships, a shared purpose, and regular communication are key to the HHSs and NGOs working together effectively to refer into and oversee the MH CSS programs.

However, significant variability was found in the way that MH CSS programs are currently delivered across Queensland. Our team observed everything along the continuum from best practice program delivery, to programs being delivered in a way that was contrary to how they were intended - either contractually or according to program specifications.

This variability was expressed by staff (HHS and NGO) and consumers alike, and found to be true at each level and stage of the process.

Staff training, **skills and experience**, alongside **consumer complexity and capacity** to engage in the programs, were found to be key factors in the wide variability seen in program delivery.

Based on these findings, **Figure 1**, below presents a summary of the cumulative best practice across the MH CSS programs, which should be viewed as the benchmark.

FIGURE 1.

SUMMARY OF THE CUMULATIVE BEST PRACTICE ACROSS MH CSS PROGRAMS: A PRACTICE BENCHMARK