University of South Australia
Department of Rural Health

Evaluation of the Country Health SA Community Mental Health Rehabilitation Service (CMHRS)

2016

EVALUATION TEAM

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The views expressed in this report are the authors' and do not necessarily reflect those of Directorate, Country Health SA Local Health Network for Mental Health or the South Australia Department of Health.

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CONTENTS

ACRONYMS

ATSI	Aboriginal and Torres Strait Islander
ACCHO	Aboriginal Community Controlled Health Organisations
AHCSA	Aboriginal Health Council of South Australia
AHREC	Aboriginal Health Research Ethics Committee
AC-CARE	Anglican Community Care
AIHW	Australian Institute of Health and Welfare
CEA	Cost Effectiveness Analysis
CDC	Centre for Disease Control
CME	Client Management Engine
CMHRS	Community Mental Health Rehabilitation Service
CMHT	Community Mental Health Team
CRC	Community Rehabilitation Centre
CBA	Cost Benefit Analysis
COAG	Council of Australian Governments
CCCME	Country Consolidated Client Management Engine
CHSALHN-MH	Country Health SA Local Health Network (Mental Health)
CALD	Culturally and Linguistically Diverse
DRH	Department of Rural Health
GP	General Practitioner
HoNOS	Health of the Nation Outcome Scale
HREC	Human Research Ethics Committee
IHPA	Independent Hospital Pricing Authority
ITT	Independent Tenancy Tribunal
IMHIU	Integrated Mental Health Inpatient Unit

ICS	Intermediate Care Service
K-10	Kessler 10 Psychological Distress Scale
LSP	Life Skills Profile
LEG	Local Evaluation Group
MDGs	Millennium Development Goals
MEF	Monitoring and Evaluation Framework
NOCC	National Outcomes and Casemix Collection
NGO	Non-Government Organisation
PEG	Project Evaluation Group
R&R	Rural and Remote
RR	Response rate
RCT/CCT/MACS	Regional Community Team, Continuing Care Team, Mobile Assertive Care Services Team
SNA	Social Network Analysis
SROI	Social Return on Investment
SA	South Australia
SDGs	Sustainable Development Goals
SRF	Supported Residential Facility
TAFE	Technical and Foundational Education
TOR	Terms of Reference
UniSA	University of South Australia
WHO	World Health Organisation

SUMMARY OF KEY FINDINGS

APPROPRIATENESS

- The CMHRS is providing a unique service that is complementing and supplementing but not duplicating the services being offered under the stepped model of care.
- The implementation of the CMHRS in Mount Gambier and Whyalla has been closely aligned with the service model.
- The CMHRS is reaching its target group with 52 voluntary consumers having entered the service during the period 1 July 2014 and 30 September 2015.
- The clustered accommodation model offered in Whyalla is considered to be more appropriate than the geographically dispersed accommodation model in Mount Gambier.
- The current service model does not incorporate the in-reach services being provided in Mount Gambier.
- Lengthy and complex referral pathways, processes and procedures were widely perceived as a barrier to service access.
- The multi-disciplinary skill mix of the CMHRS staff is seen as a key strength in the provision of rehabilitation services with a focus on functional improvements for consumers.

EFFECTIVENESS

- The profiles of the CMHRS consumers being supported by the CMHRS is consistent with the service model in regard to age, mental health diagnosis, voluntary entry status, geographical reach and representation of Aboriginal people.
- Opportunity exists to establish, expand and renew links to other services and organisations identified as key partners in the service model, as well as in the South Australian Social Inclusion Board's *Stepping Up: A Social Inclusion Action Plan for Mental Health Reform 2007-2012* report.
- There were aspects of the service where carer engagement was minimal.
- Discharge planning was not always inclusive of all relevant key stakeholders.

EFFICIENCY

- Results of the Cost Benefit Analysis (CBA) and Social Return on Investment (SROI) showed that the CMHRS is creating benefits with a value equal to or greater than every dollar invested in the program.
- The tenancy management arrangement with non-government organisations is widely perceived by staff as unnecessary and costly.
- Continuity of care, cost savings, and working partnerships with other services promoted and supported the saving of resources.

Outcomes

- The CMHRS is contributing to improvement in the mental, physical and social health and wellbeing of consumers who participate in the service. Multiple consumers reported having attained educational and employment outcomes in addition to the health outcomes.
- The CMHRS is contributing towards reduced hospital admissions and readmissions, presentations to Emergency Departments and inpatient psychiatric care days, thus creating cost savings.
- The appropriateness of the tools being used to assess the outcomes of consumers has been questioned, particularly regarding their relevance within a community rehabilitation setting.

Sustainability

- The vast majority of interviewees felt that the CMHRS should continue to be funded due to the demonstrable tangible and intangible benefits it has delivered and continues to deliver to a range of beneficiaries, including the State Government.
- Murray Bridge was identified as a potential third site, should it be decided to replicate the CMHRS model elsewhere in regional South Australia. Murray Bridge is geographically central and accessible by communities in the Riverland and Murray Mallee regions as well as in rural and outer metropolitan Adelaide.

EXECUTIVE SUMMARY

The Community Mental Health Rehabilitation Service (CMHRS) has kept mental health consumers out of acute mental health services and has increased the level of independence gained by consumers transitioning into independent living within their community

INTRODUCTION

Evaluation objectives

This evaluation was commissioned by Country Health SA Mental Health Directorate and undertaken by the University of South Australia Department of Rural Health to assess the effectiveness and impact of the program.

The evaluation scope covered the period 1 July 2014 until 30 September 2015.

Evaluation design and methodology

A mixed methods evaluation design incorporating quantitative and qualitative research methods was used, along with Cost Benefit Analysis, Social Return on Investment and Social Network Analysis frameworks.

The evaluation was undertaken during the period from September 2015 to March 2016

FINDINGS

Appropriateness

The evaluation found that the CMHRS is an essential step in the stepped model of care in regional South Australia, in line with the *Stepping Up: A social Inclusion Action Plan for Mental Health Reform (2007-2012)* report. Furthermore, the rehabilitation service does not duplicate existing services. It fills a previously existing gap, keeping consumers closer to home and providing both a complementary and supplementary role, in alignment with State and National Mental Health policies and reform agenda.

The range of services offered by the CMHRS is appropriate, with potential for expansion to include group-based and structured educational activities, such as psychoeducation and the arts. The current model of care is meeting the needs of the consumers by being flexible, building on practical independent living skills, and providing intense activities within a 24 hour schedule. The services are being provided by a multidisciplinary workforce with a strong focus on consumer-led rehabilitation.

A total of 24616 service contacts lasting 19078 hours were provided during the period under review. Compared with the number of consumers, an average 473 contacts lasting 367 hours per consumer were achieved. Therapeutic counselling/support provided in the home or at the centre accounted for most of the service contacts and contact time. The governance

structure provides oversight and guidance to the CMHRS and is closely aligned with the service model. However, a key weakness in the structure is that the Steering Committee does not include consumer and carer representation as envisaged in the service model.

The current design of the consumer referral pathways is seen as a barrier to service access. The evaluation established that the CMHRS, in the initial start-up phase, had not been widely promoted amongst various stakeholders and communities. This meant the service may not have reached the target group most in need in its early months of operation. However, as the service matured this issue was resolved.

In response to need the Mount Gambier CMHRS provided an in-reach service into some consumers' homes; in addition to what was outlined in the original service model and could be perceived as unplanned or responsive to need following implementation. While a number of issues were identified with the current in-reach arrangements, it has potential value as an alternative care delivery model to support mental health consumers to live independently.

The 'clustered' housing model of residential accommodation being provided by the CMHRS in Whyalla was preferred over the geographically dispersed accommodation model being used in Mount Gambier, mainly due to the extra resource required by staff travelling to the residents and social interaction for the consumers.

The guidelines, procedures and tools used by the CMHRS are appropriate, useful and continually updated. However, staff perceived that the tools for supporting consumer movement between services, and tools for screening and selection of referred consumers, require further improvement.

The number of positions and professional mix of staff was adequate (when vacancies were minimal) to meet the needs of consumers in the rehabilitation environment. However a small number of stakeholders both external and internal to the service expressed that the CMHRS was over-staffed. Balancing gender of staff, where possible, may assist in making the service more culturally inclusive for consumers including Aboriginal people.

Ongoing training and development has been vital to ensuring the skills of staff are adequate to provide consumer-led rehabilitation that achieves optimal outcomes. The difficulties experienced attracting and retaining staff initially were due to broader regional recruitment challenges, as well as uncertainty of funding and availability of recurrent positions.

The strategies used to engage the community in the establishment of the CMHRS were mostly perceived as appropriate. However, the CMHRS staff and other service providers felt the extent of community engagement was insufficient, leading to poor awareness of the CMHRS and difficulty establishing links to other services and organisations and, in the case of Mount Gambier, unfavourable publicity.

Effectiveness

The evaluation identified that the service is meeting its objectives. The program is helping to keep mental health service consumers in country locations and closer to home instead of

travelling to metropolitan-based mental health services.

The CMHRS is reaching its target group. A total of 52 voluntary consumers entered the CMHRS during the period 1 July 2014 and 30 September 2015. Of these, 31 consumers entered the services in Whyalla and 21 consumers entered the services in Mt Gambier. Twelve consumers were still in the CMHRS at 30 September 2015. The consumers were predominantly male (37, 71%) with an average age of 32.8 years.

Aboriginal people represented 13% of consumers in the CMHRS which is higher in comparison to other mental health services. This suggests that the service may be appropriate to the needs of this group. The inclusion of culturally and linguistically diverse (CALD) groups and people with other disabilities appears to be limited.

The most common primary mental health diagnosis was schizophrenia whilst personality disorders were the most common secondary mental illness diagnosis.

The implementation of the CMHRS has resulted in an additional 30.94 FTE positions being created in Country SA, an important contribution to the country mental health workforce and to reducing inequities in distribution of mental health specialists across urban and rural South Australia. Staff diversity in terms of health discipline was seen as a key strength of the CMHRS which enabled the provision of holistic rehabilitation services.

Adjusted data indicate there have been significant reductions in Emergency Department (ED) admissions and inpatient psych care days, pre and post CMHRS. For example, among a sub-sample of CMHRS consumers (n=14) who had been out of the service for over 8 months (at October 31 2015), ED presentations were calculated in the comparable time period before entry and after discharge to/from the CMHRS. ED presentations reduced by over half among this group, with 14 total presentations in the 8 months to 1 year prior to CMHRS entry, and only 6 post-discharge: a 57% reduction.

Alternately, adjusted estimates across the whole sample were calculated. Across the 41 consumers who had exited the CMHRS by 31st October 2015, using adjusted monthly rates, each had (or was estimated to have) on average 1.3 fewer ED presentations in the year after compared with the year before CMHRS stay (2.1 presentations pre to .8 presentations post). Scaling this figure up, an estimated 48% reduction in ED presentations, or total of 53 fewer presentations among this group was calculated.

Similarly, the estimated reductions in inpatient psych care days pre- CMHRS entry and post-CMHRS exit were calculated. This analysis, considering comparable timeframes for consumers' pre and post-CMHRS, estimates an average reduction of 1.4 days per consumer per month post CMHRS, or 16.8 days per year per consumer

The 24 hour roster, inclusive of the on-call night shift, is appropriate. Feedback indicated the on-call night shift is important in helping consumers feel confident and safe.

Opportunity exists to strengthen existing and establish new links to key services and organisations that offer support for people with a mental illness to live independently. The

existing links to the tertiary education institutions have the potential to be used as a rural mental health workforce strategy.

Compliance with routine procedures such as post-discharge follow up and recording of GP details was poor, indicating inconsistencies with monitoring and documentation by staff.

Inadequate knowledge about the CMHRS among the potential referral sources, along with complex referral processes, a strict no alcohol and drugs policy, and inadequate engagement of families and carers were identified as barriers to service access. Distance of consumers' place of usual residence from the CMHRS sites was seen by some to contribute to inequitable access, further exacerbating rural disadvantage.

Opportunity exists to improve discharge planning by ensuring effective links to relevant services and organisations in order to achieve continuity of care and smooth transition into the community for the consumer.

The initial meet and greet between CMHRS team leaders and potential consumers during the referral stage was seen as a useful ice-breaker and could be described as being extremely compassionate assisting in building consumer confidence and willingness to enter the rehabilitation service.

Strong leadership was perceived as key to ensuring role clarity and respect among clinical and non-clinical staff.

Efficiency

This evaluation used the health outcome-related Cost benefit analysis (CBA) and Social Return on Investment (SROI) to determine the worth of the CMHRS. The CBA shows a ratio of 1: 1.12 suggesting that the CMHRS investment is financially attractive. This positive result was confirmed by the SROI analysis of the two rehabilitation services which showed a ratio of 1:1. This suggests that the social program is producing social benefits of value greater or similar to cost.

There were perceived legal weaknesses with the existing lease agreements with consumers and inefficiencies were observed with the tenancy arrangements with the non-government organisations.

Overall, service efficiency was achieved by the set targets in relation to the average length of time from referral to allocation, allocation to service entry and from referral to service allocation.

Mount Gambier and Whyalla achieved average monthly occupancy rates of 74% and 62% respectively which were below the target of 85% occupancy. This suggests that the CMHRS residential facilities were not fully utilised in this early stage of establishment.

Staff perceived the operational guidelines and procedures used by the CMHRS as being helpful, regularly updated and working well. However, staff indicated the tools to support

the movement of consumers between services were inadequate.

Arrangements for post discharge follow-up compared favourably against those achieved for country and metropolitan residents discharged from acute and non-acute hospital settings.

Overall, the CMHRS operated within the budget allocations during 2014/2015 and the first quarter of 2015/16.

The sharing of resources between the CMHRS and other mental health services and service providers was seen as contributing to cost savings and promoting continuity of service and partnership.

Outcomes

The CMHRS was contributing two key outcomes for the consumers of its services: independent living and improved health and well-being. These two key outcomes were linked to four strands of:

- *Self-confidence* - medication adherence and reduced use of alcohol and drugs. Self-confidence impacts on both of the final outcomes through facilitating social inclusion
- *Living skills* - which impact primarily on the independent living outcome
- *Education and training* - leading to the ability to volunteer or work in paid employment. Being in paid employment or volunteering leads to greater social inclusion and independent living, and has a direct effect on personal well-being.
- *Being away from family and friends* - which can promote independence and capacity to share with others

A total of 19 past CMHRS consumers have transitioned into independent living in the community. The enablers were identified as increased confidence, reduced intake of alcohol and other drugs, reconnection with services, improved budgeting skills, and increased understanding of the purpose, use and adherence to medication.

Participation in education and employment represent a key outcome and life changing experience for people who live with mental illness. Ten consumers had reportedly re-engaged with the education system with 3 having completed a TAFE course and a further 7 still enrolled at TAFE. Employment outcomes were reported for some consumers. Two past consumers gained employment and two were participating in voluntary work.

The evaluation established that the CMHRS is making significant contribution towards hospital avoidance, including relapse prevention and a reduction in hospital admission over time. The data indicate that Emergency Department (ED) presentations of CMHRS consumers reduced by approximately one half (48%) in comparable time periods before and after CMHRS entry and exit respectively. When translated into financial benefit, the positive changes account for cost savings for SA Health.

Gains in clinical, personal, social and functional outcomes were also calculated using the

clinical diagnostic assessments. Some improvement occurred on the K10 measure, with approximately 20% of consumers showing an improvement in their K10 scores. Analysis of the Life Skills Profile (LSP) showed a reduction by 13 percentage points in the number of consumers rating in the "extreme problem" category from review to discharge, and a 27% increase in the number of consumers rated as having "no problem" from review to discharge. The Health of the Nation Outcome Scale (HoNOS) scores showed 33% of consumers had an improvement between admission and discharge, while approximately 50% showed no change and nearly 20% reported a worse outcome at discharge.

Benefits to carers and family members as a result of the CMHRS include improved health and wellbeing due to reduced stress, respite and reduced burden of care. Improved family relationships were also reported as evidenced by reports of family re-unification and improved communication.

The CMHRS significantly increased the capacity of the regional mental health system by completing the stepped system of care as recommended in the Social Inclusion Board's Stepping Up Report. It enabled a continuum of care by improving flow and removing bottlenecks, resulting in increased capacity in other parts of the system.

Sustainability

There was overwhelming agreement by participants (98%) in the evaluation that the service should continue. The evidence strongly demonstrated the benefits to-date, and highlighted the potential negative implications the decommissioning of the service would have on the mental health system, the health of consumers, carers and the local communities.

A number of respondents identified the need to expand and replicate the CMHRS in other geographical settings across South Australia. For example, Murray Bridge was identified as a logical choice for a third site due to its capacity to cater for populations in the Riverland and Murray Mallee regions, and outer metropolitan Adelaide areas.

CONCLUSION

The evaluation established that the consumers of the CMHRS services achieved significant outcomes ranging from improved organisational skills, mental, physical and social health and wellbeing to independent living, adult education and voluntary or some form of employment, which could be attributed to the person centred approach and the care and compassion demonstrated by the CMHRS team leaders and their staff. Staff acknowledged that there was an important role for families/carers, along with a role for the service in better connecting with families and carers and assisting them to understand and be supportive of the service. However, it was noted that there was opportunity for improvement in this area.

The evaluation found that the CMHRS is a unique and vital component of the stepped system of mental health care in country South Australia that is providing services close to where people live.

The implementation of the CMHRS has largely been consistent with the service model with different housing models being used in Mount Gambier and Whyalla. The 'clustered' housing model in

Whyalla is preferred over the geographically dispersed model in Mount Gambier.

The program is reaching its target group including a good representation of Aboriginal consumers although the inclusion of CALD groups and people with other disabilities requires further work. The 24 hour roster, inclusive of the 'on call night shift', is perceived as being appropriate.

Opportunity exists to build and expand links to other services and organisations especially those outside the traditional mental health services.

RECOMMENDATIONS

	Please Note: the recommendations are not in order of priority.
1	Review the referral process including associated documentation requirements with a view to reducing complexity.
2	Ensure that the CMHRS is widely promoted among its stakeholders.
3	Data captured and reported by CMHRS should include a full identification of referral sources (as identified in the service model) in order to facilitate clearer understanding of the distribution and pattern of referrals.
4	Any decision to continue the in-reach service could be based on full consideration of the advantages and disadvantages of the mode of service delivery and the experienced gained to date with the service model being modified accordingly.
5	Minimise distances between staff, consumers and community services/hubs could contribute to increased efficiency and improved outcomes for consumers
6	In line with quality management principles, continually review and update service protocols based on feedback from staff, consumers and other service providers.
7	Balancing gender of staff, where possible, may help increase appropriateness for consumers from various cultural groups, including Aboriginal people.
8	Review the current staffing model in relation to workload without upsetting the multidisciplinary nature of the teams. The alternative would entail keeping occupancy levels at their optimum in order that staff are fully utilised.
9	Ensure sufficient resources to support staff training and development continue to be provided, to address challenges recruiting appropriately qualified staff.
10	Stability of funding, and subsequently employment, will be crucial in addressing retention challenges.
11	Ensure adequate stakeholder consultation processes are undertaken prior to introducing new services.
12	Routine collection of linked data would enable tracking of performance in relation to hospital admissions
13	Work towards increasing accessibility for consumers from CALD communities and people with disabilities
14	Ensure discharge planning is well coordinated with the relevant services and organisations including the family members and carers.
15	A system of routine internal checks and monitoring should be put in place in order to ensure staff compliance with set discharge planning procedure and guidelines.
16	The CMHRS, working jointly with its partners, should investigate and implement strategies to improve service access for people living outside the two cities where the program is based.
17	It is essential to further embed the person centred approach used by the CMHRHS across all levels of the service, including appropriate representation of consumers and carers on service model design, implementation and evaluation.
18	Establish and strengthen links to the services and organisations identified in the service model and the South Australian Social Inclusion Board's report, 2007.
19	Establish and consolidate links to the tertiary education sector with the view to optimising student placement opportunities and encouraging future rural mental health practice.
20	Meaningful, trusting and respectful relationships should be promoted amongst the CMHRS staff and between the staff and other teams working in adult mental health.
21	Review the existing arrangements for tenancy management of consumers living in CMHRS properties that are outlined in the service model.
22	Establish a systematic approach that is individualised to the consumer which includes the family or significant other in the model of care. This can include family / significant other therapeutic approaches, improved communication on admission, during rehabilitation stay and discharge.

23	Investigate and adopt appropriate tools for measuring health and wellbeing outcomes within a mental health rehabilitation setting.
24	Investigate the adoption of a partnership model with an NGO or private provider who provides a supported housing model where consumers are placed in appropriate end-point housing with the provision of intensive specialist mental health rehabilitation services. End-point housing can be houses or units, public or private, and with or without other like-consumers.

INTRODUCTION

Country Health SA Local Health Network Mental Health Directorate contracted the University of South Australia Department of Rural Health to undertake an evaluation of the Community Mental Health Rehabilitation Service (CMHRS). The evaluation was conducted during the period 1st September 2015 to 31st March 2016.

PURPOSE OF REPORT

This report presents the results of the evaluation of the CMHRS. It is the third and final deliverable under the contract; other reports include the Monitoring and Evaluation Framework, presented in April 2015, and the Interim Report delivered in November 2015.

MENTAL HEALTH CONTEXT

A person who has good mental health and wellbeing can make a vital contribution to the overall health and wellbeing of the community. Good mental health and wellbeing enables people of all ages and cultural backgrounds to contribute to social and economic outcomes for all South Australians. (SA Health, 2012)

GLOBAL MENTAL HEALTH

Mental disorders have become a major issue of public health concern and pose a huge challenge for health systems worldwide. The Global Burden of Disease 2010 study indicates that mental and substance use disorders account for 10% of total disease burden, exceeding HIV/AIDS and tuberculosis, diabetes and transport injuries (World Health Organization, 2015, Whiteford et al., 2013). Depressive disorders accounted for most of the disease burden across all regions, followed by anxiety disorders, drug use disorders, and alcohol use disorders. The burden is increasing, largely driven by population growth and ageing. It impacts all age groups, although it is greatest in people aged 10-29 years and peaks between ages 30 and 49 years (Whiteford et al., 2013). The burden of drug use disorders is experienced between ages 15 and 29 years (World Health Organization, 2015).

The growing burden of disease due to mental and substance use disorders was recognised in 2015 by the United Nations as a global health priority. Accordingly, Targets 3.3 and 3.5 of the Sustainable Development Goals (SDGs) call for the promotion of mental health and wellbeing and strengthening of the prevention and treatment of substance abuse (World Health Organization, 2015); (Whiteford et al., 2013).

MENTAL HEALTH IN AUSTRALIA

In Australia, mental and behavioural disorders are ranked fourth behind cancer, musculoskeletal conditions and cardiovascular disease in terms of disease burden. They accounted for 40% of all physical and mental disability and an estimated 13% of the total national burden of disease in 2003 (Australian Institute of Health and Welfare, 2014, Institute for Health Metrics and Evaluation, 2013). Mental and behavioural disorders are associated with poor physical health outcomes and comorbidities such as heart or circulatory conditions, diabetes, epilepsy, obesity and severe headaches (Morgan et al., 2012). They are also associated with economic disadvantage, unemployment or under-employment, homelessness and reduced productivity, and exert a huge

burden on individuals, families and the community (Australian Institute of Health and Welfare, 2014).

The Federal and State government response to the burden of mental illness has been demonstrated through mental health reform and investment. The reform has been provided through successive policies including National Mental Health Strategy (1992) and its four five-year National Mental Health Plans which covered the period 1993 to 2014; the Council of Australian Governments' (COAG) National Action Plan on Mental Health 2006-2011; South Australia Mental Health Act 2009; and South Australia's Mental Health and Wellbeing Policy 2010-2015. At the core of the policies has been a shift of the model of care from an institutional and medical model to a recovery-oriented, consumer-focused and community based model that emphasised step-up and step-down services aimed at preventing admission to hospital and supporting consumers to return to the community (Australian Institute of Health and Welfare, 2014). The policy initiatives provide clear commitments to providing appropriate, high quality and equitable services for people with a mental illness in not only metropolitan Australia but also rural, regional and remote areas of South Australia.

In 2005-2007 mental disorders were the second highest health conditions, after nervous system and sense organ disorders, responsible for reducing South Australians' healthy years of life in both metropolitan Adelaide and country areas. The prevalence of diagnosed mental health conditions in regional South Australia is 15.7% compared to 17.6% in metropolitan areas (Health Performance Council, 2013).

In South Australia, the stepped model of care has been the centrepiece of mental health reform, driven largely by the recommendations of the South Australian Social Inclusion Board's *Stepping Up: A Social Inclusion Action Plan for Mental Health Reform 2007-2012* report. The stepped system is comprised of graduated levels of care including supported accommodation, community rehabilitation centres, intermediate care, acute care and secure care, allowing people to 'step-up' to more intense health care when they become unwell and 'step-down' to other support services when their health condition improves.(South Australian Social Inclusion Board, 2007a)

CMHRS PROGRAM

The CMHRS represents an essential step in the stepped system of care and provides community-based residential mental health rehabilitation services in Mount Gambier and Whyalla in country South Australia. The CMHRS was established on 1 July 2014 and was allocated $4 million annually initially, until 30 June 2016, under a grant by the Federal Government through its National Partnership Agreement on Improving Public Hospital Services. It aims to provide subacute mental health care within residential settings, with the goal of improving well-being and building practical skills for independent living for persons with high and complex mental health needs. Currently there has been no commitment by the state or federal governments to continue funding beyond 30 June 2016.

The CMHRS is an individually tailored, goal-orientated rehabilitation program built within a recovery framework. It offers 10-bed residential accommodation at each site in fully furnished, leased residential properties. It provides support to people from anywhere in country South Australia 24 hours a day, 7 days a week. The working hours include a 7:30am - 3:30pm early shift, 08:30am-

4:30pm day shift and 1:30pm – 9:30pm late shift. An on call shift operates from 9:30pm until 7:30am.

The Mount Gambier CMHRS site operates a blend of in-reach rehabilitation services into consumers' homes and six rented residential accommodations, four of which are shared and two house single residents. In contrast, Whyalla CMHRS operates six clustered 3-bedroom residential accommodations, all of which are shared.

The CMHRS resembles the Community Rehabilitation Centres (CRCs) (Elpida House, Trevor Parry Centre and Wondakka) established in metropolitan Adelaide in South Australia, with some differences. The CMHRS consumers stay in rented residential accommodation whereas the metropolitan-based CRCs offer purpose built facility-based accommodation.

OBJECTIVES

According to the Service Model, the CMHRS is built around the four pillars of:

1. *Residential Accommodation* - provision of accommodation during participation in the service.
2. *Tenancy Management* – management of requirements and expectations in relation to the property and tenant.
3. *Clinical Care* - provision of consumer centred clinical care and services.
4. *Psychosocial Support* - assistance with personal care, budgeting, relationship support, and participation in the resources and facilities of the local community (CHSA LHN Mental Health Services, 2011)

It has three main goals:

1. To deliver individualised, recovery focused rehabilitation programs that strengthen social, vocational and recreational engagement.
2. To provide accommodation with 24/7 care where consumers can reside to strengthen the skills of daily living in a supported environment.
3. To ensure inclusive and productive engagement with consumers of the service and facilitate a successful transition to independent living.

EVALUATION OBJECTIVES

The Terms of Reference (TOR) for the evaluation were to assess the impact of the CMHRS and the implementation of the stated service objectives in order to inform decision making regarding improvements to service delivery, policies and practices. The evaluation was also required in order to demonstrate accountability and achievements for funding purposes.

Specifically, the evaluation was required to:

1. Review the implementation of the service, including the facilitators and barriers to implementation, the effectiveness of the partnership between clinical and non-clinical psycho-social staff, the NGO partnership, and consistency of implementation across sites.

2. Identify and assess the early impacts of the service on system practices and improvements. This should include an assessment of the impact of patient flows within the Country Health SA jurisdiction and to and from metropolitan services, as well as a cost benefit analysis.
3. Identify and assess the outcomes of consumers who have participated in the service.
4. Identify opportunities for strengthening linkages with other aspects of the service system, including other mental health services, housing, community, employment and vocational sectors.
5. Review and identify elements that will strengthen community engagement.
6. Identify opportunities and make recommendations for improving service delivery.

EVALUATION METHODOLOGY

The overarching approach adopted for this evaluation was to assess the appropriateness, effectiveness, efficiency, outcomes and sustainability of the CMHRS program (Organisation for Economic Cooperation and Development, 1991). The approach and associated methodology used was endorsed by the members of the Project Evaluation Group (PEG) which also served as the project steering committee.

The Monitoring and Evaluation Framework (MEF) prepared and presented as part of Deliverable 1 under the contract catered as the base document for this evaluation.

PROJECT EVALUATION GROUP/LOCAL EVALUATION GROUP

The governance of the evaluation was provided by a Project Evaluation Group (PEG) and two Local Evaluation Groups (LEGs). The PEG provided guidance and advice on the evaluation processes, reviewed the data collection tools, identified the participant groups, including the individuals within them, and approved this and previous reports. The LEGs supported the development and review of the monitoring and evaluation plans, supported related data collection activities by recruiting participants for the interviews and surveys, and facilitated observation visits to the residential accommodation.

DATA MANAGEMENT

DESIGN AND DATA COLLECTION METHODS

A mixed method evaluation design involving quantitative and qualitative components was adopted for this evaluation, comprising of:

- *An online survey* completed by the current and past CMHRS staff. The survey was launched using the Surveymonkey ® Web-based platform (https://www.surveymonkey.com). The initial invitation was followed with two reminders culminating in 32 out of a possible 36 invitees responding to the survey, equating to a response rate of 89%.
- *A Social Network Analysis (SNA) survey* used to examine the nature and strength of links and partnerships established with other services and organisations working in mental health and within the regions served by the CMHRS. The list of services studied was collaboratively

identified by the CMHRS Team Leaders and two independent advisors chosen on the basis of their knowledge of mental health service delivery within their region. A total of 10 (53%) out of a possible 19 identified services were surveyed in Mount Gambier and 10 (48%) out of 21 services were surveyed in Whyalla. Overall, the SNA survey response rate was 50%.

- *Interviews*: Four sets of interviews were held with a corresponding number of participant groups including Consumers, Carers, Service Managers and Policy Makers and other Service Providers. Altogether 49 interviews each lasting approximately one hour were held with:
    - Service Managers and policy makers - 11 were interviewed out of a possible 12 participants. (Response Rate (RR) 92%);
    - Other Service Providers selected from the services and agencies working in mental health and linked with either of the two CMHRS sites. These included Community Mental Health Teams (CMHT), Integrated Mental Health Intensive Unit (IMHIU), Intermediate Care Service (ICS), Non- Government Organisations (NGOs) and Tenancy Managers. Eighteen representatives from the services and agencies were interviewed against the target of 20 (RR 90%);
    - Consumers - 14 interviews were held with past and present consumers of the CMHRS (RR 70%); and
    - Carers – 6 interviews were conducted with carers (RR 60%).
- *Desk review* of:
    - the CHSALHN-MH Country Consolidated Client Management Engine (CCCME) data
    - CHSALHN reports and other documents
    - relevant literature
- *Observation* of the CMHRS facilities in each site.

Furthermore, Cost Benefit Analysis (CBA) and Social Return on Investment (SROI) approaches were adopted. CBA was conducted as per the TOR and performed using some of the financial, output and outcome data generated by this evaluation. In contrast, SROI was an additional method provided by the evaluators (DRH) due to its capacity to demonstrate the social impacts of the program as well as to complement and supplement CBA. SROI used the outcome information from the wider evaluation. (Refer to Appendix 12).

The multiple data collection methods and sources used supported triangulation and therefore the validity of the data and findings (Shenton, 2004). Informants with diverse roles and interests were included, ensuring consideration and inclusion of multiple perspectives and valuing the lived experiences of consumers and their carers (Shenton, 2004) (Kitto et al., 2008).

Interviews were conducted by members of the research team. Interview recordings were transcribed by private transcription services. NVivo 10 data analysis software (www.qsrinternational.com) was used to code qualitative data: two members of the research team consecutively themed and analysed the data. The qualitative data analysis process ensured that member-checking and inter-rater reliability were maximised.

The members of the Evaluation Team came from diverse backgrounds and experience of working in mental health and mental health research including wide-ranging research and evaluation skills. This is demonstrated by the depth and breadth of the approaches used in this evaluation.

Purposive sampling in which participants were chosen to participate in interviews on the strength of their knowledge of the CMHRS was used to select interviewees. Regarding the online survey, all current and past staff of the CMHRS were eligible to participate. Sampling was not necessary.

Literature searches enabled an assessment of the extent to which the evaluation findings are consistent with those of previous studies at national and global levels (Shenton, 2004).

DATA ANALYSIS AND REPORTING

All the qualitative data from interviews were transcribed, coded and analysed for themes using NVivo 10 data analysis software. The quantitative data from the online survey and the secondary data were analysed using STATA ® (www.stata.com) statistical analysis software and Microsoft Excel ™ (www.microsoft.com) software, whilst UCINET (www.analytictech.com) software was used with the SNA data.

Cost Benefit Analysis (CBA) and Social Return on Investment (SROI) techniques were used with the financial information and the output and outcome data generated by the evaluation.

A diagrammatic representation of various data elements and how they were analysed, synthesised and collated into this report is shown in Appendix 1.

Frequent debriefing amongst the authors ensured that issues emerging during data collection were quickly addressed whilst the use of several authors during data analysis ensured member checking and inter-rater reliability, which are essential to verify themes and inferences being made from the data. Similarly, peer scrutiny of the evaluation project by academics internal and external to UniSA DRH was helpful in challenging some of the assumptions made by the authors (Shenton, 2004, Kitto et al., 2008).

ETHICS APPROVAL

Ethics approval was provided by the SA Health Human Research Ethics Committee (SAHREC), the University of South Australia (UniSA) Human Research Ethics Committee and the Aboriginal Health Research Ethics Committee (AHREC) of the Aboriginal Health Council of South Australia (AHCSA).

LIMITATIONS

The analysis of outcome measures is intended to provide an indication of trends only. A number of limitations to the dataset exist, including the small data sets which limit statistical power overall that prohibits stratification of the analysis (e.g. by site, gender or age).

Inconsistencies were identified in the data sets submitted by CHSALHN (MH) who have acknowledged that poor data collection and reporting may impact on the results.

Regarding the SNA, 50% of the services were mapped. This has an effect of the strength and quality of the maps produced.

FINDINGS

APPROPRIATENESS

GOVERNANCE

An outline of the service's governance arrangements is provided in Appendix 2. This includes constituents of Steering and Allocation committees. The membership of both the Steering and Allocation Committees does not include representation from consumers and carers, contrary to the provisions of the service model and Standard 2 of the National Safety and Quality Health Service Standards, as well as Principle 1 of the SA Health Policy Framework, 2012, both dealing with partnering with consumers and the community (Australian Commission on Safety and Quality in Health Care, 2012, SA Health, 2012).

Key members of the Allocation Committee felt that it needed to be more transparent and consistent in its decision making, and identified a preference for allocation meetings to be held twice each week to aid timely allocation.

***Finding 1*:** The design of the service model in relation to the referral process may be acting as a barrier to service access, with associated paperwork seen to be complicated and lengthy.

Recommendation 1: Review the referral process including associated documentation with a view to reducing complexity.

Recommendation 2*:* Ensure that the CMHRS is widely promoted among its stakeholders.

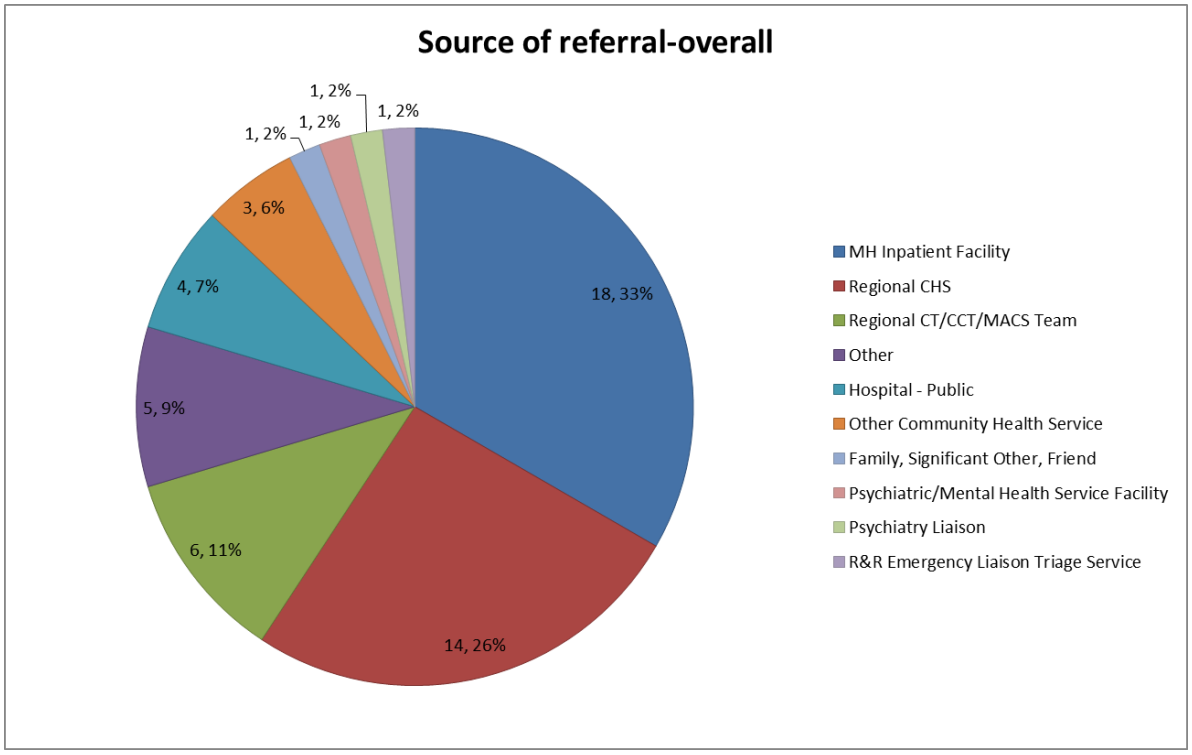
Recommendation 3*:* Data captured and reported by CMHRS should include a full identification of referral sources (as identified in the service model) in order to facilitate clearer understanding of the distribution and pattern of referrals.

REFERRALS

REFERRAL SOURCES

Overall, the major source of referrals to the CMHRS was the Mental Health Inpatient Facility (IMHIU) (33%) followed by the Regional Community Health Service (26%) and Community Team, Continuing Care Team, Mobile Assertive Care Services (Regional CT/CCT/MACS Team) (11%). The IMHIU was the main source of referrals for the Whyalla site, whilst the Regional Community Health Service was the major referral source in Mount Gambier. One consumer in Whyalla was referred by a family member, significant other or friend. It could not be determined from the CHSALHN data what role other referral sources identified in the Service model including private Psychiatrists, General Practitioners, Non-Government Organisations (NGOs), Aboriginal Community Controlled Health Organisations or consumers played in referring to the CMHRS (Figure 1).

FIGURE 1: SOURCE OF REFERRAL-OVERALL



According to the SA2 regional classification, the majority of referrals came from the major regional centres such as Mount Gambier, Whyalla and Port Augusta. This suggests the service may not be significantly addressing patterns of inequitable service access for consumers in more rural remote locations. That said, the geographical reach of the CMHRS was wider in Whyalla than Mount Gambier (See Appendix 3).

Feedback from the interviews suggests, and the above information confirms, that referral sources have been skewed internally within the dominant mental health services in the region with minimal diversity across the other services and organisations. There was a perception among interviewees that this might be due to a weakness in the service model, which requires referrals from non-traditional services to occur through the Community Mental Health Team (CMHT). It was also felt that a lack of promotion of the CMHRS among its stakeholders could have contributed to this.

One service provider noted that [the CMHRS]

> *"…don't necessarily get the referrals that you want… GPs could be referring… there are lots of people that could be referring to the program." (Other Service Provider).*

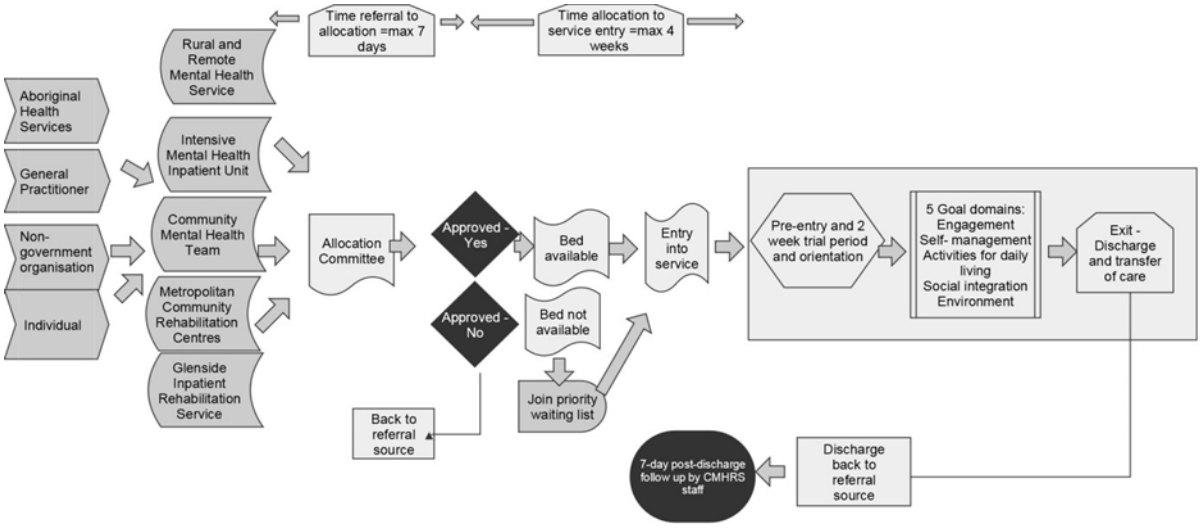
Another suggested

> *"…review[ing] the model, the referral process, the way it's governed." (Other Service Provider).*

REFERRAL PROCESS

For a detailed written description of the consumer journey through the referral and discharge processes see Appendix 4.

Figure 2: Consumer journey and referral process



Staff and other service providers responsible for completing the referral processes and procedures frequently found relevant forms to be lengthy and complex, and a barrier to access as well as potentially undermining program effectiveness and efficiency.

> *"At times there's a bit of anxiety around referring, because they actually don't know what they put on the forms and also the forms, from feedback from my local Community Mental Health Team is that it's quite a long and lengthy referral process, which I think can put off a community mental health team that's under high demand as it is." (Service Manager)*

It was indicated that this complexity may have led to referring agencies including insufficient detail in each section of the relevant forms, impacting timely admission of consumers into the CMHRS.

APPROPRIATENESS OF REFERRALS

Finding 3: A number of inappropriate referrals were noted, however the majority occurred in the context of initial set-up.

Numerous references were made to inappropriate referrals during the interviews, highlighting pressures both internal and external to the CMHRS leading to inappropriate admissions. The inappropriate referrals have also been linked with inconsistent application of the allocation criteria during the early stages. In particular, the service may not have been responsive to consumers' needs but rather to organisational needs, in that consumers may have been inappropriately referred to the

service simply to comply with occupancy levels.

> *"It was really poorly setup to begin with so we had people who were in established housing, socially supported housing and had been really stable for a long period of time who were actually being asked to go into the CRS (CMHRS)…it was communicated that it was 'bums in seats'." (Other Service Provider)*

Pressure on other services was also seen to be a driver of inappropriate referrals.

> *'There's quite a bit of pressure on some of the other parts of the services, so sometimes community rehab is seen as an opportunity to get people out of hospital and support them, but they might not fit in within the recovery rehab model,' (Service Manager/ Policy Maker)*

One Service Manager/Policy Maker noted that consumers who left the service within the two week trial period or a short time thereafter may have found the service did not meet their needs.

SERVICES PROVIDED

Finding 4: The range of services offered by the CMHRS is appropriate. There is potential to expand the services to include group-based and structured educational activity such as psycho-education, and the arts.

Overall, the CMHRS provided 24616 service contacts lasting 19078 hours. The number of service contacts was greater in Mount Gambier (15587) compared with Whyalla (9029) whereas the reverse was true for contact time with Whyalla (9867 hours) having spent 656 more contact hours doing consumer-related work than Mount Gambier (9211 hours). Each consumer received on average 473 contacts while in the service, totalling an average of 367 hours per consumer.

Therapeutic counselling/support provided in the home or at the centre accounted for most of the service contacts and contact time. The most predominant service contact provided in Mount Gambier was home based therapeutic counselling/support, followed by administrative client services, centre-based therapeutic counselling/support, case planning /coordination and advocacy/information, in that order. In comparison, the most predominant service contact provided in Whyalla was centre-based therapeutic counselling/support, followed by case planning/coordination and home based therapeutic counselling/support. The length of contact time mirrored the service contacts. See also Appendix 5.

Due to space limitations, most of the therapeutic counselling/support in Mount Gambier is provided from any one of the residential units, with the residents hosting their peers. In Whyalla, a dedicated centre-based activities facility is used to provide the therapeutic counselling/support. This explains the difference between centre-based therapeutic counselling/support and home based therapeutic counselling/support being provided by the two CMHRS sites.

The evidence indicates that the CMHRS has provided services which have a focus on development of skills for independent living and personal development. Skills taught include: cooking, cleaning, laundry, managing budgets, shopping, transport, developing social networks, returning to employment, meeting physical needs, personal care, medication, transition to independent living,

management of mental illness and anxiety management skills. Assistance is also provided to move to more appropriate living conditions.

The majority of staff agreed that the services being provided by the CMHRS were appropriate for the consumers (79%) and carers (79%). Almost all consumers interviewed felt that the service was responsive to their needs, as did many 'Other Service Providers'.

Some CMHRS staff felt that the range of services provided by the program could be expanded to include more group-based activity that is goal-oriented, structured and educational, including psycho-education and creative work such as art and music groups. Furthermore, staff indicated that more health promotion activities could be offered, for example physical activity and education on healthy eating, and other skills based activities including budgeting, managing illness and consumer initiated activities. The implementation of these activities could be cost neutral by linking consumers into existing programs and utilising the subject matter specialists from the other services as resource persons, opportunistically improving and building partnerships with other service providers. The importance of promoting healthy eating and physical activity is significant due to associations between mental illness and chronic diseases linked to sedentary behaviour, including diabetes and cardiovascular disease (Richardson et al., 2005, Ströhle, 2009, Wolff et al., 2011, Walsh, 2011, Morgan et al., 2012). Similarly, the observation to introduce art and music groups is most relevant given research shows the therapeutic effects in terms of improved levels of mental wellbeing (decreased mental distress, reduced levels of primary and secondary care service and medication use) and increased social inclusion (higher levels of social contact, reduced levels of stigma and discrimination, and higher levels of engagement in employment and education) (Secker, 2007).

It was also felt that the range of discipline specific therapies utilised could be increased to include tertiary modulation techniques based on occupational therapy, cognitive remedial therapy, social work-based family inclusiveness or family therapy, and group psycho-education, where they have not been attempted before. Some consumers, staff and other service providers perceived that there was opportunity to schedule activities over weekends to reduce boredom.

RESPONSIVENESS TO CONSUMER NEED

***Finding 5**:* The CMHRS operates an appropriate service model that is meeting the needs of consumers through its multidisciplinary staff, a strong focus on consumer-led rehabilitation and flexibility, focus on building practical independent living skills, intensity and 24 hour support.

Finding 6: It is a unique and important step in the stepped system of care for remote, rural and regional South Australia, filling a previous gap, and playing both a complementary and supplementary role, in alignment with State and National Mental Health policies.

Finding 7: Staff were largely seen to be supportive, non-judgemental and professional; the skill development they facilitated especially the focus on consumer centred care was seen as appropriate in assisting consumers to transition to independent living.

Staff were seen to be supportive, non-judgemental and professional, and the skill development they

facilitated, especially the focus on consumer centred care, was seen as appropriate in assisting consumers to transition to independent living. Consumers stated the service enabled them to take charge of their lives and to be in control of their rehabilitation by helping to set and meet their own targets and goals. As one consumer stated:

> *'I'd be the captain of the ship if you like with my own life, and they would help me.' (Consumer)*

Consumers identified that support and learning skills to maintain a household were crucial to positive outcomes. Similarly, medication management, stability, socialisation, and a mandatory reduction in drug and alcohol consumption were important features of the service. Support to connect/reconnect with family and friends was commonly considered appropriate and necessary, as were opportunities to connect with education and volunteer/employment opportunities.

A number of interviewees indicated the value of the CMHRS as an important component in the stepped model of care. Service providers outside of the CMHRS felt the service allowed them to get support for *"people before they get in to the really really unwell stage"* (Other Service Provider), and was therefore an efficient use of resources. They also indicated that the CMHRS provided a valuable step-down service after acute illness.

> *"It's that additional level of care in regional South Australia that was a gap previous to this" (Service manager/policy maker)*

The CMHRS model calls for formal and informal opportunities for family and loved ones to be encouraged to ask questions about their loved ones and to contribute ideas to the person's recovery path, 'unless otherwise indicated by risk of harm or the expressed preference of the consumer.' The model also requires that consumers are 'encouraged (where appropriate) to engage with and include their family members or support persons in their recovery journey'. Additionally, the literature discusses the significant contribution that carers make to the wellbeing of Australians including an estimation that in 2015, 86 million people were providing informal care, saving the Australian economy as estimated $60.3 billion per year. (Government of Tasmania, 2015) (p6-7).

The feedback from consumers, carers and staff suggests that there is opportunity to improve family and carer involvement in the provision of the service. The composition of the Steering Committee demonstrates that the consumer voice was overlooked at the strategic planning level.

Interviews highlighted inconsistencies in communication and support with carers. Many carers noted and appreciated ongoing communication and support from the CMHRS staff, feeling lines of communication were open and opportunities to access carer support provided. One carer noted how staff accompanied a consumer to visit them when they were unable to travel alone. Others noted staff being open to carer visits. Conversely, a number of carers felt communication was insufficient, stating they were not receiving updates after being informed that they would, not being informed of major events, or as involved in care planning as they had hoped to be. The lack of communication resulted in a breakdown in relationships and communication between family members.

Staff acknowledged that there was an important role for families/carers, along with a role for the

service in better connecting with families and carers and assisting them to understand and be supportive of the service.

Not having telephone landlines in the units was identified as a direct barrier to communication between consumers and their carers. Several carers noted a sense of helplessness due to lack of contact and ability to help. Service managers described that involving family of consumers who did not come from Whyalla or Mt Gambier was logistically challenging. They also discussed difficulties in carer engagement due to needing consumer consent to contact or involve family. Interviewees noted:

> *"The contact with the staff was good… there was everything there that I needed as a carer..."* (Carer)
>
> *"……. that family carers be included more in the developing care plans…..also just to give feedback on the progress of their loved one, without having to seek it themselves, without having to ring up and ask for it."* (Carer)
>
> *"I do think as well we could……. do a bit more work with regard to working with carers as well as consumers."* (Service Manager)
>
> *"Carers need to be kept in the loop, because ultimately they're the ones that are back to having to do most of the negotiation and advocacy for their loved one. They're the ones that have to deal with it once they leave the rehab program."* (Other Service provider)

The inconsistencies suggest that more work is required to embed the consumer-focused approach into the CMHRS. Consumer-focused care is the focus of the recommendations 1, 2 and 41 of the Stepping Up report, as well as of the current literature which calls for the meaningful involvement of consumers and carers in the delivery of services meant for them. (South Australian Social Inclusion Board, 2007a).

The areas for improvement (regarding responsiveness to need) identified by consumers and carers were minimal, however included;

- follow up after discharge,
- connections to services within consumers' own local residential towns, including information about available housing, and
- options regarding the shared accommodation as this did not suit everyone, particularly those who were used to living on their own.

SERVICE DUPLICATION

Finding 8: The CMHRS is a unique service that offers an intensity and style of service that was otherwise not available in country South Australia, and generally does not duplicate existing services.

Almost all interviewees from within and outside of the CMHRS felt it was a unique service that did not duplicate existing services. The overwhelming majority of 'Other service providers' interviewed felt the CMHRS complemented the services they offered; that its focus on independent living and

intensity of support was not offered by other organisations.

> *"I don't think they do duplicate really. They're a particular flavour which isn't really achievable anywhere else in country." (Other service provider)*

One 'Other service provider' noted some duplication and felt the model should be reviewed, but also referred to the 24 hour access to support as a unique feature of the CMHRS. A CMHRS Service manager explained the role of funding in dictating some level of duplication:

> *"Yes there are duplications of service, however the NGOs will duplicate that service because they're getting funding from either federal or state government and they need to provide those services to maintain their existence. So yeah, there will always be duplication." (Service manager/policy maker)*

IN-REACH

Finding 9: In-reach service provided by Mount Gambier CMHRS is not covered in the service model and therefore unplanned, although it has potential use as an alternative care delivery model to support mental health consumers to live independently.

Recommendation 4: Any decision to continue the in-reach service could be based on full consideration of the advantages and disadvantages of the mode of service delivery and the experience gained to date with the service model being modified accordingly.

Interviewees expressed mixed views in relation to the in-reach approach used on occasion in Mount Gambier. In-reach involves travelling up to 30 kilometres from the staff base to see a consumer. Although it was perceived as being proactive, it was also seen as an imposition from 'the top' that was not ideal for logistical purposes, costly in terms of travel costs, and exposed staff to risk, depending on the level of acuity of the consumer's illness and support needs. However, others noted that in-reach was less costly to run compared against the existing residential model. The staff in Mount Gambier felt very strongly about the discontinuation of the in-reach as part of the service. Furthermore, they highlighted that presently there is no clear policy covering the in-reach service and noted that the service model is silent about this type of service delivery.

Staff noted that there was a feeling of accountability within the CMHRS, as opposed to when in individuals' homes, and that staff had the authority to say when things were not acceptable within the context of CMHRS-managed facilities.

> *"We don't have the same control over the environment…If they're not maintaining it we can say "This needs to be done, that needs to be done..." When they're in their own we don't have that same control". [Service Manager/Policy Maker]*

However not all were opposed to the in-reach model, with some indicating that although it was outside of the service model, it was responding to a clear unmet need, and consistent with independent living principles. For example, it allows provision of services to consumers who choose

not to come into the CMHRS for reasons such as having a pet to care for, and hence those who are excluded despite being appropriate candidates for rehabilitation. Numerous staff members and service managers felt that there is a potentially valuable role for in-reach in the form of post-discharge follow up visits to support transition to independent living and to reinforce skills developed during rehabilitation.

ACCOMMODATION MODEL

Finding 10: The clustered accommodation model offered in Whyalla is considered to be more appropriate than the geographically dispersed accommodation model in Mount Gambier.

Recommendation 5: Minimise distances between staff, consumers and community services/hubs to increase efficiency and improve outcomes for consumers.

Of CMHRS staff surveyed, 75% felt that the type of residential accommodation available for consumers is appropriate. Most consumers and carers perceived that the residential accommodation provided by the CMHRS was appropriate, safe and of reasonable quality.

It was reported during interviews that the initial model of the CMHRS involved construction of ten-bed purpose-built facilities in Mount Gambier and Whyalla. This was changed to residential housing in the community late into the planning and design stages due to funding constraints. The late change of plans affected timelines, resulting in a rushed opening of the service.

A number of interviewees, particularly service managers and policy makers, felt the earlier planned 'residential facility' style service would have been more appropriate in meeting consumers' needs, and a more efficient use of staff time and resources. That said, the Whyalla model of 'clustered' housing was seen as the better of the two existing services, although the model of integrated community housing used in Mount Gambier was seen as promoting a more realistic community living arrangement and consumer integration into community.

> *"It's quite a long distance for the staff to come from a hospital out the community. If we're looking to providing intense rehab it's good for them to be onsite." (Service manager)*

> *"Having that connectedness with the community and linking in and being in partnership with your community and the services around - that is probably the best fit to meet the wide range of needs that people with mental health issues tend to have." (Service Manager)*

It was also reported that shared accommodation presents a challenge with exit inspections when consumers move in or out. The exit inspections invariably involve several people being present at once for joint inspection, including the two support workers, two consumers and the non-government organisations (NGO) responsible for tenancy management.

Generally, the two CMHRS sites were perceived as being well resourced. It was indicated that the Mount Gambier site had an excess supply of equipment, some of which may not have been in use at the time of the evaluation.

TENANCY MANAGEMENT

Tenancy management is being achieved through tenancy management contracts and lease agreements with the non-government sector and real estate agencies, respectively. Mount Gambier has a tenancy management contract with Anglican Community Care Incorporated (AC Care) and lease agreements with Complete Real Estate and Malseeds Real Estate. Whyalla has a tenancy management agreement with Uniting Care Wesley (Port Pirie) and lease agreements for residential accommodation with Whyalla Real Estate. The Service Managers and staff did not perceive that these arrangements were appropriate and cost-effective; this is discussed further in 'Efficiency', Pages 51.

GUIDELINES AND PROCEDURES

Finding 11: The guidelines, procedures and tools used by the CMHRS are appropriate, useful and continually updated although staff perceived that the tools for supporting consumer movement between the services as well as the tools for screening and selection of referred consumers required further improvement.

Recommendation 6: In line with quality management principles, continually review and update service protocols based on feedback from staff, consumers and other service providers.

A list of the operational guidelines and procedures developed by the CMHRS is shown in Appendix 6.

The CMHRS staff perceived that the guidelines and procedures used by the CMHRS are appropriate (86%), useful to their work (86%), and are continually reviewed and updated (74%). Sixty one percent of staff indicated that they were confident that the assessment process for consumers is working well, and 63% felt that the tools for screening and selection of consumers are appropriate.

An early consumer in the service felt the *"rules kept changing" (Consumer)* around expectations of consumers and the frequency and intensity of services they received, with changes poorly communicated. This was seen to be due to the service being in its early set-up phase. Similarly, an 'Other service manager' felt guidelines and procedures to support continuity of care were unclear from the outset:

> *"…… when the CRS (sic) was set up, there was never any systems or processes and I have asked regarding how people have a continuity of care within the CRS (sic) in coming out into the community and receiving psychosocial rehab services but there is no clear process and there's been little discussion about that." (Other service provider)*

Only 54% of staff surveyed agreed that there are adequate tools to support the movement of CMHRS consumers between services. This contributes to broader issues around collaboration, which are further explored in 'Effectiveness', page 46.

HUMAN RESOURCES

STAFF LOCATION AND CHARACTERISTICS

Finding 12: The number of positions and professional mix of staff were adequate (when vacancies were minimal) to meet the needs of consumers in this unique rehabilitation environment although there was perception that the CMHRS was over-staffed.

Finding 13*:* The implementation of this service has resulted in an additional 30.94 FTE positions to Country SA, an important contribution to the country mental health workforce and to reducing inequities in distribution of mental health specialists across urban and rural South Australia.

Recommendation 7: Balancing gender of staff, where possible, may help increase appropriateness for consumers from various cultural groups, including Aboriginal people.

Recommendation 8: Review the current staffing model in relation to workload without upsetting the multidisciplinary nature of the teams. The alternative would entail keeping occupancy levels at their optimum in order that staff are fully utilised.

Each of the CMHRS sites has been allocated an equivalent 15.47 full time equivalent (FTE) positions. Whyalla has been operating with 14.9 FTE positions and Mount Gambier with 12.8 FTE positions. The Community Health Worker category is the most predominant, comprising 35% of total authorised FTEs (Table 1).

TABLE 1: APPROVED CMHRS STAFF POSITIONS

Category	FTE's authorised		Mount Gambier		Whyalla
		FTE's filled	Sex	FTE's filled	Sex
Team Leader	1	1	1F	1	1M
Occupational Therapy	2	2	2F	2	2F
Mental Health Nursing	2	2	1F, 1M	2	1F, 1M
Mental Health Clinician (multi-class)	1	0.5	1M	1	1F
Social Worker	1	0	0	1	1M
Psychologist	1	1	1F	0.8	1F
Psychiatrist	0.5	0	0	0.1	1M
Community Rehabilitation Support Worker	5.47	4.8	5F	5.5	4F, 2M
Peer Support Worker	0.5	0.5	1F	0.5	1M
Aboriginal Mental Health Cultural Worker	0.5	0.5	1M	0.5	1F
Administrative Officer	0.5	0.5	1F	0.5	1F
Total	**15.47**	**12.8**	**12F (80%), 3M (20%)**	**14.9**	**11F (61%), 7M (39%)**

Staff were predominantly female (70%), with the gender mix more balanced in Whyalla in comparison with Mt Gambier (61% vs 80% female). Of the 19 (59%) staff survey respondents who indicated their age, 63% were aged below 35 years, with 48% being aged 30 years and below suggesting that the CMHRS staff is relatively young.

The staff gender imbalance has potential implications for gender sensitivity and safety for both staff and consumers, considering that the consumers of the CMHRS have been predominantly male.

Several interviewees, staff of 'other services', indicated they felt the CMHRS was over-resourced and staffed, in comparison with the resources afforded other mental health facilities in the community

as well as relative to the workload. That said, a greater number of interviewees, predominantly service managers, policy makers and consumers, felt the staff-consumer ratio was adequate (when fully staffed), and necessary to allow for truly consumer-driven rehabilitation and optimal outcomes. The capacity of staff to spend more time with consumers was considered crucial to achieving the desired outcomes.

> *"The need to have adequate staffing to meet rehab needs, in terms of it's only been since we've been fully staffed that I feel we've been as effective and achieving optimal or doing optimal things on a shift by shift basis." (Service Manager/Policy Maker).*

SKILLS MIX AND TRAINING

Finding 14: Ongoing training and development has been vital to ensuring the skills of staff are adequate to provide consumer-led rehabilitation that achieves optimal outcomes.

Recommendation 9*:* Ensure sufficient resources to support staff training and development continues to be provided, to address challenges recruiting appropriately qualified staff.

Overall, the staff mix and positions created at the two CMHRS sites mirror the service model. Staff mix reflects clinical, psychosocial, peer and cultural aspects of care. Staff diversity in terms of health discipline reflects a key strength of the CMHRS in relation to holistic service delivery. The Aboriginal and peer worker positions were considered by one Service Manager/Policy Maker to be key additions to the teams that helped make them truly multi-disciplinary.

Respondents to the staff survey mostly indicated they felt staff have appropriate knowledge and skill to deliver mental health rehabilitation services (68%). Three quarters of staff were satisfied with the arrangements for staff supervision and staff training (75%). Sixty four percent of the staff felt that they were satisfied with the arrangements for reflective practice.

The CMHRS faced significant challenges in hiring staff with adequate qualifications and experience to facilitate a consumer-oriented rehabilitation experience. Feedback from interviews suggested that many of the staff initially hired were relatively inexperienced, with some background in mental health though little experience and understanding of mental health rehabilitation concepts and principles.

However, interviewees also reflected the significant effort made to train and upskill staff, indicating a clear shift to a more skilful and effective workforce over time. The low occupancy rates during the early weeks and months of service operation allowed for time to be taken to conduct this training.

> *"Our support workers have certainly developed good rehab skills… and I think all of our support workers now would acknowledge their difference in approach from the start of the service until now. They understand the nature of rehab more." (Service Manager/Policy maker)*

The Service model and the National Mental Health Standards anticipate that the staff employed by the mental health services are appropriately trained, developed and supported to safely perform the

duties required of them. The policy documents also encourage that mental health services deliver services that are responsive to the cultural and social diversity of its consumers and meet their needs, as well as those of their carers and community, throughout all phases of care.

A variety of mandatory and non-mandatory staff development programs have been organised for the CMHRS staff at the two sites. The staff training and development provided had strong bias on mental illness and drug use and less emphasis on psychosocial education and rehabilitation. The training covered clinical, occupational and food safety issues and was attended mostly by Community Rehabilitation Support Workers. The training provided so far reportedly does not include cultural awareness training and consumer-centred approaches. The two skill areas are important for the CMHRS workers considering the two services work with a significant number of Aboriginal consumers, and given the largest proportion of the Aboriginal population reside in rural and remote areas of South Australia. Cognisance is also taken of the fact that the rehabilitation model is anchored upon the consumer-focused approach. A list of the staff training provided is attached as Appendix 7.

Recruitment and retention

Finding 15: Difficulties in recruitment and retention of staff are likely to be mostly due to broader regional recruitment challenges, as well as lack of security of funding/positions within the CMHRS.

Recommendation 10: Stability of funding, and subsequently employment, will be crucial in addressing retention challenges.

Recruitment and retention were ongoing challenges for the CMHRS, from start-up to present day, but were largely seen to be beyond the direct control of the CMHRS. Many of the challenges with 'inexperienced staff' discussed above stem from the broader challenges around recruitment of specialised mental health staff in country areas.

As well as regional-level challenges in specialised health staff recruitment, the lack of secure funding and therefore security of positions created for CMHRS staff contributed to challenges attracting and retaining qualified staff. Challenges filling positions were ongoing, particularly level two positions, and led to difficulties in covering leave, with services relying largely on the goodwill of staff to work additional shifts. The service was described as a '*recruiting ground*' for other country mental health services.

COMMUNITY ENGAGEMENT

Finding 16: Although the CMHRS staff perceived that the strategies used to engage the community in the establishment of the CMHRS were appropriate, adequate engagement with relevant stakeholders including the local planning authorities would have helped to reduce the problem encountered in Mount Gambier over the location of residential accommodation.

Recommendation 11: Ensure adequate stakeholder consultation processes are undertaken appropriate to the local community prior to introducing new services.

ENGAGEMENT WITH LOCAL COMMUNITY/PLANNING AUTHORITY

Community engagement is increasingly an essential part of consultation in designing and developing health services. The Centre for Disease Control and Prevention [CDC] in 1997 defined community engagement as the "process of working collaboratively with and through groups of people affiliated by geographic proximity, special interest, or similar situations to address issues affecting the well-being of those people" (Centers for Disease Control Prevention, 1997) (p9).

Sixty four percent of the CMHRS staff felt that the strategies used to engage the community in the establishment of the CMHRS were appropriate with 71% believing that the strategies being used to engage the community in the provision of CMHRS services were appropriate.

The location of residential housing in a certain area of Mount Gambier caused unfavourable media publicity due to a petition by local residents who resisted having the CMHRS consumers in their neighbourhood. Adequate prior consultation with stakeholders would have helped to build positive relationships between the residents, neighbours and local community whilst reducing stigmatisation of the consumers and minimising potential for conflict. Conversely, a number of interviewees felt the community consultation that occurred in neighbourhoods where CMHRS houses were to be located was unnecessary. As neighbours do not normally get to choose who lives next to or close to them, it was questioned as to why this was deemed appropriate in the broader context of mental illness, particularly given the potentially stigmatising effects of such consultation.

> *"As far as I know one property that was rented attracted a lot of public negative critique so that was abandoned after a while…do you need to consult who is going to live next door to you?" (Other service provider)*

Inadequate consultation with key stakeholders when the CMHRS was established was identified. As in other aspects of implementation, the tight timeframe in the set-up phase was seen to lead to challenges in effective collaboration and communication early on. There were initial challenges with developing collaborative organisational relationships, with 'Other service providers' feeling they were not consulted nor collaborated with to the extent that had been initially promised, especially during the start-up phase. It was felt that consultation is important in order to share knowledge, avoid possible duplication, avoid costly mistakes by learning from others' experiences, and promoting in advance continuity of care for the people entering the service.

"…one of the difficulties is that once again as the service was actually set up and planned without the involvement of community services… so we were told that there was a CRS (CMHRS) starting a number of years ago… then we were told that it was actually going to start and we didn't have any involvement at all or any communication with the CRS until really consumers were in the CRS or going into the CRS." (Other service provider)

EFFECTIVENESS

CMHRS OBJECTIVES MET

Finding 17: CMHRS staff and other service providers strongly agree that the service is meeting its objectives

***Finding 18*:** The 24 hour roster, inclusive of the 'on-call' night shift, is appropriate. The on-call night shift is important in helping consumers feel confident and safe.

OBJECTIVE 1: TO DELIVER INDIVIDUALISED, RECOVERY FOCUSED REHABILITATION PROGRAMS THAT STRENGTHEN SOCIAL, VOCATIONAL AND RECREATIONAL ENGAGEMENT

Rehabilitation in the context of recovery is the focus of several commonwealth, state and territory policies in Australia, all of which stress the need for rehabilitation to commence at the earliest possible point in a person's recovery (Queensland Health, 2005, Tasmanian Department of Health and Human Services, 2009, NSW Health, 2006, SA Health, 2012). Furthermore, national standards and frameworks (Commonwealth of Australia, 2010, Commonwealth of Australia, 2013, SA Health, 2012) focus on recovery being for the individual gaining and retaining hope, understanding of one's abilities and disabilities, having the opportunity to engage in an active life, experience autonomy, social identity, meaning and purpose in life, as well as a positive sense of self.

The survey data showed that 85% of staff agreed that the CMHRS is successful in meeting its objectives, and 82% agreed that the program is meeting the objectives of both clinicians and non-clinicians with the interviews confirming this:

"I suspect it's the one aspect of the mental health in town here that's actually working best. Colleagues have said that too." (Other Service Provider)

"I think this service has filled a gap and it's met its need in that it was to help country consumers to stay in country and it offers that." (Service Manager)

Staff also agreed that the service was effectively supporting consumers with their recovery (86%), reducing the burden on carers (89%), and providing improved psychosocial support (96%). The perception is supported by the hospital data which showed significant reductions in hospital presentations.

The evaluation has identified within the CMHRHS Model of Care a high level of coordinated care and

significant outcomes for consumers and their families. This has occurred by placing the consumer at the centre of the care with a high level of respect that has enabled independence and a purpose in life for people who have participated in the service. One task of the evaluators was to assess the viability of the service for example showing cost savings in the acute health sector. The service has clearly achieved this outcome which is not surprising as universally there is evidence that funding of mental health rehabilitation services will have a range of positive flow on effects at a number of levels within the community, the individuals' lives and the service sector (SA Health, 2012). The question now is whether this model is sustainable for country South Australia where 28% of the state's consumers reside.

EMERGENCY DEPARTMENT PRESENTATIONS

Finding 19: Adjusted data indicates there have been significant reductions in ED admissions and inpatient psych care days, pre and post CMHRS. Accuracy of data will increase over time as greater numbers of consumers complete a full 12-months post-CMHRS.

Recommendation 12: Routine collection of linked data would enable tracking of performance in relation to hospital admissions.

Early figures (given the young age of the service) indicate that the number of mental health presentations to country and metropolitan emergency departments among CMHRS consumers has reduced significantly from pre to post CMHRS stay.

For example, among a sub-sample of CMHRS consumers (n=14) who had been out of the service for over 8 months (at October 31 2015), ED presentations were calculated in the comparable time period before entry and after discharge to/from the CMHRS. ED presentations reduced by over half among this group, with 14 total presentations in the 8 months to 1 year prior to CMHRS entry, and only 6 post-discharge: a 57% reduction.

Alternately, adjusted estimates across the whole sample were calculated. Across the 41 consumers who had exited the CMHRS by 31st October 2015, using adjusted monthly rates, each had (or was estimated to have) on average 1.3 fewer ED presentations in the year after compared with the year before CMHRS stay (2.1 presentations pre to .8 presentations post). Scaling this figure up, an estimated 48% reduction in ED presentations, or total of 53 fewer presentations among this group was calculated[1].

INPATIENT PSYCHIATRIC CARE DAYS

[1] *To develop estimated adjusted figures we considered the number of post-CMHRS psychiatric care days/ ED presentations for each consumer who had exited the CMHRS by October 31 2015. We adjusted these figures to a monthly average rate for each consumer, based on the number of months they had been out of the CMHRS. We also adjusted their pre-CMHRS figures to only consider psychiatric care days/ED presentations that occurred within a comparable time period. For example, if a consumer had been out of the service for 6 months, hospital data for 6 months prior to CMHRS entry date was considered. Monthly rates were then averaged and applied to the total sample.*

Similarly, the estimated reductions in inpatient psych care days pre- CMHRS entry and post-CMHRS exit were calculated. This analysis, considering comparable timeframes for consumers pre and post-CMHRS, estimates an average reduction of 1.4 days per consumer per month post CMHRS, or 16.8 days per year per consumer (Table 2).

TABLE 2: PSYCH CARE DAYS - CONSUMERS WHO HAD EXITED CMHRS BY 31/10/2015

	Psych Care days	
	Pre (12 mths)	***Post***
Crude No.	888	127
Ave. p/consumer (n=41) ***(measurement period not adjusted)***	21.7	3.1
Ave. p/consumer p/month ***(measurement period accounted for)***	1.8	0.4

Of the 22 consumers who had exited the CMHRS by October 31st 2015, and had any days in inpatient psych care (in the year) prior to CMHRS entry, only 3 had any inpatient days post CMHRS.

Consistent with these results, the survey respondents perceived that the CMHRS is helping to reduce hospital admissions (86% of respondents), reducing hospital readmissions (89%) and improving transition from acute care (89%).

OBJECTIVE 2: TO PROVIDE ACCOMMODATION WITH 24/7 CARE WHERE CONSUMERS CAN RESIDE TO STRENGTHEN THE SKILLS OF DAILY LIVING IN A SUPPORTED ENVIRONMENT.

The CMHRS is providing 24/7 care with on call after-hours shifts as opposed to outright night shifts, which are reportedly used in the metropolitan community rehabilitation centres (CRCs) (Barnett et al., 2011). Interviewees across respondent groups spoke to the importance and effectiveness of the 24/7 roster as it has been operating:

> *'Even though staff weren't living in the house with [consumer], still had that 24/7 contact really if [consumer] needed it. I think that continuing support by the professional team is what helped [consumer] to get those changes'. (Carer)*

Interviewees did not perceive the model in operation to be less ideal than outright night shifts, and saw it as an important cost-saving measure that wasn't reducing the quality of care being delivered.

OBJECTIVE 3: TO ENSURE INCLUSIVE AND PRODUCTIVE ENGAGEMENT WITH CONSUMERS OF THE SERVICE AND FACILITATE A SUCCESSFUL TRANSITION TO INDEPENDENT LIVING.

The achievement of this objective has been assessed through the CMHRS service utilisation lens and the nature of the engagement with the consumers.

SERVICE UTILISATION

Finding 20: The service is reaching its target group, with good representation of Aboriginal consumers although the inclusion of CALD groups and people with other disabilities requires further work.

Finding 21: Consumers participating in the program are building skills and pathways towards achieving independent living.

Recommendation 13: Work towards increasing accessibility for consumers from CALD communities and people with disabilities.

CONSUMER PROFILE

DEMOGRAPHICS

The service model envisages the CMHRS providing support to adults aged 18 or younger to 65 years or older with a primary diagnosis of mental illness and who have high and complex needs.

A total of 52 consumers were admitted to the CMHRS during the period 1 July 2014 and 30 September 2015[2]. Thirty one and 21 consumers entered the services in Whyalla and Mt Gambier respectively. Most consumers were born in Australia and all except one had English as their main language. Twelve consumers were still in the CMHRS at 30 September 2015.

Of these consumers, 37 (71%) were male and 15 (29%) were female. This finding is consistent with past studies which show a preponderance of male consumers within the mental health rehabilitation services (Killaspy et al., 2008, Barnett et al., 2011). The low representation of female consumers within the CMHRS is also consistent with trends across community mental health settings in South Australia, although featuring at the lower end, as shown below. The trend is rather unusual considering that past studies show that it is the male counterparts who were less likely to seek mental health services (Wendt, 2015). This could suggest the existence of a barrier that is hindering women from accessing the CMHRS (and other mental health) services (Table 3).

TABLE 3: GENDER REPRESENTATION IN COMMUNITY MENTAL HEALTH SETTINGS

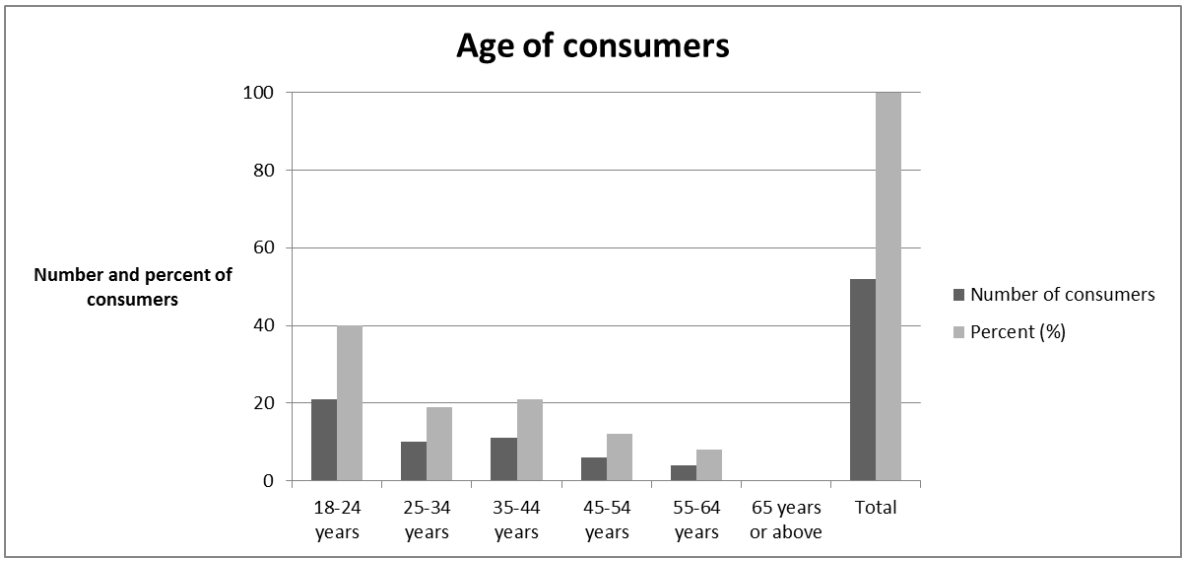
Gender	Setting – percentage of representation						
	SA population	**CMHRS**	ICC	CRC **	Forensic community *	Supported accommodation #	CMHS
Female	50.4	**29**	54.3	25.2	15.4	44.7	49.8
Male	49.6	**71**	45.7	74.8	84.6	55.3	50.2
Adapted from Chief Psychiatrist Annual Report 2014-15 and Evaluation of the Three Community Rehabilitation Centres report, 2011 (*2013-14 data (2011 data) (#2012-13 data)**							

Consumers ranged from 18 to 63 years old upon admission with the average age being 32.8 years. Eighty percent of consumers were aged below 44 years, the predominant age groups being 18-24

[2] Please note; different numbers of consumers included in certain parts of the report reflect that various data sets were received on different dates.

years (40%), 35-44 years (21%), and 25-34 years (19%). This age distribution is consistent with that of consumers accessing adult mental health services more broadly, and mirrors the prevalence of common mental disorders in the Australian population (Australian Institute of Health and Welfare, 2014). Demographics above suggest the need to target activities and support based on age characteristics, amongst other considerations (Commonwealth of Australia, 2008) (Figure 2).

FIGURE 2: AGE OF CONSUMERS



ABORIGINAL CONSUMERS

Seven (13%) consumers (2 women, 5 men) reported that they were of Aboriginal origin, 3 in Mt Gambier and 4 in Whyalla. This is a significant achievement compared with the 9% representation of Aboriginal consumers in adult Community Mental Health services (South Australian Social Inclusion Board, 2007a), thus suggesting a level of cultural acceptability of the service (Taylor, 2012). That said, the gender of the CMHRS staff is predominantly female and this has cultural significance as Aboriginal men were less likely to prefer being seen by a female health professional. This underscores the importance of providing training in cultural awareness / sensitive to practice and resources for staff working with Aboriginal people.

CULTURALLY DIVERSE GROUPS

There were no consumers from culturally and linguistically diverse (CALD) backgrounds. This is consistent with evidence that this population group has a significantly lower level of access to mental health care and support in the wider community health services (Commonwealth of Australia Department of Health, 2006, Barnett et al., 2011). The lack of CALD representation in this service suggests the need for the CMHRS to promote participation of this group.

MENTAL ILLNESS DIAGNOSIS

Schizophrenia was the most common primary mental health diagnosis among CMHRS consumers (n=18), followed by personality disorders (n=5) and depression (n=3) (not all consumers had their diagnosis recorded). Personality disorders and depression were the most common secondary mental illness diagnosis (Appendix 8). Ninety eight percent of the consumers entered the service 'voluntarily'. The legal status of one consumer was not disclosed. Twenty two consumers (7 in

Mount Gambier, 15 in Whyalla) had at least one IMHIU admission in the 12 months prior to entering the CMHRS.

OTHER COMORBIDITIES

No consumers were reported to have a physical and/or intellectual disability or multiple disabilities. This demographic was not captured in the CMHRS data provided for this evaluation apart from the psychiatric disability. There was no information to indicate whether disability was a barrier to entry to the CMHRS and it could not be established whether any consumers had activity restrictions or required special support, although it is known that certain consumers were discharged early due to alcohol and drug issues. It is noted that the service model is silent about people with a physical disability.

CONTINUITY OF CARE

Finding 22: Opportunity exists to improve discharge planning by ensuring that it is better coordinated with the relevant services and organisations in order to achieve continuity of care and smooth transition into the community for the consumer.

Finding 23: Compliance with routine procedures such as post-discharge follow up and recording of GP details was weak suggesting problems with monitoring and supervision of the workforce.

Recommendation 14: Ensure discharge planning is well coordinated with the relevant services and organisations including the family members and carers.

Recommendation 15: A system of routine internal checks and monitoring should be put in place in order to ensure staff compliance with set procedure and guidelines.

DISCHARGE/DISCHARGE PLANNING

The vast majority of staff surveyed agreed the CMHRS is being effective in improving referral pathways (82%) and referral between various levels of care (93%). Feedback from some consumers and other service providers suggests that exits from the CMHRS could have been better coordinated with the relevant services and organisations and the transition of consumers back into the community made much smoother. Several consumers noted a lack of referral or continuity on discharge leading to a potential loss of gains made in rehabilitation:

> *"…..just a proper discharge plan, like you have an address to go to when you leave, you have a job or study lined up, all that sort of stuff. You have to have a life to go back to, there's no point coming into the program and then just going back to your old life." (Consumer)*

Service managers and other providers also noted poor discharge planning/ procedures:

> *"I'm not sure if they have written plans for each client, but if they were supplied to us, it would probably be useful as well. So we're working off the same page…… helps when we're writing, if we have to write a Centrelink certificate or something, if we know what people are thinking about, return to work programs, or whatever." (Other Service Provider)*

POST DISCHARGE FOLLOW-UP

The data provided by CHSALHN showed that Post-Discharge Follow-up (PDFU) was conducted for 54% (7/13) of consumers in Mount Gambier and 64% (18/28) of consumers in Whyalla. Overall, 61% of consumers received the planned 7-day PDFU, a rate slightly above the minimum target of 60%. Compared against trends in regional and metropolitan areas, the aggregated and site-specific PDFU rates achieved by the CMHRS are much higher than the 39.4% and 53.5% achieved for country and metropolitan residents released from acute and non-acute hospital settings, respectively, in 2011-2012 (Health Performance Council, 2013).

Most of the consumers interviewed confirmed getting the two-week post-discharge follow up, although there was a feeling expressed that some form of in-reach or other support should continue after this period in order to support transition into the community.

> *"So for that six months you've got that and then two weeks, couple of phone calls…… bang and then that's it". (Consumer)*

GP details were recorded for 62% of the consumers in Mount Gambier and 96% of the consumers in Whyalla. Overall, GP details were recorded for 88% of consumers.

EXITS FROM THE CMHRS

Exit from the CMHRS occurred through formal and informal (unplanned) discharge. Formal discharge occurred once the consumer had achieved their goal whereas informal discharge happened early often against advice from the CMHRS staff. Unplanned exits were reported to have occurred as a result of one or more of the following reasons:

- behaviour inconsistent with the service model, for example smoking, drug and alcohol use, violent behaviour;
- families unsupportive of participation in the service, or consumers missing family involvement in the process; and/or
- circumstances changing after the two-week trial period.

TRANSITION TO INDEPENDENT LIVING

The interviews showed that 19 past consumers have transitioned into independent living in the community.

> *"Well right now I'm in a process of going into independent living, and basically I'm getting a lot of support towards housing, to a lot of things that without it I'd be extremely overwhelming." (Consumer)*

ENABLERS TO ACCESS

Finding 24: Meetings between CMHRS team leaders and (potential) consumers during the referral stage is pivotal in building consumer confidence and willingness to enter the service.

A number of consumers commented on the referral process as an enabler to access. Despite 'Other service providers' noting challenges associated with the required paperwork, they also noted that the CMHRS team was able to effectively engage consumers from the early stages of admission and throughout their stay with the CMHRS.

Consumers and 'Other service providers' also commonly cited the availability and willingness of CMHRS Service Managers as a key enabler to access. Consumers reported that the initial meetings with Team Leaders (to gauge their suitability for the service) helped them to feel comfortable and engaged with the service from the outset. Other service providers commented on the willingness of CMHRS managers to visit potential consumers or services to support the referral process as extremely positive and engaging. The one-on-one approach taken with consumers by CMHRS Team Leaders is helping facilitate effective admissions. A number of consumers and carers noted disengagement with mental health services prior to entry to the CMHRS:

> *"I didn't really want to do anything... And the person who did the referring and stuff like that, he was the person who built my self-esteem up enough to actually come here, because I was agoraphobic and I didn't leave the house or anything like that." (Consumer)*

Over time, as could be expected, process, policies and procedures for referral and allocation were developed and clarified, increasingly enabling effective and efficient access.

The two week trial period was considered an enabler to access by some staff members, who felt it gave consumers a way to try the service without having to commit long term. Many consumers spoke of the 'week or two' between referral and admission as sufficient in allowing them to organise and prepare themselves for service entry, particularly when they were travelling to another town to access the CMHRS. One consumer did state that they felt the timeframe from referral (as an inpatient) to admission was too quick.

The intensity and frequency of support and contact received whilst in the CMHRS were seen as key to maintaining consumer engagement and working towards positive outcomes.

BARRIERS TO ACCESS

Finding 25: Barriers to service access were attributed to inadequate knowledge about the CMHRS among the potential referral sources, along with complex referral processes, strict no alcohol and drugs policy, inadequate engagement of families and carers.

Finding 26: The geographical distance of the CMHRHS sites was identified by some as contributing to inequitable access to mental health rehabilitation services and further exacerbating rural disadvantage.

Recommendation 16: The CMHRS, working jointly with its partners, should investigate and implement strategies to improve service access for people living outside the two cities where the program is based.

AWARENESS ABOUT CMHRS

The Service Managers, staff and the 'Other service providers' alike felt that the CMHRS was not widely promoted among existing and potential referral services, organisations and the relevant communities. The result was seen to be that people who could have potentially been reached by the program were being missed, thus undermining access to and the effectiveness of the program. Promotion of the CMHRS in the community was viewed as being essential given that people's understanding of what rehabilitation meant was still low. Some interviewees felt awareness raising was essential to attract people who are currently outside of the mental health system but would benefit from the service, and to enhance opportunities for collaborative practice.

> *"…there's a lot more clients out there who don't have contact with their rehabilitation team…." (Other Service Provider)*

> *"Just be out there all the time, selling it as you would sell a product." (Service Manager/ Policy Maker)*

Interviewees offered suggestions to support promotion of the CMHRS which included:

- Use the success stories that have built up over the years as case studies in promotional material including a promotional DVD to showcase the CMHRS to consumers;
- Organise 'Meet and Greet' visits to the CMHRS by other service providers.

LACK OF MOTIVATION

Staff were the only group of respondents that consistently indicated lack of motivation or personal drive of consumers was a key barrier to service access and rehabilitation outcomes. Staff also perceived unsupportive families/carers were both a barrier to access and determinant of early discharge. Conversely, some carers described lack of motivation to participate in mental health services as due to a string of 'bad' experiences with the system.

NO DRUG AND ALCOHOL POLICY

While the strict no drug and alcohol policy was largely supported, it was indicated that this did prove a barrier for a number of consumers who suffered from addiction. Instead it was suggested to address the problem using the multidisciplinary and partnership approach. Similarly, an 'other service provider' felt that dual diagnosis of disability and mental illness was a barrier to service access which could potentially be addressed through improved information sharing and collaboration.

> *"Why don't we treat that and we'll bring them back here, so we'll bring in someone from Housing SA, we'll bring in someone from [PHAMS], bring in someone from [FAYS] or bring in someone from AA again or DASSA." (Other Service Provider)*

DISTANCE AWAY FROM CMHRS

Twenty five (approx. 50%) consumers attended CMHRS in towns other than their usual place of residence, while the other 50% resided in the same town as the CMHRS site. It was indicated that access was somewhat more difficult for those living outside of the two CMHRS towns. Interviewees across all groups spoke of distance as a challenge and potential barrier to access. Issues included:

- the cost of travel to CMHRS location;
- the time, energy and cost required for family (sometimes elderly parents) to visit consumers in the CMHRS; and
- challenges in care collaboration where consumers' existing social networks and service providers were in other towns.

Some interviewees noted the benefits of consumers being at least some distance from families, particularly in regards to consumers gaining autonomy where carers were potentially over-involved, or when consumers didn't want significant engagement of their carers in the rehabilitation process.

SHARED RESIDENTIAL ACCOMMODATION

The prospect of sharing accommodation was a deterring factor for several consumers, particularly when those sharing had different levels of need, personalities and challenging behaviours. At least one consumer is known to have left the service due to problems with house sharing. Despite this, interviews indicated that, when possible, arrangements were made to house people individually until they were comfortable sharing accommodation.

SERVICE INTEGRATION AND COLLABORATIVE PRACTICE

Finding 27: CMHRS is helping to improve and facilitate timely transition from acute care although there is room to improve care coordination with other organisations outside the traditional mental health settings.

Finding 28: Opportunity exists to build on the existing and to establish new links to key services and organisations that offer support for people with a mental illness to live independently.

Finding 29: Links to tertiary education institutions could potentially be used as a rural mental health workforce strategy.

Recommendation 17: It is essential to further embed the person centred approach used by the CMHRHS across all levels of the service, including appropriate representation of consumers and carers on service model design, implementation and evaluation.

Recommendation 18: Establish and strengthen links to the services and organisations identified in the service model and the South Australian Social Inclusion Board's report, 2007.

Recommendation 19: Establish and consolidate links to the tertiary education sector with the view to optimising student placement opportunities and encouraging future rural mental health practice.

The service model envisages the CMHRS establishing linkages and partnerships to facilitate access to services for CMHRS consumers and to ensure coordinated service delivery. Collaboration occurred through appropriate inter-service agreements, mechanisms for shared clients, referral mechanisms and protocols, provision of support to consumers from other services and innovative partnership programs including pooling of resources and expertise.

> *"Overall, what really has been the key is good, transparent communication with consumers and the rehab team, and then between all three of them with the caseworkers as well. Good medical follow-up as well, like with the discharge, get linked up really quickly with the GPs and if they need psychiatric follow-up they get that as well.." (Other Service Provider)*

Evidence suggests the CMHRS is now embedded in the daily operations of the broader mental health services within their respective regions, allowing for effective operation, for example through timely referrals.

Staff overwhelmingly agreed that the transition of consumers from the CMHRS to other services is well managed (93% agreement), and that the transition of consumers from the CMHRS into the community is well managed (86% agreement). Staff also felt that the CMHRS is being effective in enhancing coordination of care planning (93%), and 75% believe the service facilitates a team approach to consumer management.

The majority of staff agreed that the CMHRS helps to improve the transition from acute care, and facilitates early transition from acute care (89% in both instances).

That said, only 57% of CMHRS staff felt care coordination with other organisations is well managed. This is consistent with the findings of the social network analysis (SNA) survey; that information sharing, referrals and care coordination for people with a mental illness in order to support them to

live independently was stronger between and among the traditional mental health services than with education, employment and some non-government organisations. The SNA survey also revealed that CMHRS information sharing with the metropolitan Community Rehabilitation Centres (CRCs) was weak despite the latter having played an important role during the establishment phases of the former and also the fact they were actually exchanging consumers.

The CMHRS service model and the Social Inclusion Board's 2007 report identify the key partnerships that should be established in mental health service delivery, among them; education, employment, drug and alcohol and vocational education (South Australian Social Inclusion Board, 2007a). This is an area, by its own admission and confirmed by the Social Network Analysis, that the CMHRS has not as yet given full attention, having spent the initial year of the program setting up the service. Whilst formal and informal links have been established with key services and organisations, significant work remains to be done to strengthen the established links and to create new relationships with key stakeholders in the government and non-government sectors. The links established to the education and vocational sectors have largely been determined on the basis of consumer need and therefore ad-hoc rather than planned and systematic.

> *"……I think that partnership would've been better developed in the second year, the second half, ... the first priority was implementing that service and getting it up and running and building that foundation." (Service manager)*

There were challenges identified around building necessary linkages with employment opportunities (for consumers) due to lack of employment opportunities in regional locations. However, there was some evidence of collaboration with employment agencies, with one consumer able to continue working while in the CMHRS.

There were also numerous examples of the CMHRS working with NGOs and Housing SA to support consumers to attain and manage housing. That said, Service Managers identified a desire to strengthen relationships with Housing SA to facilitate housing identification and management process for consumers while in the service, and facilitating a quicker transition of consumers into Housing SA properties on discharge from the CMHRS, where appropriate.

Interviewed participants felt that opportunities exist to build on the existing networks that have been established to the tertiary education sector through rural placements hosted by the CMHRS. It was mentioned that opportunities existed to bring in allied health students including occupational therapy, dietetics and exercise physiology students. Rural placements have potential benefit as a rural mental health workforce strategy. Research evidence suggests that rural placements during undergraduate years are associated with rural practice in later years (Kondalsamy-Chennakesavan et al., 2015).

> *"….we were looking at having exercise physiology students involved, for example, in the program and doing that as group sessions and things like that. So, I think some of that physical functioning around exercise, also around diet, there was going to be a much bigger focus on that." (Service manager/policy maker)*

ENABLERS

The multi-disciplinary nature of the CMHRS staff was seen as key to effective service delivery and care coordination.

> *"Having the strong multi D team has been very, very good to support both, you know, the psychologists that can support individuals and the other clinicians, the OT and social workers, that can support individuals, but also put very strong support into care plans and support the learning of the whole team in, you know, that multi-disciplinary discussion." (Service manager)*

Good leadership and management support were also highlighted as strengths of the service and enabling effective care coordination, especially in demonstrating care coordination processes and practices to new and less experienced staff.

BARRIERS

Communication was commonly cited as a barrier to care collaboration, both within the CMHRS team and between the CMHRS and other organisations/practitioners. Only 57% of CMHRS staff agreed that the flow of information with organisations involved in the provision of the CMHRS related services is good.

> *"There wasn't a lot of communicational collaboration when people were actually in the CRS (sic) or exiting the CRS so we actually had to ask for discharge plans for people coming out and there wasn't a lot of clarity… I think probably there needs to be a lot more work done...' (Other Service Provider)*

Several staff members felt a top-down approach taken by some [CMHRS staff] towards care collaboration meant the process was not as consumer-driven as it should be, and therefore not responding sufficiently to individual need.

High levels of staff turnover also created challenges for achieving smooth care coordination, with some consumers consequently having multiple care coordinators over their time with the CMHRS.

The distance of consumers from previously existing service supports and networks, in relation to those who travelled significant distances to access the service in either Mt Gambier or Whyalla, was considered a barrier to effective care coordination and continuation of care between home towns and CMHRS site.

STRENGTHS

Relationships between the CMHRS and other providers were seen overall to be positive and facilitating collaborative practice.

Digital Telehealth Network (DTN), a video conferencing facility that enables consultations, assessments and appointments across two or more teams, supported collaborative link ups with the CMHT, Inpatient Unit and CMHRS around individual consumers. Furthermore, 'Other service providers' greatly appreciated the opportunity to be involved in clinical reviews of consumers whose care they had been/were involved in, and noted visiting consumers while in the CMHRS to maintain relationships.

> *"The systems and processes for collaboration were clearly laid out from the very start of the service, what was required for a client to access the service and what was required for the clinician to make sure that happened." (Other service provider)*

The stepped model of care supported collaborative practices, and transparent communication and collaboration between inpatient unit and the CMHRS, GP's and NGO's is evident. Good clinical handover has assisted with this.

Generic email addresses for CMHRS staff to support contact with the Mt Gambier CMHT have been beneficial, especially when staff are on leave.

There was an example given of how the CMHRS team was able to support other mental health services in the region to provide local options and support to consumers who didn't want to enter the CMHRS.

Strong and open communication between team leaders of the CMHT and CMHRS was considered important. The Whyalla CMHRS has built particularly good links with the local Community Mental Health Team. Co-location of Whyalla CMHRS staff and team leader within the hospital was a key to relationship building:

> ***"The Whyalla team are based in the same building as the mainstream mental health so a bit more of an awareness of rehab and rehab come and sit in intake, well one of the clinicians, so there's a greater working relationship."*** **(Service manager)**

CMHRS staff were considered to be effectively facilitating collaboration and integration. For example, 'Other service providers' interviewed believed that CHMRS staff support integration by working across acute and community to provide a continuum of care to consumers. Informal relationships held by CMHRS staff and staff in other teams were seen to be beneficial to both service providers and consumers in promoting information flow and collaboration. The focus on collaborative practice was seen to have positively influenced relationship building across all levels of care, with formal collaboration building social ties which have further supported the integration of mental health services, discussed particularly in relationship to the Whyalla site.

Carers explained how staff worked to meet the specific needs of consumers and their families, particularly in regards to transitioning out of the CMHRS and across locations. They also appreciated regular feedback from the service, as well as the collaboration between the CMHRS and NGOs in supporting them.

Consumers were aware of organisational collaboration, particularly in regard to discharge and transition to independent housing. They also indicated appreciation that CMHRS staff has liaised with specialists in regard to their care, working together rather than against each other.

AREAS FOR IMPROVEMENT

Staff felt that relationships with other NGOs and services were essential to meeting the needs of consumers, and 75% agreed that the service is promoting partnerships with other relevant organisations. However, a lack of resources and support were seen as barriers.

Other areas where collaborative processes are less evident include:

- assisting consumers in their contact with Government departments
- consumers having to cease contact with NGOs whom they previously received services from during their time with the CMHRS
- improved collaboration and communication around entry and discharge to and from the CMHRS. This includes a lack of sharing of discharge plans and collaborative discharge planning to support transition back to community, as well as sharing of information regarding rehabilitation entry criteria. (Interviews, Service managers, Other service providers)
- communication both to and from the CMHRS and to/from acute units
- knowledge of referring agents of the role and scope of the CMHRS remains a barrier to access

RELATIONSHIPS BETWEEN CLINICAL AND NON-CLINICAL CMHRS STAFF

Finding 30: While the multidisciplinary skill set of staff was seen as a key strength of the service, there is a level of tension between clinical and non-clinical staff, driven largely by role ambiguity and staff feeling disrespected.

Recommendation 20: Meaningful, trusting and respectful relationships should be promoted amongst the CMHRS staff and between the staff and other teams working in adult mental health.

The multidisciplinary nature of the CMHRS staffing complement is a clear strength of the CMHRS, and was acknowledged by all interviewee groups.

The staff survey results showed that lack of role clarity and poor communication during the formative stages of the program led to difficult relationships between the clinical and non-clinical staff. A lack of role clarity has led to both over-involvement and insufficient involvement of certain staff in care coordination. Staff from both 'groups' felt their role is/ they are disrespected, and that the other 'group' does not take their opinions seriously, 'looks-down' on them, and/or makes decisions without their involvement. It was also reported that not all staff are able to attend all meetings regarding consumers whose care they were involved in, impacting effective care coordination, due to both role ambiguity and rostering issues.

> *"… the relationships are good however there has previously been conflict where psycho-social staff have felt that clinical have 'looked down' on them and have not treated them equally." (Survey respondent)*

The situation has reportedly improved due to improved role clarity, mutual respect of each other's role and recognition of the importance of teamwork in a rehabilitation environment.

Some clinical staff involved in CMHRS service provision expressed interest in being more involved in decisions about allocation and discharge, and receiving regular information regarding consumers.

EFFICIENCY

CMHRS REVENUE AND EXPENDITURE

As at 30 September 2015, the total revenue accrued to the CMHRS since it started was $5,047,000 against the total expenditure of $4,565,000 over the same period.

The two CMHRS sites each received an equal annual budget allocation of $2 million. The financial data from CHSALHN showed that during the financial year 2014/2015, Mount Gambier was allocated a budget of $2,023,000 (including revenue from rentals, other grants and fees) and spent $1,841,000 during the same period whilst Whyalla spent $1,986,000 out of a budget of $2,005,000 million.

Revenue from other government grants, recharges relating to occupancy rent and rates and other fees totalled $22,000 for Mount Gambier and $5,000 for Whyalla.

In 2014/15, staff costs constituted the major budget and expenditure item and accounted for 68% of the total expenditure during the first year of operation of the CMHRS. This finding is consistent with the expenditure patterns achieved by the metropolitan CRCs (Barnett et al., 2011).

RESOURCE SHARING

Resource sharing with other mental health services as well as other service providers was seen as contributing cost savings whilst promoting continuity of service and partnership. Regarding staff, it was felt that having access to a consultant that is across the whole service provides a quicker response when consumers are deteriorating, with appointments being scheduled as soon as possible, thus reducing the presentations to ED. For example:

> *"Having the same consultant for the same service… that provides that continuum of care… I mean resource sharing….. that does not impact too much financially"* (Other Service Provider)

One 'Other Service Provider' perceived that training could have been extended to support other key CMHRS partners as part of resource sharing in order to fully embed the rehabilitation concept, given that it was still a novel concept for most of the services and organisations working in adult mental health. This could also have been an ideal avenue to promote and strengthen partnerships as well as promoting the work of the CMHRS. The efficiencies associated with resource sharing would have been gained here.

PAYMENT OF RENT

According to the service model the amount of rent payable in respect of the CMHRS residential accommodation is dependent upon the consumer's income, and for a person on the Disability Support Pension is a maximum of 25% of income plus Commonwealth Rental Subsidy. The rental fee for the CMHRS property may be waived if an individual currently pays rent elsewhere which is equal to or more than social housing rent.

The need to pay rent (if not paying elsewhere) caused some access issues for consumers. It was noted that families who were previously receiving rent money were reluctant to lose this income. While some interviewees felt the amounts of rent charged were 'not realistic' of what consumers

would need to pay on discharge, others noted consumers in other rehabilitation services would not be paying any rent, and that the rates charged by the CMHRS were therefore reasonable.

Having the consumers pay their utility bills would help effect cost savings whilst embedding budgeting skills needed for independent living by the consumers. Regarding waiver of rent payment, it was mentioned during the interviews that the criteria for achieving this was not clearly defined with the result that decisions around waiver were inconsistent.

> *"In terms of the rent, if people have their own place, then they don't pay rent and if they don't, then I think we're only charging kind of housing trust rates anyway. But I guess, compared to being metro CRC (CMHRS) or inpatient rehab where you don't pay anything, I suppose it's different." (Service manager/policy maker)*

Interviews identified process issues around the refunding of overcharged rents, particularly in relation to consumers who were no longer in the service. Reimbursements were reported to take a long time, much to the frustration of the consumers.

LEASE AGREEMENTS WITH CONSUMERS

There are perceived/potential legal weaknesses with the existing lease agreements with consumers. It was suggested that the way they are presently structured may not be legally binding and tenable before the Independent Tenancy Tribunal (ITT). It was reported that the problem may not be unique to the CMHRS but also generalised across most of the supported accommodation provided by human service organisations.

TIME FROM REFERRAL TO ALLOCATION

Finding 31: The average lengths of time between referral and allocation and allocation to actual CMHRS residential stay start date complied with the standards set for the program.

The average length of time from referral to allocation was 8 days in the case of Mount Gambier and 3 days for Whyalla, with a program average of 5 days. The outliers were zero days (same day) and 80 days in the case of Mount Gambier, and zero days and 37 days for Whyalla. The standard was no more than 5 working days or 7 calendar days. This suggests that overall, the standard was met.

TIME FROM REFERRAL TO SERVICE ENTRY

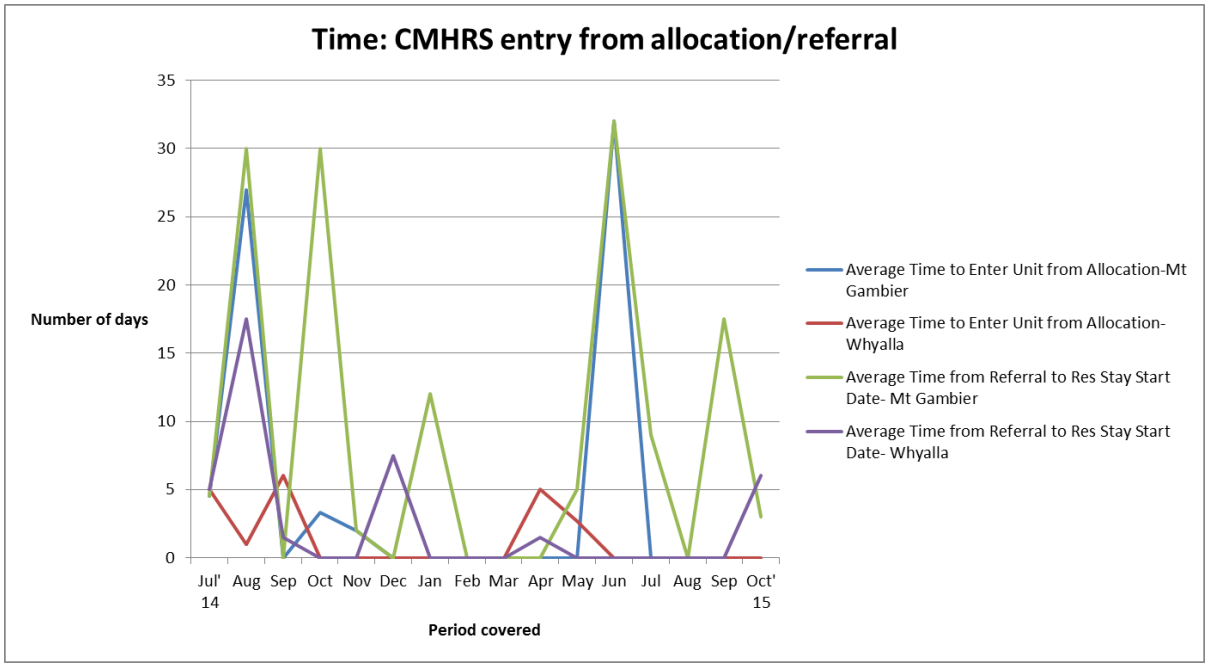
The average length of time from referral to actual CMHRS residential stay start date was 12 days for Mount Gambier and 3 days in the case of Whyalla (program average of 6 days). The shortest time from referral to CMHRS residential stay start date was same day (zero days) and the longest 90 days in Mount Gambier, and zero and 35 days for Whyalla respectively.

TIME FROM ALLOCATION TO SERVICE ENTRY

The average length of time between allocation and actual CMHRS residential stay start date was 4 days for Mount Gambier and 2 days for Whyalla (average 3 days). This ranged from zero days to 32 days in Mount Gambier and zero days to 6 days for Whyalla. The standard of not more than 4

calendar weeks was achieved (Figure 3).

FIGURE 3: TIME: CMHRS ENTRY FROM ALLOCATION/REFERRAL



OCCUPANCY AND LENGTH OF STAY

Finding 32: The occupancy rates were at less than optimal levels, due to challenges with admissions at the establishment stage of the service and some initial issues with the referral process.

On average the CMHRS consumers spent 120 days/4 months in the service, with length of stay (LOS) ranging from 4 to 420 days. Average LOS was 171 days in Mount Gambier and 96 days in Whyalla. This was well within stipulated targets, with the service model indicating a target of between 3 and 9 months average LOS, whilst CHSALHN-MH operates a general target of 6 months or below. That said, there were some extreme outliers. In Mount Gambier, 4 consumers stayed over 300 days, with 2 consumers staying over 1 year.

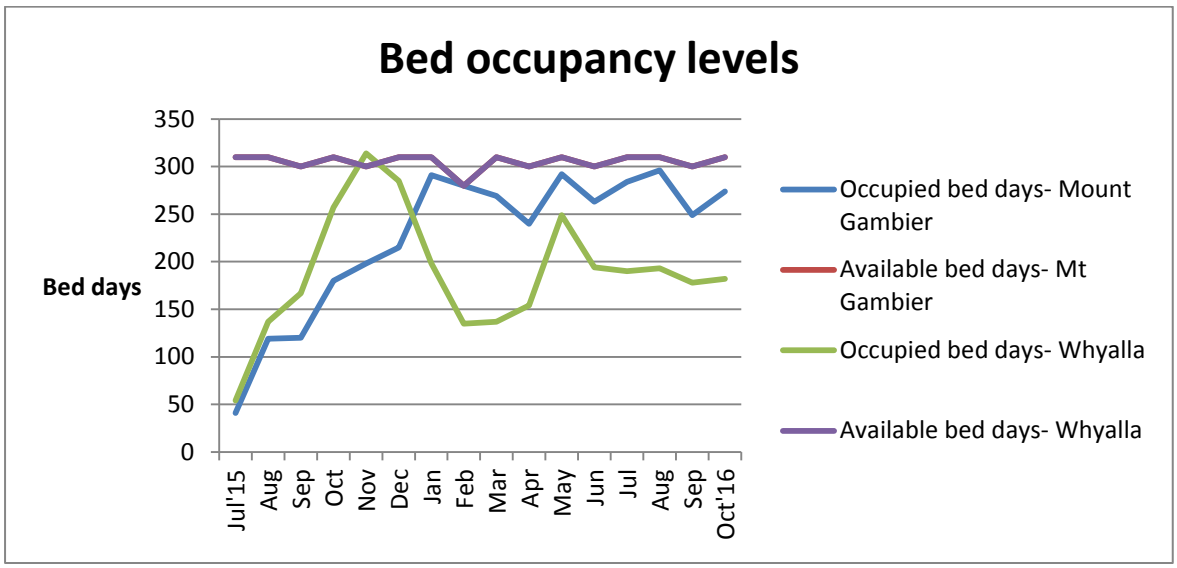
The interviews showed that length of stay was determined by the voluntary nature of CMHRS entry, and demonstration of capacity to live independently. The flexibility demonstrates the CMHRS responsiveness to consumer needs. However, staff of other services in the community and some consumers felt that there was risk of the prolonged stays creating dependency.

> *"I'm not sure if there's been enough focus on supporting people's independence and independent involvement with activities in the community. It's sort of like, you're in the CRS (sic) and so therefore we provide everything for you and then consumers are really at a bit of a loose end when they are in the community, like how is that sustainable for*

them?" (Other Service Provider)

Mount Gambier and Whyalla achieved average monthly occupancy rates of 74% and 62% respectively. The target of 85% occupancy was not met in either site, indicating that the CMHRS residential facilities were not fully utilised. It must be noted that average rates include the earliest months of start-up, when lower occupancy is to be expected. Occupancy levels fluctuated throughout the period under review with the greatest fluctuations being experienced in Whyalla. Interviewees stated that they believe occupancy will increase over time due to increased understanding of the service and visibility of outcomes within the communities (Figure 4).

FIGURE 4: BED OCCUPANCY LEVELS



(Note: The two CMHRS sites have an equivalent number of available bed days and hence are represented by one line above)

INAPPROPRIATE ALLOCATIONS/REFERRALS

Inefficiencies were experienced as a result of inappropriate allocation or referral of some consumers to the CMHRS. (See Appropriateness section for details). Most of these consumers did not stay for long periods of time in the CMHRS and exited early, mostly through unplanned discharge. This suggests the need to formalise the selection criteria used by the allocation committee.

> *"Probably at least three others, where people have been discharged from IMHIUs and probably early into community rehab and then they have not coped and ended up back in hospital and that sort of thing". (Service manager/ policy maker)*

> *"Unplanned discharges… are the one that were referred through the local IMHIUs who were still reasonably acutely unwell and never really engaged." (Service manager/policy maker)*

TENANCY MANAGEMENT

Finding 33: Overall, contractual arrangements regarding property and tenancy management were seen to require improvement, with current arrangements inefficient and unnecessarily complex.

Recommendation 21: Review the existing arrangements for tenancy management of consumers living in CMHRS properties that are outlined in the service model.

Consistent with feedback from interviews with the Service Managers, only 43% of the staff surveyed reported that they were satisfied with the arrangements for tenancy management in relation to residential accommodation. While some positive comments were made regarding the effectiveness of property and tenancy management arrangements, particularly with regard to effective communication between the CMHRS and relevant NGOs and real estate agents, it was commonly noted that the model itself was tedious and inefficient. Managers felt engaging NGO intermediaries to manage the tenancy process was unnecessary, adding cost and complexity. The role of NGOs was seen to be minimal.

> "*What we've found is that the responsiveness of that service at times hasn't met the needs, so there's been times when the team have had some clinical time going directly to the landlord and advocating that." (Service manager)*

Managers felt the CMHRS could handle this component of the service internally.

> "*I think going forward it should maybe be a direct tenancy with the estate agents or something." (Service manager)*

The comments raised in relation to the arrangement suggest a review of the service model.

CO-LOCATION OF MENTAL HEALTH STAFF

One Service manager/policy maker believed there is merit in having a separate location for rehabilitation services within the community. Another felt that in relation to Mount Gambier, co-location with the Community Mental Health Team – a 'mental health hub' - would be a cost benefit in terms of reduction in rentals and possible sharing of staff, including allowing staff to work across teams and systems. Yet another perceived that the CMHT maintaining a three pronged focus on youth, older persons and rehabilitation would create cost savings.

> *"It'd be good to have a mental health hub where you could work altogether... but again that comes down to budget and costs and logistics of moving offsite." (Service Manager)*

ON-CALL SHIFT WORK

As discussed previously, the CMHRS operates a 9:30pm to 7:30am on-call shift unlike the metropolitan CRCs. The mode of operation does not require overnight staff thus ensuring financial savings. All interviewees felt the model was appropriate and efficient.

> *"In comparison to metro CRCs is that we don't have overnight staff and that must be a huge financial saving … overnight staff isn't always required…." (Service Manager)*

COST BENEFIT ANALYSIS

Finding 34: Cost Benefit Analysis and the Social Return on Investment demonstrate that the CMHRS is a worthy investment that is returning every dollar spent on it.

Traditionally, CBA has been used to demonstrate the worth of a project and differs from Cost Effectiveness Analysis (CEA) in that all costs and benefits are given a monetary value.

This health outcome-related Cost benefit analysis (CBA) used information collected from the CHSALHN service utilisation and expenditure data and information collected through the surveys and interviews. It has been built around the outputs and outcomes of the CMHRS as opposed to the purely outcome information, as was used for the Social Return on Investment (SROI).

Monetary values assigned to the costs and benefits have been based on actual expenditure obtained from the CMHRS financial data, and on financial proxies derived from the results of literature searches.

The Discount Rate and Consumer Price Index have been applied to the CBA based on figures obtained from the Government of South Australia websites.

The CBA shows a ratio of 1: 1.12 suggesting that the CMHRS investment is financially viable.

The identified benefits are presented in Table 4 below whilst information showing how the CBA has been calculated appears in Appendix 10.

TABLE 4: CMHRS BENEFITS

Benefits domain	Benefit Description
System impacts	Reduced inpatient readmissions
	Reduced ED presentations
	Reduced psych care days
	Savings on transport/accommodation costs to metro centres -cost to individual/family member/carer
	Carer respite- saving on Carer allowance and Carer payment
Health workforce skills	Improved practice/care
	Staff gain knowledge and skills in mental health rehabilitation
Revenue from rentals	Revenue from leased property being rented out to consumers
Education, Employment, Income	Increased vocational knowledge and skills
	Consumers enrol with TAFE, obtain extra knowledge and skills and become work ready
	Increased employability
	Consumers become employable and become volunteers. Employment is linked with recovery, improved physical and mental wellbeing and social inclusion as well as anti stigmatising behaviour
Independent living and daily living skills	Independent living
	Consumers have access to own rental property
	Consumers attain improved budgeting and self-care skills
	Consumers increase their understanding of the purpose, use and adherence to medication.
Health and wellbeing	Improved mental health
	Consumers achieve stable mental health
	Improved physical health
	Consumers become aware of the importance of physical activity and undertake physical activity on regular basis
	Improved social well being
	Consumers re-establish and establish new connections to parents, siblings, girlfriends; community connectedness and other relationships
	Increased confidence
	Consumers report experiencing an increase in their level of confidence, level of self-esteem, establish control over their lives and achieve set goals

SOCIAL RETURN ON INVESTMENT (SROI)

Social Return on Investment (SROI) was not specifically requested in the evaluation terms of reference. It has been included in this evaluation in order to complement and supplement the CBA findings described above and also due to the increasing use of the framework as a tool to evaluate social impact of mental health interventions. Unlike CBA, SROI relies on outcomes identified in a participatory manner through a workshop involving the evaluation team and a representative from the CHSALHN and later presented in an impact map that uses the theory of change approach (Figure 3).

The analysis and resulting Theory of Change identified that the CMHRS is contributing two key outcomes, namely 1) **independent living** and 2) **improved health and well-being**. These two key outcomes are linked to four strands of:

- Self-confidence, medication adherence and reduced use of alcohol and drugs. Self-confidence impacts on both of the final outcomes through facilitating social inclusion.

- Living skills, which impact primarily on the independent living outcome.

- Education and training, leading to the ability to volunteer or work in paid employment. Being in paid employment or volunteering leads to greater social inclusion and independent living, and has a direct effect on personal well-being.

- Being away from family and friends, which can promote independence and capacity to share with others.

As with CBA, the greatest difficulty and limitation were associated with trying to determine the financial proxies for the outcomes.

An overall SROI of the two rehabilitation services of a ratio of 1:1 has been calculated. This suggests that the social program produces social outcomes greater or similar to cost.

OUTCOMES

SYSTEM IMPACTS

As highlighted above (see Effectiveness section, page 35) informants across all groups perceived, and secondary data confirmed, that the CMHRS has contributed to hospital avoidance, including relapse prevention and a reduction in hospital admission over time. When translated into financial cost, positive changes account for significant saving of government financial resources.

> *"We're catching people before they get in to the really really unwell stage. That's a good use of resources, it avoids admissions." (Other service provider)*

Increasing the capacity of the regional mental health system overall has allowed other services to see new consumers, as existing consumers move into the CMHRS.

> *"The fact is they've actually got into rehab, we've been able to pick up new referrals because that person's freed up a place so we can actually do some more work with somebody else so that's definitely a positive." (Other service provider)*

Other service providers also noted the benefit of the informal relationships developed between staff of the CMHRS with other services, and the contributions this has made to collaborative working practices. The increased number of staff, as well as greater diversity of staff experiences (professional and personal) brought into the regional communities via CMHRS recruitment has been valued by other mental health staff as contributing to the professional culture.

Interviewees described strengthened relationships across different components of the mental health system leading to increased communication which is, in turn, facilitating better flow across services.

The CMHRS has contributed an additional 31.94 FTEs to the mental health sub-sector in country South Australia. This is an important contribution, given staff distribution in the state is often skewed in favour of the urban areas, despite evidence that the burden of disease is likely to be greater in regional areas.

The rehabilitation concept has become more widely understood and appreciated as a key component of the stepped model of mental health care among the mental health services community. Awareness and knowledge sharing was reportedly occurring as part of inter-professional learning between individual staff and also between teams. One interviewee stated that the 'biggest positive effect' was the introduction, through the CMHRS, of a different way of doing things within the traditional mental health services and systems due to its focus on recovery, especially the psychosocial component of the service. The introduction of the new cadre, the community support worker, as part of the team was also perceived as a novel concept.

An increase in the number of mental health staff and specialists in the relevant regional locations has been perceived as benefiting the mental health system as a whole, beyond the CMHRS. For example, resource sharing between teams has reportedly been enhanced; the establishment of the psychologist position within CMHRS has benefited the CMHT which now can access the services of that position in an informal relationship. This has proved beneficial in terms of filling a gap created

by shortage of psychologists in the community.

> *"There's two days a week that the clinical psychologist works for the community team in effect providing psychotherapy to our clients. Which in that sense is very useful because there is a high demand for that and there's not many psychologists in the community that are easily accessible and so cheap of course as well. That's maybe an unplanned side effect." (Other service provider)*

CONSUMER OUTCOMES

The consumer outcomes achieved by the CMHRS have been measured using the mental health assessment measures currently used by CHSALHN-MH, along with interview data.

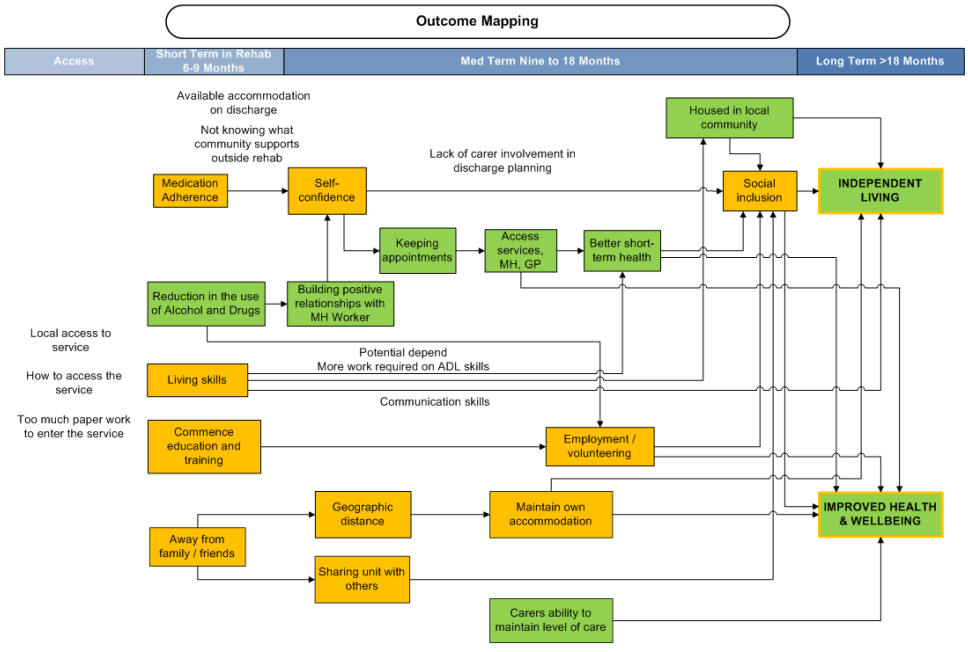
Consumer and carer interviews identified that, overall, the CMHRS has resulted in positive health and wellbeing outcomes for consumers and carers of the service.

> *"I feel more confident that [consumer] has been given an absolute golden opportunity to have been able to do this rehabilitation this year, and so close to [home town], without having to go to Adelaide..." (Carer)*

Throughout the evaluation the consumers and carers interviewed, discussed the numerous outcomes they achieved resulting in their lives having purpose with meaningful relationships and feelings of hope for the future. To demonstrate the value of such outcomes the evaluation undertook a Social Return on Investment (SROI).

The SROI reveals the economic value of social and environmental outcomes creating a holistic perspective on whether the CMHRHS is both beneficial to the consumers, community and environment, and financially viable. Figure 5 highlights the Theory of Change and the golden threads discussed previously on page 59. Further detail can be found in Appendix 12.

FIGURE 5: SROI OUTCOME MAPPING



INDEPENDENT LIVING AND DAILY LIVING SKILLS

Recommendation 22: Establish a systematic approach that is individualised to the consumer which includes the family or significant other in the model of care. This can include family / significant other therapeutic approaches, improved communication on admission, during rehabilitation stay and discharge.

A total of 19 past CMHRS consumers have transitioned into independent living in the community.

Independent living has been enabled by an increase in confidence, a reduction in alcohol and other drug use resulting in reconnection with services, access to own rental property, improved budgeting skills, and increased understanding of the purpose, use and adherence to medication. Other examples of relevant skills gained include regaining driver's licence, using public transport, paying bills, and using EFTPOS facilities.

> *"Now I've actually moved out, live by myself, pay my own bills, have got a girlfriend, I rarely ever have anything very anxious to deal with anymore." (Consumer)*

> *"This consumer was deemed "untreatable" but yet we were able to discharge him to live independently again with numerous strategies that worked when implemented here." (Survey respondent)*

As noted by several consumers, the stability and confidence gained by living in secure accommodation was seen as key to their rehabilitation. In instances where they had previously been homeless this was noted as particularly important:

> *"It gives me a foundation to build on because as long as you're homeless, and you don't have that foundation. By having this foundation I can build upon this. I can go into volunteer work. I can achieve more. I can get my licence sorted out and organise a car for myself. I feel like I can build a life again because it was so demolished only six months ago." (Consumer)*

Numerous consumers interviewed also discussed improvements in activities of daily living e.g. personal hygiene, household chores and cooking skills, caring for animals, learning and improving their organisation skills, and being involved in groups. Learning and maintaining a routine was also key to achievements in other areas.

One carer, however, felt some key aspects of skill development had been missed:

> *"I will say I don't think some bits of it were very good. I don't think they really helped him enough to literally do things on his own, because now I'm finding it difficult for him to actually look after himself. To do the normal things that we do. Dishes and housework and all that." (Carer).*

Very few comments like the above were identified. Feedback from staff did indicate that some carers were reluctant to "let go" to allow the independence to grow by letting their loved one make some mistakes and learn from what they have and have not achieved. At times the carers would intervene and do some of the tasks the consumer hadn't got around to doing that day.

It was identified that more family therapy could be incorporated into the management plan for some consumers (with their consent) with the aim of benefiting both the consumer and carer/s.

HEALTH AND WELLBEING

Although outcomes have been separated under subheadings, **please note** that the outcomes are inherently interconnected. For example, confidence is directly linked to improved relationships and ability/motivation to engage in new activities, training or employment. In many cases, outcomes were dependent on each other, reflecting the benefit of (and need for) holistic approaches to care such as that provided by the CMHRS.

MENTAL AND PHYSICAL HEALTH

Respondents across interviewee groups noted consumers' health and wellbeing improved through participation in groups and exercise activities such as walking, swimming, tennis, and cricket sessions at the gym, facilitated by links to local Non-Government Organisations (NGO).

> *"I am feeling in a good mood, I feel stable and I do feel quite healthy, you know, I've been walking for like four or five days straight days nearly 8,000 steps a day.." (Consumer)*

There is early evidence that some consumers have kept up activities and routines and maintained linkages important to their wellbeing post-discharge.

> *"The peer support worker organised for me to go to [name] the Native Plant Nursery and do some gardening there, and I still do that twice a week for a couple of hours." (Consumer)*

During interviews with consumers a 5-point Likert Scale was used to obtain a cross-sectional (as opposed to before/after) assessment of how consumers rated their health (with 1=Poor and 5=Excellent). Thirteen consumers who participated in the interviews rated their health as being fair to excellent with the average rating being good (3.4 out of 5). The evaluation also used the wellbeing measure to assess the consumers' perception of their life satisfaction, happiness and anxiousness using the Likert Scales (Score 1-10). The consumers positively rated their life satisfaction (mean score 7.5), their life as being worthwhile (8.3) how happy they felt the previous day (7.3) and how anxious they felt the previous day (5.2). Despite the absence of baseline comparable data, this provides an indication of the relatively good state of mind of consumers who were in, and who had exited the service.

Consumers identified a number of enablers to improved health and wellbeing, including:

- consumer and health worker perseverance and commitment to goals,
- a sense of achievement of goals,
- positive relationships with the workers, and
- being treated with respect.

There were several consumers and carers interviewed who felt the service hadn't helped them/ their family member achieve meaningful change. These consumers perceived that lack of support after discharge, and support not being tailored to their unique needs, were key to poor outcomes.

Several consumers felt like their autonomy and preferences as adults were not respected by staff.

This was in regards to, for example, being woken up early, a lack of privacy (both with shared accommodation and with staff entering the premises), and not feeling respected in their preferences despite extensive experience with their own condition.

Several consumers noted that a lack of follow up (despite a phone call) meant it was very easy for them to relapse into previous unwell states and living conditions. It was noted by at least one staff member that a more gradual transition out of the service might be beneficial, and may also help combat 'dependencies' that may have developed. This suggests that arrangements for continuity of care provided by other services may not have been adequate or appropriate.

MENTAL HEALTH OUTCOME MEASURES

Please note: The low number of responses received in regard to the following assessment measures highlights the need for caution when interpreting results.

Finding 35: A strong perception amongst interviewees identified that the tools currently being used to measure health outcomes may not be entirely appropriate for assessing outcomes within a mental health rehabilitation service. It was feared that the actual benefits of the rehabilitation service were being missed and therefore not reported.

Finding 36: Some improvements were seen on the K10, LSP and HoNOs measures, though missing data undermined completeness of the data and reliability of the analysis. Greater severity of mental health condition was correlated with longer stays in the CMHRS and of ED presentations.

Finding 37: Consumers felt by increasing their independence, their ability to manage emotions, communication and interactions, their carers and family members had improved health and wellbeing, reduced levels of stress leading to improved family relationships.

Recommendation 23: Investigate and adopt appropriate tools for measuring health and wellbeing outcomes within a mental health rehabilitation setting.

KESSLER- 10 (K10)

Some improvement occurred on the K10 measure. A higher proportion of consumers rated as 'likely to be well' or 'likely to have a mild mental disorder' on review and discharge compared with on entry to the CMHRS. Of the consumers who provided K10 scores at all the three time points (admission, review and discharge), approximately 20% showed an improvement in their K10 scores (Table 5).

TABLE 5: NUMBER OF CONSUMER SCORES PROVIDED

	No. and percentage of clients for whom scores were recorded		
	Admission	**Review**	**Discharge**
Whyalla N=31	27/87%	15/48%	25/81%
Mt Gambier N=21	14/ 67%	18/86%	5/24%

Tables 6 and 7 show the proportion of consumers who provided K10 scores at each time point, for

whom K10 scores improved, stayed the same or became worse, between admission and review, and between admission and discharge. While about one fifth of consumers showed an improvement in the K10 score, about 80% showed no change between admission and discharge.

TABLE 6: K10 SCORES - TRENDS OVER TIME

	Categories as used by CRUfAD and CPcare (5)			
	1=likely to be well	**2=likely to have a mild mental disorder**	**3=likely to have a moderate mental disorder**	**4=likely to have a severe mental disorder**
Admission (n=32)	31%	13%	13%	44%
Review (n=25)	44%	20%	4%	32%
Discharge (n=18)	50%	17%	6%	28%

TABLE 7: PROPORTIONS OF CONSUMERS FOR WHOM K10 SCORE, INCREASED, DECREASED AND STAYED THE SAME

	Better (%)	**Same (%)**	**Worse (%)**
Admission-review	24	65	12
Admission-discharge	17	83	0

Interesting correlations with Length of stay and Emergency Department presentations were found. The Review K10 score was positively correlated with length of stay (rho=0.30) and Emergency Department presentations during rehabilitation ie. higher mental disorder was associated with longer stay and more ED presentations during stay.

HEALTH AND FUNCTIONAL OUTCOMES: LIFE SKILLS PROFILE (LSP)

It would be expected that consumer scores on the LSP would decrease over time, indicating an improvement in life skills. The LSP categories reported here were created arbitrarily using the item-level categories, so that an aggregate score of:

0 - means that there was no difficulty/problem with any of the subscales

1-4 - is a score that would be attained by someone who would have slight difficulty with between one and all subscales

5-8 - is a score that would be attained by someone who had moderate difficulty on at least one subscale

9 and above - is a score that would be attained by someone who had extreme difficulty on at least one of the sub-scales.

These categories have been created to allow for clear identification of trends.

Initial analyses do show an indication of movement from more extreme problem categories to less severe problems over time. For example, there was a reduction by 13 percentage points in the number of consumers rating in the "extreme problem" category from review to discharge, and an increase by 27 percentage points in the number of consumers rated as having "no problem" from review to discharge (Table 8).

Table 8: LSP scores, Trends across time

	LSP Categories			
	0=no problem	**1-4=slight problem**	**5-8=medium problem**	**9-30=extreme problem**
Review (n=33)	3%	9%	18%	70%
Discharge (n=30)	30%	0%	13%	57%

However, when only consumers who provided data at review and discharge are considered, the majority (69%) showed no change, while 13% improved and 19% reported poorer life skills on discharge.

Note: Zero scores are a legitimate total score on this tool, yet they can also be used to indicate that a measurement was not completed/valid/whole. The number of zero scores recorded on review and discharge was relatively low (1 and 5 at each time point, respectively) and we therefore do not anticipate a considerable skew in the data in this case.

There were interesting correlations between discharge LSP and Length of stay. Length of stay was significantly correlated with discharge LSP (rho = 0.38), indicating that longer stay was associated with poorer aggregated life skills at discharge. This might be seen as a surprising result.

Analysis was also conducted at the subscale level of the LSP: self-care; antisocial behaviour; withdrawal; and compliance. Clients with valid scores on the LSP from at least two time points were included in this analysis (n=37). For each client, the change in the LSP score between time points was calculated. Where the LSP score was available at more than two time points, the largest difference between time points was used. This overall change score was correlated with changes in the subscales using the corresponding time point data.

At the sub-scale level, the largest decrease in score (and therefore improvement), was seen with self-care, while negligible change was seen with anti-social behaviour. Correlations between total LSP change and sub-scale changes were all highly significant, indicating that all sub-scales contributed to the improvement in LSP. While limited sample size suggests caution in interpreting deeper level analyses, a comparison of correlation coefficients suggest that change in the withdrawal subscale was most strongly correlated with overall LSP change, while compliance was the least correlated.

It is promising to see the biggest change occurring in the area of self-care, given the focus of the CMHRS on this component of living and life skills. The analysis highlights the importance of considering sub-scales and not only aggregate scores to assess changes in 'mental health'. Most

scales, when developed, are not intended for (effective) aggregated use, despite the reliance on such (aggregated) scores in many organisational settings.

HEALTH AND FUNCTIONAL OUTCOMES: HEALTH OF THE NATION OUTCOMES SCALE (HONOS)

It is expected that discharge HoNOS scores would be lower than scores obtained at admission, reflecting lower levels of mental health-related symptoms and dysfunction.

A trend indicating some improvement between admission and discharge is evidenced in Table 9, with fewer consumers rated as 'moderately severe' and more consumers rated as 'subclinical' on discharge compared with at admission. Clinically significant HoNOS change (a decrease of 8 points; (Parabiaghi et al., 2005) was seen in only 3 out of 25 consumers between admission and review, and 2 out of 24 from admission to discharge (Table 9).

Table 9: HoNOS scores over time

	HoNOS categories			
	<7 Subclinical	**7-9 Mild**	**10-15 Moderately severe**	**>16 Very severe**
Admission (n=41)	20%	7%	37%	37%
Review (n=33)	24%	33%	21%	21%
Discharge (n=30)	33%	10%	20%	37%

Table 10 shows the proportion of consumers who provided HoNOS scores at each time point, for whom HoNOS scores improved, stayed the same or became worse, between admission and review, and between admission and discharge. While about one third of consumers showed an improvement in the HoNOS score, about one half showed no change between admission and discharge, while nearly one fifth reported a worse outcome at discharge compared with admission.

Table 10: Proportions of consumers for whom HoNOS score increased, decreased and stayed the same

	better (%)	**same (%)**	**worse (%)**
Admission-review	36	24	40
Admission-discharge	29	54	17

Again, there were interesting correlations with Length of stay and Emergency Department presentations. The admission HoNOS score was negatively correlated with length of stay (rho=-0.40), indicating that consumers with more severe symptoms at admission stayed longer in rehabilitation. There was a significant, positive correlation (rho=0.41) between HoNOS score at review and Emergency Department presentations during rehabilitation ie. a more severe disorder was

associated with more ED presentations during stay.

APPROPRIATENESS OF MEASUREMENT TOOLS

Some interviewees and staff perceived that the tools used by the CMHRS to measure health outcomes were not entirely appropriate for assessing outcomes within a mental health rehabilitation environment. Concerns raised, questioned if the actual benefits of the rehabilitation service were being missed and therefore not reported. To that end, the CCCME system reportedly does not capture most of the activities provided by the program and are therefore not reported. Some staff questioned the relevance of the NOCC suite of tools as a measure of the state of mental health in an environment that emphasises functional outcomes and independence.

The Australian Mental Health Outcomes and Classification Network (AMHOCN) talks about the use of outcome measures as an attempt "*to measure whether a change has occurred for a consumer as a result of mental health care. By using a range of outcome measures, consumers and clinicians can work together to map the journey of recovery over time*". Rehabilitation is a key component of the step system of care and part of the continuum of care which incorporates self-determination, clinical and psychosocial care. Within a person centred framework of practice incorporating rehabilitation from the start of the consumer's journey is essential. To that end and to maintain the continuum of care at a system level, consistency in the measurement tools used is required; currently in Australia the NOCC tools are the ones used to measure consumer outcomes.

It was understood during the interviews with the service managers that some locally developed tools based on occupational therapy were being trialled by the service. This work should continue based on the available best practice in Australia and internationally. Information sharing could also be done with the metropolitan CRCs where the Assessment of Motor and Process Skills (AMPS) and the Occupational Self-Assessment (OSA) tools were being used (Barnett et al., 2011).

> *"….. we need to use some…….. specific occupational therapy measures as an outcome, but I think again that could probably be developed further going forward and use specific outcome measures that ….. would measure the benefits of a rehab program more effectively than…… whatever that we currently use." (Service manager/policy maker)*

The Mental Health Council of Australia through their Activity Based Funding and Mental Health Issues Paper (2012) identified that '*the Health of the Nation Outcome Scales (HoNOS) and other mental health outcome measures have well documented measurement problems and continue to be regarded with some scepticism by many professionals and consumers due to the broad nature of the scales'* (Mental Health Council of Australia, 2012)(p 12)

Indeed the Independent Hospital Pricing Authority (IPHA) acknowledge some issues with the availability of subacute care data with both clinical variables and costing information, and identified that some data such as the Functional Independence Measure scores (used to measure behaviour from dependent to independent) is not currently captured. (IHPA, 2016) (p17)**.** To address these issues the IPHA will be developing and reviewing appropriate Australian Mental Health Care Classification for activity funding after July 2017, in the meantime non admitted services will remain block funded.

TRAINING, EMPLOYMENT AND VOLUNTEERING

Over half of consumers interviewed discussed their involvement in training, and several spoke of applying for jobs.

> *"I've been confident enough to be applying for jobs, I've been applying for jobs over the last month." (Consumer)*

Feedback from service managers indicates that 3 consumers have completed a TAFE course and a further 7 are currently enrolled at TAFE. Furthermore, two past consumers gained employment and two are participating in voluntary work.

CONSUMER CONFIDENCE

Improved confidence and self-esteem emerged as key outcomes for consumers, discussed by consumers and carers alike. Improved confidence was linked by interviewees to outcomes in a number of other areas including daily living skills such as going out to do grocery shopping, relationship building, participation in employment and training, maintaining a household, and "happiness".

> *"From when he left here to when he finished with them, we believe that it has helped him a great deal. In confidence and just probably realising that he can do things. But we would say the confidence mostly. He's got, gained a lot more confidence." (Carer)*

For a person and their carer, who live daily with complex mental health issues, to recognise they have gained confidence and improved their self-esteem is a significant step forward and in line with recovery oriented practice. The SA Health Framework for recovery-oriented rehabilitation in mental health care focuses on the individuals' unique strengths, resilience and capacity to grow and change. Furthermore it recognises that each individual owns their own recovery, however mental health rehabilitation services that are recovery-oriented play an important role in creating environments that facilitate and support a person's own personal recovery journey (SA Health, 2012).

Having improved confidence and self-esteem emerging as a key outcome for consumers in a service that, at the time of evaluation, has been functioning for 18 months demonstrates this service has the foundations and qualities in line with the Framework for recovery-oriented rehabilitation mental health care (SA Health, 2012). Furthermore these emerging outcomes are the foundations on which a person can move forward in life and further build their resilience and independence.

> *"This is actually rehab, the rehab services shone a light on the fact that there's a different way of facilitating people's recovery. So I think that's the biggest positive effect." (Service manager/ policy maker)*

RELATIONSHIPS AND SOCIALISING

Improved interpersonal skills and the building/re-building of relationships with family and friends were raised as key wellbeing outcomes for consumers and carers.

A number of consumers and carers discussed being re-united and rebuilding relationships with family and carers, friends and other CMHRS consumers.

> *"I'm seeing my father and other brother in about three months from now, we're having dinner together. I haven't seen either of them for six years. So we are getting the family back together". (Consumer)*

Interviews indicate that other outcomes, such as medication adherence and ability to maintain a tidy household, helped to facilitate reconnection with family, who were encouraged by such improvements. As one carer noted:

> *"As in terms of us all going loopy, yeah. It probably saved us as a family… If [consumer] didn't go in to that system, well, we probably would be going separate ways by now. Yeah. So it was a rescue, I suppose, which was really appreciated." (Carer)*

CARER AND FAMILY OUTCOMES

Beyond the strengthening of relationships, carers felt the CMHRS benefited their lives in a number of ways. They discussed receiving information on carer support groups and services, and getting respite and stress alleviation by being relieved of the need to provide daily transport assistance to appointments and rehabilitation.

> *"I feel like I've got somebody I can talk to and go to." (Carer)*

> *"It's been good to finally take a back seat for a change…." (Carer)*

A number of consumers felt their family members had benefited from improved health and wellbeing as a result of reduced stress due to lower levels of consumer dependence on carer and family support, increased respite and reduced burden of care whilst consumers were part of the CMHRS. Some carers talked about improved communication largely due to behavioural and emotional changes in consumers leading to more pleasant engagement among families. Consumers also spoke of wider benefits among family members. One spoke of having been able to help other family members suffering from mental health issues by offering strategies learnt in the CMHRS. Another discussed reduced stress in the wider family:

> *"My sister I can see a big difference in…. Because she never used to agree with any of my stress levels or things like that towards my parents. But now that I have stopped being so snappy and grumpy and even though I had an excuse for all of it, even since I've stopped being all grumpy and snappy and that, I can see a big difference in my sister because she's calmed down a lot now as well." (Consumer)*

As one service manager described:

"We're certainly building some independence and some resilience for the consumer which has a direct impact on the carer, because they're not having to go in and rescue all the time." (Service manager/policy maker)

Service managers and staff also felt carers were more equipped with information and strategies to support consumers' ongoing rehabilitation and mental health support needs. The CMHRS experience reportedly had a knock-on effect on the mental health of persons other than the consumer. One consumer reported sharing his knowledge with his agoraphobic brother who has since turned his life around and established new positive relationships.

A potentially unanticipated consequence on carers of family members entering the service was loss of income in the form of the carer pension. This issue was raised by one carer and one consumer during the interviews. In at least one case the income was not reduced immediately on entry to the CMHRS, but family members nevertheless felt stressed by the meaningful loss of income.

SUSTAINABILITY

CONTINUATION OF THE CMHRS

Finding 38: There is general strong sentiment that the CMHRS continues to support mental health service consumers to live independently.

Finding 39: Murray Bridge has been suggested as the logical third site of the CMHRS should it be decided to expand or replicate the program in other parts of regional South Australia.

Recommendation 24: Investigate the adoption of a partnership model with an NGO or private provider who provides a supported housing model where consumers are placed in appropriate end-point housing with the provision of intensive specialist mental health rehabilitation services. End-point housing can be houses or units, public or private, and with or without other like-consumers.

Extensive feedback was provided in relation to the need for the continuation of the CMHRS. Service Managers, Other service providers, consumers, carers and staff alike felt the continuation of the program was crucial, after taking into account its demonstrated benefits to-date, the implications non-funding would have on the mental health system and on the health of the consumers, carers and the local communities. One 'Other service provider' noted that there was already general shortage of rehabilitation services in regional areas whilst another emphasised the need to ensure equitable distribution of services between metropolitan and country areas.

> *"Re-admission rates would go through the roof!" (Other Service Provider)*

> *"We certainly can't afford to lose programs like this rehabilitation program. It should really be the lynchpin; it should be there for everyone who has to transition from acute care to community life." (Carer)*

Interviewees were asked about future funding of the CMHRS, to which there was an overwhelming positive response indicating that the service should continue, with some being quite passionate about why the government support should be continued. Of 29 interviewees who made a comment about future funding, 93% are lobbying/supportive of future funding of the service, with the remaining two interviewees not being against it, but rather questioning how the service can operate without the funding.

Comments included such issues as equity between country and metro, how this program should expand and become a national program, and how previous mental health services had not been responsive to need, for example:

> *"… (Consumer) has been in hospital five times in the last two years and each time it was for a week. He was still psychotic when he was discharged, with no supports in place. What's the point of a revolving door? It doesn't do anything for anybody*." [Carer]

> *"The rehab services have got to stay because if you take that away from us, ... that they're going to have to go onto a very long waiting list and go down to Adelaide, and invariably they'll not go. They'll just say no, it's too far, or my family can't come and visit, or there's no access". (SNA survey respondent).*

A key point made was around the expectations of the two communities where the CMHRS have been established. There was a theme around community backlash. The new service has created options for country consumers, which if terminated, were likely to create a backlash in the community.

There is also a perception that if the CMHRS is not funded, this will place extra stress onto metropolitan services.

As well as this, CHSALHN (MH) will have some employees across the two sites that will either be made redundant or will be redeployed, causing some disruption as there are many who have relocated to country positions. This would go against the recruitment and retention of workforce in country areas.

The positive findings of the evaluation show that if funding of the service ceased it would create a further disadvantage for people who live with mental illness in country areas of South Australia. Even though the prevalence of a diagnosed mental health condition in regional areas is similar to metropolitan areas, the absence of the rehabilitation step in the stepped system of care means mental health consumers in rural areas are deprived of the opportunity for an improved quality of life. Further to this, consumers of mental health services would be exposed to the risk of increased hospital admissions, readmissions and emergency department presentations.

In light of the current risk to continuation of funding and the positive findings of the evaluation an opportunity presents to consider investigating a public private / NGO partnership model of care. The literature and policies as discussed throughout the report are strong on working in partnership. Consideration should be given to partnering up with a Supported Residential Facility (SRF) or an NGO to adopt a supported housing model where consumers are placed in appropriate end-point housing providing intensive supported accommodation which includes the regular living support, meals, and related requirements. End-point housing can be houses or units, public or private, and with or without other like-consumers. The local mental health service would be responsible for the intensive clinical, therapeutic and specialised rehabilitation services required to meet the consumer's needs. This model would require a high level of care coordination with the consumer being at the centre of the care and all relevant care providers linked into the program, like general practice, non-government services, family and carers, SRF staff and social networks. There are some Commonwealth funded programs currently in place and emerging that would support such a model, for example Partners in Recovery and the National Disability Insurance Scheme.

EXPANSION/REPLICATION OF CMHRS IN OTHER AREAS

Possible areas for expansion and/or replication of the CMHRS model were proffered. Murray Bridge was seen as the most logical and popular choice due to its capacity to cater for populations in rural and outer metropolitan Adelaide areas including the Riverland and Murray Mallee populations. The other less frequently mentioned site was Port Pirie. The choice of a third site would ensure good geographical spread of the rehabilitation services in country areas.

CONSUMER/CARER CHANGES MAINTAINED

There have been numerous positive outcomes for the consumers themselves as well as carers. The changes that have been maintained by some consumers were reported as being attitudinal, behavioural and habitual changes that they achieved during their stay with the CMHRS. One consumer reported that they stopped using drugs, another regularly maintains and uses a weekly activity planner whilst yet another has improved their medication adherence. Two consumers reported maintaining good eating habits by doing their own cooking and routinely maintaining self-care. Mental stability, volunteering, doing shopping, paying bills and household cleaning were some of the things consumers reported having maintained. Several consumers reported maintaining improvements in their self-esteem. The knowledge and skills gained by the consumers are likely to endure for some time to come; thus ensuring that they remain on the recovery path.

> *"I feel confident that I should be able to step back and know that I don't need to be tapping [name] on the shoulder or ringing him or knocking on his door, saying, you need to do your washing today, for instance.* (Carer)

> *"Yeah I've probably been able to stick to a routine whereas I had no routine beforehand, and eating a lot better, and probably looking after myself a lot better, you know, as far as showering goes and so on." (Consumer)*

CONCLUSION

A key feature of the CMHRS is the focus on the consumer and the recognition that the consumer is in charge of their own destiny. The most important stakeholders of the mental health system are the consumers, their families and carers. Without the past and potential consumers as users of the service the mental health system wouldn't exist. As found in this evaluation the consumers of the service achieved significant outcomes ranging from improved organisational skills to independent living, adult education and voluntary or some form of employment. Families and carers also play a significant role in assisting consumers to recover and live well in the community, reducing episodes of acute illness and the need for hospital admission. Staff acknowledged that there was an important role for families/carers, along with a role for the service in better connecting with families and carers in assisting them to understand and be supportive of the service.

This evaluation identified there is opportunity to improve family and carer involvement in the provision of the service particularly in regards to communication as the lack of such resulted in a breakdown in relationships and communication between family members for some consumers. Carer involvement is crucial given the financial benefits of informal care to the Australian economy.

Throughout this report and the available literature including government policies there is an agreement for need of a stepped system of care and that services should be provided as close to a person's home as possible. The evaluation found that the CMHRS is a unique and vital component of the stepped system of mental health care in country South Australia. The model of care focused on establishing independent living skills, increasing self-confidence and the consumer's ability to actually live independently and have a purpose in society, which has resulted in several consumers of the service transitioning into independent living.

The implementation of the program has generally been consistent with the service model. Different housing models are being used in Mount Gambier and Whyalla. The 'clustered' housing model in Whyalla was identified as the preferred over the geographically dispersed model in Mount Gambier. The program is reaching its target group including a good representation of Aboriginal consumers, although the inclusion of CALD groups and people with other disabilities requires further work.

The in-reach service being offered in Mount Gambier is not part of the original CMHRS service model, however was tried by the Mount Gambier team as another option for providing the service, with some staff and managers highlighting some concerns for example time and resources required visiting various locations and decreased ability to influence consumers to change behaviour. From a clinical point of view there are a range of possibilities that could be investigated to further develop the in-reach model, for example the use of Digital Tele health Network (DTN) providing virtual visits could decrease the need for travel. Interestingly consumer research affirms a preference for a supported housing recovery approach compared with residential rehabilitation (Victorian Government, 2012). To that end there is an opportunity in light of current funding issues for CHSA Mental Health to investigate appropriate end-point housing models which can be houses, units, public or private, and with or without other like-consumers with intensive or otherwise clinical rehabilitation in-reach provided by the specialist mental health service as per recommendation 24.

The 24 hour roster, inclusive of the 'on call night shift', is perceived as being appropriate. Opportunity exists to build and expand links to other services and organisations especially those outside the traditional mental health services.

The service has met a number of the recommendations from the *Stepping Up – A Social Inclusion Action Plan for Mental Health Reform 2007 – 2012* report especially recommendation 15 which states that Mental Health services must establish a focus on people with chronic conditions and complex needs, adopt a joined up approach and provide services close to where people live. Furthermore, the CMHRS, being the inaugural rehabilitation service for Country SA mental health consumers, is providing a service that is preventing some of these Australians in rural communities from falling through the gap and addressing the concerns raised in relation to the National Mental Health Commission's Review of Mental Health Programme and Services (Department of Health and Ageing, 2015).

Finally the evaluation has established that despite a number of implementation issues and time pressures to ensure the service opened and had "*consumers in the beds*" on the 1 July 2014, the CMHRS has met its objectives and the consumers of the service have attained gains in mental, physical and social health and wellbeing. Full credit is attributed to the CHMRS teams on the ground and the consumers who participated in the program to achieve these significant outcomes.

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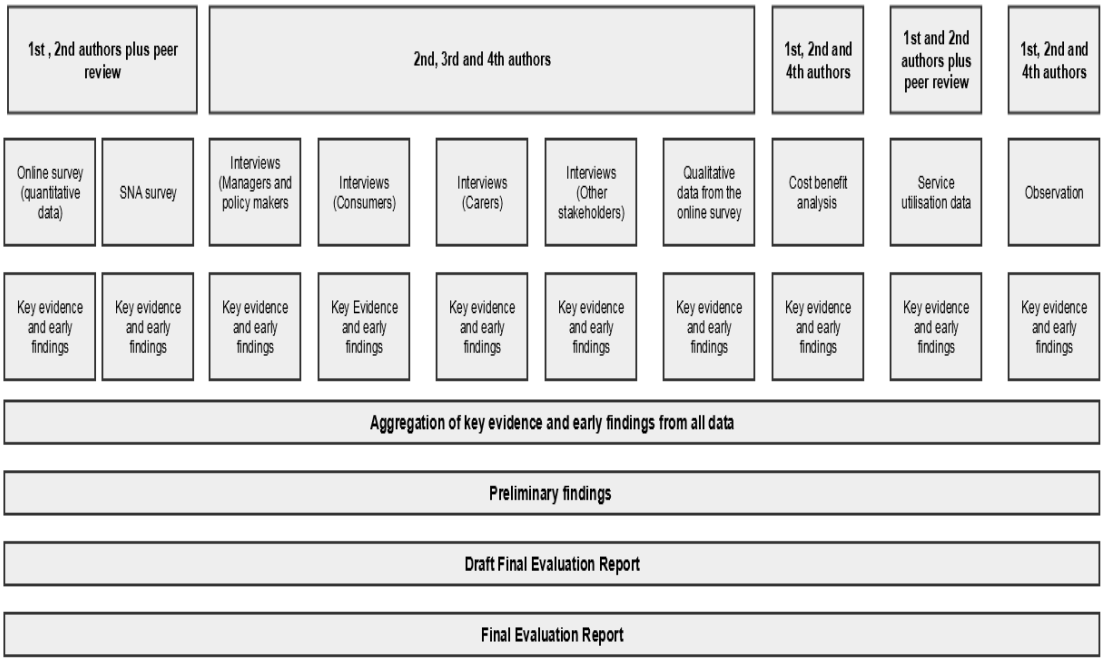
APPENDIX 1. DATA ANALYSIS CHART



APPENDIX 2. GOVERNANCE ARRANGEMENTS

Steering Committee

The implementation of the CMHRS is overseen and guided by a 12 member Steering Committee which provides overall policy and operational, but not clinical, oversight. The Committee oversees and provides guidance on the workforce, budgets and Client Management Engine (CME) activity data in order to ensure consistency of service and fidelity with the Service model. It considers issues arising from the two sites and presented by the Team Leaders.

CMHRS Steering Committee
• Manager Operations/ Director of Nursing • Network Manager, Riverland/South East • Network Manager, North/West • Network Senior Clinician , North/West • Network Senior Clinician , Riverland/South East • Allied Health Clinical Lead • Data representative • Network Manager Rural and Remote • Community Mental Health Team Representative • Team Leader, Whyalla CMHRS • Team Leader, Mount Gambier CMHRS • CMHRS Project Officer

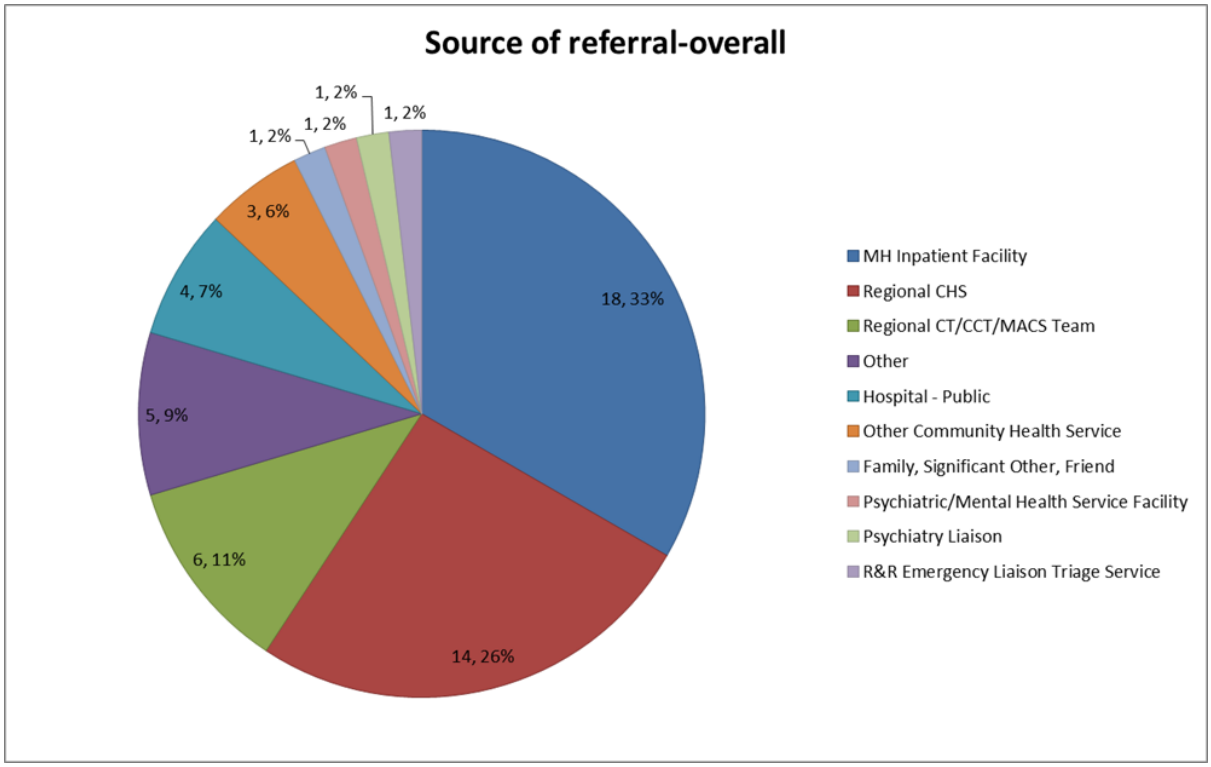
Allocation Committee

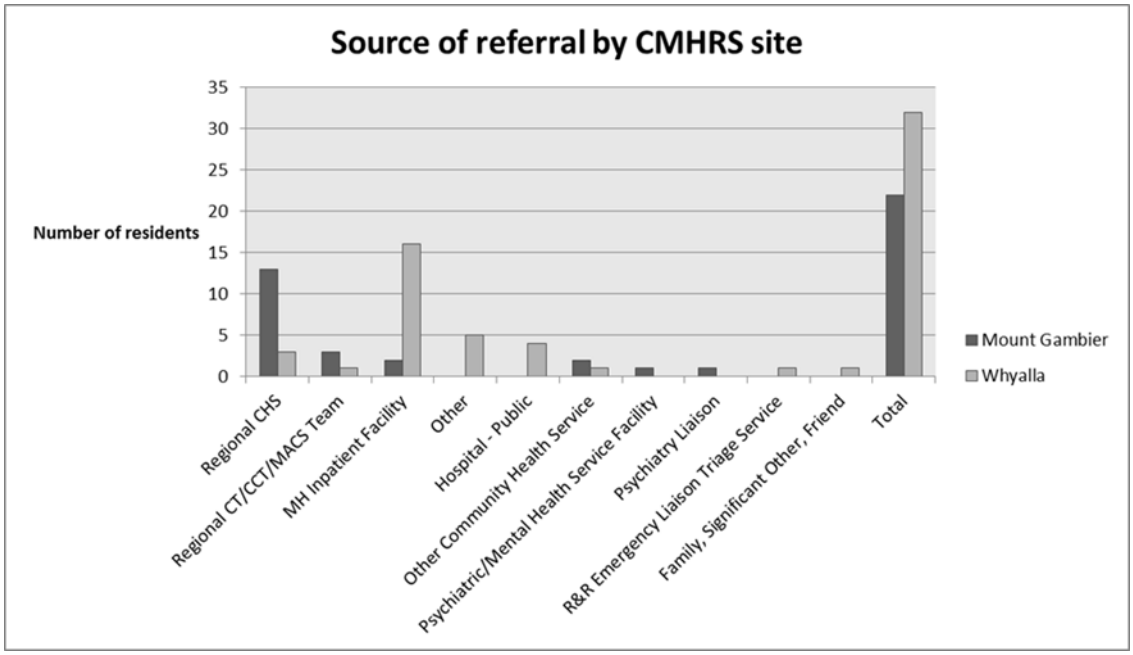
The Allocation Committee assesses and prioritises referrals to the CMHRS using an agreed set of criteria that is closely aligned with the Service Model and caters as a tool to ensure consistency of decision making. The membership of the Allocation Committee includes:

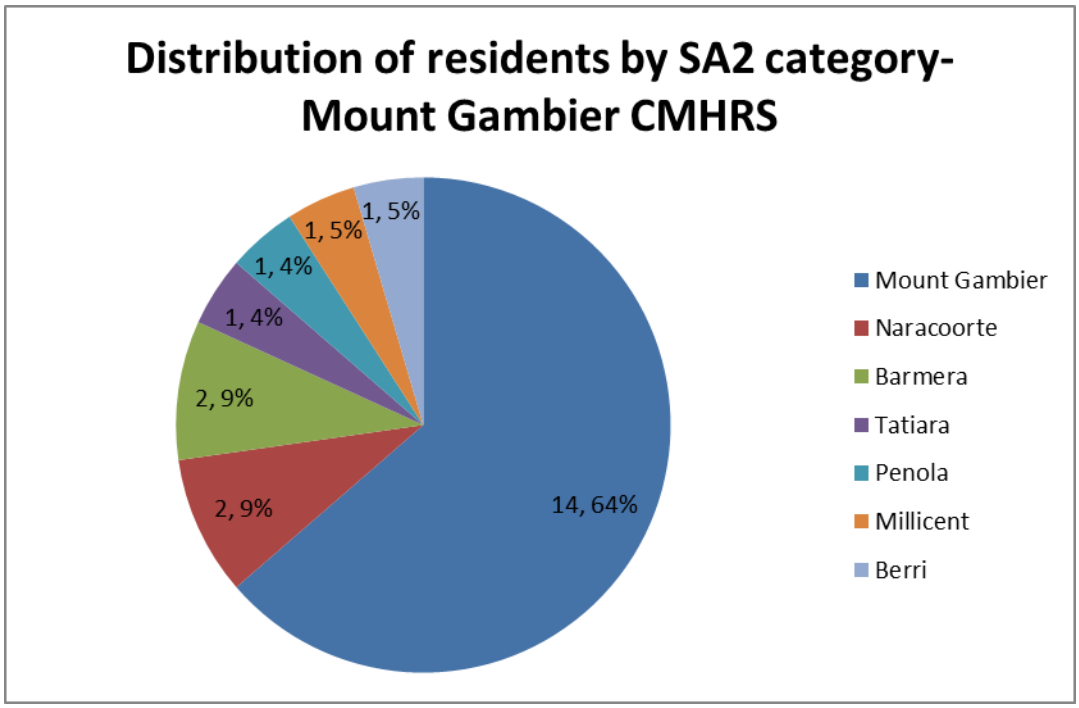
- Clinical Director, Rural and Remote
- Allied Health Clinical Lead
- Network Manager, Rural and Remote
- Network Senior Clinician Riverland/South East
- Network Senior Clinician North/West
- CMHRS Team Leader, Whyalla
- CMHRS Team Leader, Mount Gambier
- CMHRS Project Officer

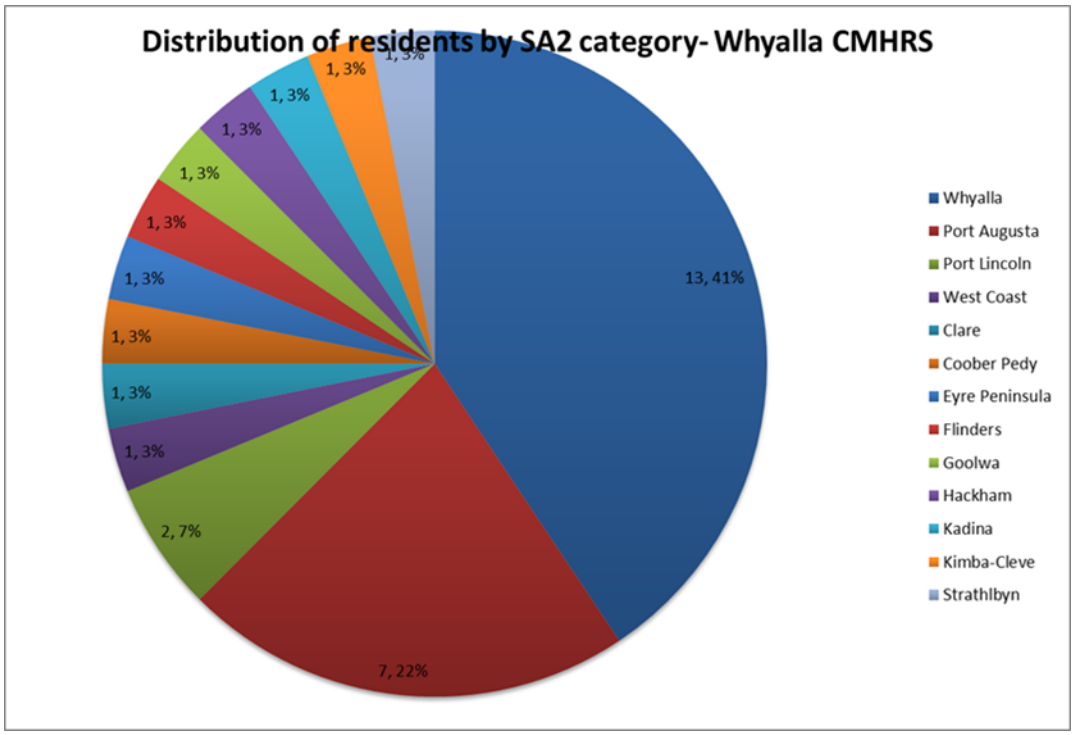
CMHRS Eligibility criteria
• with a primary diagnosis of a mental illness • aged 18-65 years old but can be older or younger • with a functional disability and require rehabilitation • able to be case-managed by CMHT • with an identified need for skills development • with identifiable rehabilitation goals • showing demonstrated motivation to change and work on their goals • with severity of illness requires a high level of support but not hospital admission

APPENDIX 3. REFERRAL SOURCES






Distribution of residents by SA2 category- Mount Gambier CMHRS
14, 64%
2, 9%
2, 9%
1, 4%
1, 4%
1, 5%
1, 5%
Mount Gambier
Naracoorte
Barmera
Tatiara
Penola
Millicent
Berri


Distribution of residents by SA2 category- Whyalla CMHRS
13, 41%
7, 22%
2, 7%
1, 3%
1, 3%
1, 3%
1, 3%
1, 3%
1, 3%
1, 3%
1, 3%
1, 3%
1, 3%
Whyalla
Port Augusta
Port Lincoln
West Coast
Clare
Coober Pedy
Eyre Peninsula
Flinders
Goolwa
Hackham
Kadina
Kimba-Cleve
Strathlbyn

APPENDIX 4. CONSUMER JOURNEY THROUGH THE CMHRS

The mental health consumer journey through the CMHRS starts with a referral by a mental health service provider which in terms of the Service Model can either be a Community Mental Health Teams (CMHT), Acute care (IMHIU, R&R), Metropolitan CRCs or the Glenside Inpatient Rehabilitation. Referrals can also be initiated by Private Psychiatrists, General Practitioners, Non-Government Organisations, Aboriginal Community Controlled Health Organisations or individual consumers wishing to self-refer although they can only do so through their local Community Mental Health Team.

The referrals are presented to the Allocation Committee following preliminary assessment by the respective Team Leader in order to gather information that will assist in determining the level and type of treatment and support required. The Allocation Committee either approves or rejects a referral based on set selection criteria.

The consumer and the referral agent are informed of the outcome and admission arranged. The time allowed between referral of the consumer and allocation is up to 5 working/ 7 calendar days. Upon approval of a referral and subject to availability of a bed, the consumer either enters the CMHRS or is placed on a waiting list. The time allowed from allocation to entry into a residential unit is up to 4 calendar weeks. This is organised with the consumer and referral agent based on individual requirements.

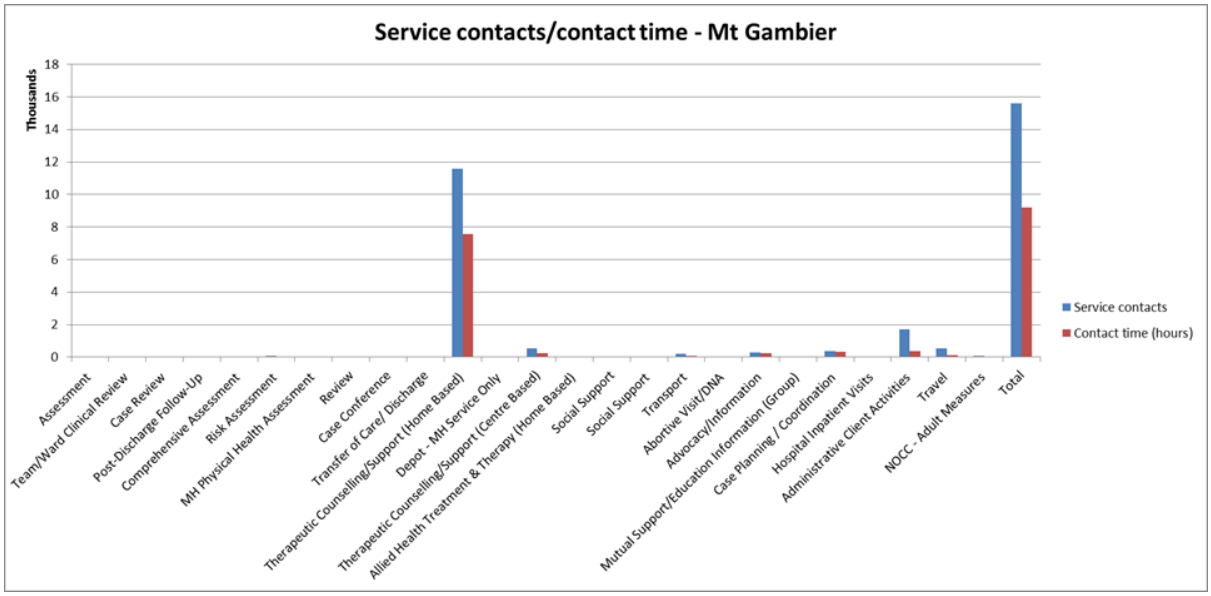
Entry into the CMHRS is voluntary and involves living in residential accommodation, with each house capable pf being occupied by 1-2 people.

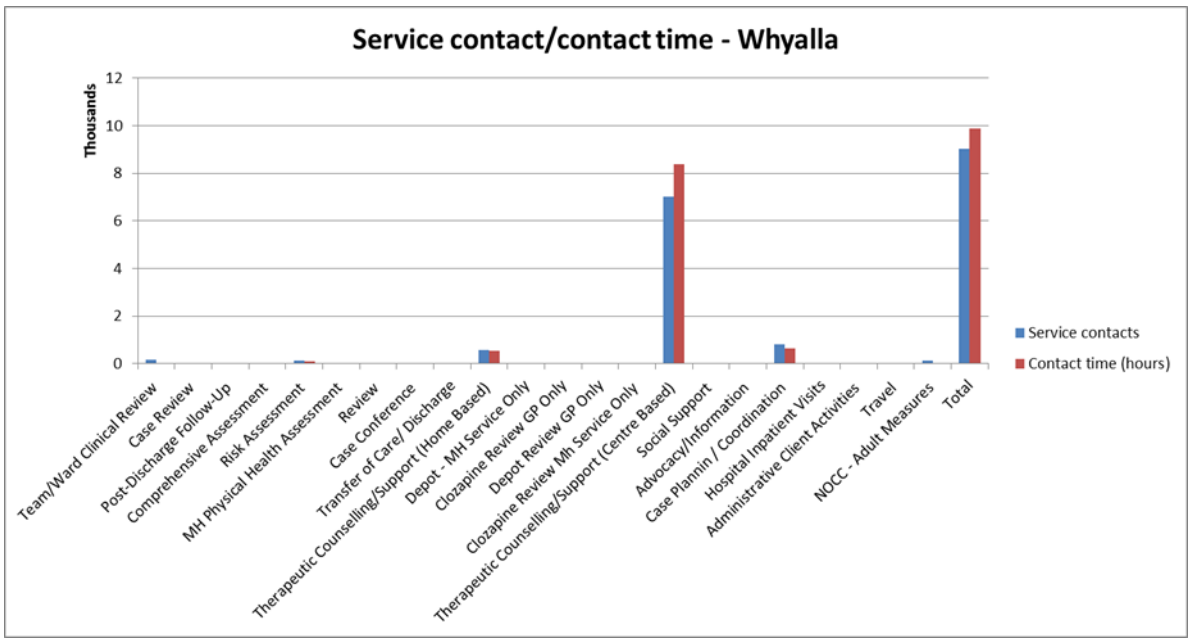
Once within the service, the consumers undergo a two-week trial period during which consumers familiarise with the CMHRS objectives and clarify the goals they wish to achieve and the steps required to achieve those goals. Goals may relate to employment, education, managing their mental illness, relationships and other lifestyle issues. If the two week trial is successful consumers then sign a tenancy agreement with the respective Non-Government Organisation (NGO). Consumers can opt out of the CMHRS at any stage and they can also enter the service more than once.

At the expiration of the trial period, the consumers commence the rehabilitation process involving them working alongside the CMHRS and other agency staff and consumers to achieve the goals that they have set for themselves.

Residential stay can last between 6 to 9 months with some consumers requiring a longer period to complete their rehabilitation journey. Discharge is planned with the CMHT and the consumer is discharged and transfer of care effected with the relevant service. Post discharge follow up is undertaken by the CMHRS staff within 7 days after which period the CMHRS support ceases.

APPENDIX 5. SERVICE CONTACTS/CONTACT TIME





APPENDIX 6. LIST OF OPERATIONAL GUIDELINES AND PROCEDURES DEVELOPED

Access & Entry - Phase 1 Rehabilitation Process	Food Hygiene	Staff visits
Assessment and Rehabilitation Plan - Phase 2 Rehabilitation Process	Overnight procedure	Shift Handover
Deteriorating patient - mental health	Referral chart	Transition/discharge- Phase 4 Rehabilitation Process
Deteriorating patient - physical health	Rehabilitation Program - Phase 3 Rehabilitation Process	Visitors
Drug & Alcohol Medication Management & Storage	Residential Agreement and Fee Management	

APPENDIX 7. LIST OF STAFF TRAINING PROVIDED

WHYALLA

Aseptic Technique online	Labelling for safety online
Bathing a baby online course	Making a difference: disability awareness online
BLS online	Manuel tasks theory
BLS Prac	Mental Health Act 2009
BLS theory	Mental Health First Aid Course
Central Sterilisation Injury Prevention online	Mental health, depression, suicide and substance abuse
Child Safe Awareness	Patient and consumer centred Care
Child safe environments online	Personality Disorder
Emergency training	Prevention of workplace violence and aggression online
Fire safety online	Safe use of personal protective equipment (PPE) online
Food safety for ward pantries	Severe Domestic Squalor & Hoarding Forum
Hand hygiene	Team STEPPS Master Trainer - observation online
Hand hygiene online	Team STEPPS refresher - coaching online
Illicit Drugs Clinical In-services via DTN Amphetamines & Stimulants	Understanding Autism
Illicit Drugs Clinical In-services via DTN Cannabis & Synthetic Cannabis	Working with people with Borderline
Illicit Drugs Clinical In-services via DTN Inhalants	

MOUNT GAMBIER

Advanced Care Directives	Leadership Training - Performance Conversations
ASSIST training	Mental Health Act
Amphetamine Training DTN	Mental Health First Aid Training
Cannabis training DTN	Mindfulness
CCCME Training	MSE, MH Risk Assessment, MH Care Plans
Coaching for Leaders	NOCC training
DBT series via DTN	Non-violent intervention training
Domestic Violence Response Training	One Procurement Approver Training
E Recruitment	Orientation Training
Fire & Emergency training	OT Forum
Hallucinogens Training DTN	Risk Assessment
Induction / Introduction to service model including MH care plan, SLS, MSE, NOCC, CCCME etc	Schema Therapy
Inhalants DTN	Youth Mental Health Training

APPENDIX 8. MENTAL ILLNESS DIAGNOSIS

Description	Primary diagnosis	Secondary diagnosis	Total consumers
Schizophrenia, unspecified	18	1	19
Personality disorders	5	4	9
Depression	3	4	7
Obsessive-compulsive disorder	2	0	2
Post-traumatic stress disorder	2	1	3
Generalised anxiety disorder	2	0	2
Drug induced psychotic disorder	2	0	2
Bipolar affective disorder, unspecified	2	0	2
Mood [affective] disorder	1	0	1
Delusional disorder	1	0	1
Asperger's syndrome	1	0	1
Agoraphobia with panic disorder	1	0	1
Anxiety disorder	0	2	2
Note: Not all consumers had their diadnosis stated			

APPENDIX 9. COST BENEFIT ANALYSIS

CMHRS: Cost Benefit Analysis - Summary

Year	Costs	Benefits	Total/Net Benefits	Discounting	Present Value
0	3,900,000	0	-3,900,000	1.00	-3,900,000.0
1	3,966,300	5,371,249	1,404,949	0.93	1,313,036
2	4,000,000	5,462,560	1,462,560	0.87	1,277,457
3	4,000,000	5,593,662	1,593,662	0.82	1,300,903
4	4,000,000	5,732,384	1,732,384	0.76	1,321,628
Total	**19,866,300**	**22,159,855**	**2,293,555**		**1,313,024**

Discount Rate	7.00%			**Net Present Value**	**1,313,024**
Benefit-Cost Ratio	1.12				

Expected Benefits

		Monetary Value				
Nature of Benefit		**Year 0**	**Year 1**	**Year 2**	**Year 3**	**Year 4**
Reduced inpatient readmissions		0	427,500	434,768	445,202	456,243
Reduced ED presentations		0	100,188	101,891	104,337	106,924
Reduced pschcare days		0	100,450	102,158	104,609	107,204
Improved health and wellbeing			19,968	20,307	20,795	21,311
Improved mental health (cost of poor mental health to businesses plus improved confidence)			1,394,380	1,418,084	1,452,118	1,488,131
Improved physical health			350,324	356,280	364,830	373,878
Improved social wellbeing			25,220	25,649	26,264	26,916
Social inclusion			848,640	863,067	883,780	905,698
Community participation			453,752	461,466	472,541	484,260
Savings on transport/accommodation costs to metro centres -cost to individual/family member/carer		0	60,500	61,529	63,005	64,568
Employment for consumers		0	97,152	98,804	101,175	103,684
Vocational training/other study		0	201,728	205,157	210,081	215,291
Revenue from leased property being rented out to consumers		0	38,100	38,748	39,678	40,662
Independent living		0	368,030	374,287	383,269	392,774
Cost saving in recruiting to regional health service for 32 mental health positions created/risk if staff lost through CMHRS not being re-funded		0	736,320	748,837	766,810	785,826
Training provided to staff by CMHRS (improved practice/care)		0	15,400	15,662	16,038	16,435
Volunteering		0	72,835	74,073	75,851	77,732
Saving on Carer allowance and Carer payment		0	60,762	61,795	63,278	64,847
Total		**0**	**5,371,249**	**5,462,560**	**5,593,662**	**5,732,384**

Consumer Price Index (Year 2)	1.70%
Consumer Price Index (Year 3)	2.40%
Consumer Price Index (Year 4)	2.48%
Consumer Price Index (Year 5)	2.47%

Source: IMF World Economic Outlook (WEO), October 2015
Source: Economic Outlook - Reserve Bank of Australia

Expected Costs	
Year 0	3,900,000
Year 1	3,966,300
Year 2	4,000,000
Year 3	4,000,000
Year 4	4,000,000

APPENDIX 10. SOCIAL NETWORK ANALYSIS REPORT

Evaluation of the Community Mental Health Rehabilitation Service

Social Network Analysis report

Muyambi, K, Martinez, L, Walker-Jeffreys, M, Vallury, K.

Introduction

Country Health SA Local Health Network for Mental Health (CHSALHN-MH) contracted the University of South Australia Department of Rural Health (DRH) to carry out an evaluation of the Community Mental Health Rehabilitation Service (CMHRS). The Terms of Reference for the evaluation required the DRH to assess the effectiveness of the partnership with the non-government organisations 'as well as to identify opportunities for strengthening linkages with other aspects of the service system including other mental health services, housing, community and employment and vocational sectors'.

Social Network Analysis (SNA) was used as a complement to interview and other data collection methods adopted for the evaluation in order to understand the strength of the linkages and partnerships that the two CMHRS sites in Mount Gambier and Whyalla established with other services and organisations.

This report presents the results of the SNA survey and is being provided as an Appendix to the main CMHRS evaluation report.

Background

Partnership working is a key feature of most Federal and State mental health policy documents (Council of Australian Governments, 2012, Commonwealth of Australia, 2009, Government of South Australia, 2010). The South Australian Social Inclusion Board's *Stepping Up: A Social Inclusion Action Plan for Mental Health Reform 2007-2012* report identifies five essential partnerships in mental health care delivery as:

- Education, Employment and Training/Mental Health
- General Health/Mental Health/Drug and Alcohol Services
- Child and Adolescent Psychological Wellbeing
- Housing/Social Care/Aged Care/Mental Health
- Justice/Mental Health (South Australian Social Inclusion Board, 2007b)

The CMHRS service model advocates the establishment of partnership and service linkages across a range of organisations and services including primary care and community services as well as vocational rehabilitation, training and employment services; consumers and carers. The service model also identifies the sources of referral to the CMHRS. This information was helpful in the identification of the services that were to be surveyed (Government of South Australia, (undated)).

Interprofessional collaborative care models are being used in health care systems in order to address complex and challenging health needs and to improve health outcomes for consumers of health services, their families and carers. These models usually involve teams with different healthcare disciplines working together towards common goals to meet the care needs of consumers of health services and can include the consumers and their families or carers (Canadian Health Services Research Foundation, 2012, Brown et al., 2011).

Social Network Analysis has become a key technique used in the social and behavioural sciences, as well as in

marketing. It focuses on relationships among social groups and has emerged as an important survey tool for identifying the links between actors within the human services sector and the nature of the ties that connect them (Fuller et al., 2012, Provan et al., 2005, Quissell and Walt, 2015). An actor can be either an individual or a service organisation.

Methodology

A workshop on Social Network Analysis facilitated by Jeff Fuller Research Services was held for the DRH Evaluation Team and selected staff from CHSALHN-MH during the period 21-22 July 2015. The purpose of the workshop was to introduce the participants to the technique.

The main output from the workshop was an SNA Data Collection and Analysis Manual that explained the procedure for conducting the SNA survey and analysing the collected data. The manual also included two theoretical lists of services to be mapped at the two sites where the CMHRS is operating. The lists were based of the existing links as identified by the Team leaders as well as the service model. They were later re-confirmed with the Team Leaders and in the case of Mount Gambier, an Adviser who added other services, as relevant.

Overall, the identified services were comprised of traditional mental health services and social care services and further categorised as 'internal' or 'external' depending on their location inside or outside the region of the CMHRS service, respectively (Table 1).

Table 1: Features of the services surveyed

CMHRS site	Description of services	Internal/External to region	Number of services		
			Identified	Surveyed	Percentage
Mount Gambier	Mental health	Internal	7	3	43%
		External	3	1	33%
	Community and Social care	Internal	4	4	100%
	General Practice	Internal	1	1	100%
	Aboriginal Medical Service	Internal	1	1	100%
	Education services	Internal	1	0	0%
	Employment services	Internal	1	0	0%
	Psychiatrist	Internal	1	0	0%
Whyalla	Mental Health	Internal	7	4	57%
		External	4	2	50%
	Hospital	Internal	1	0	0%
	Community and Social Care	Internal	4	2	50%
	Aboriginal Medical Service	Internal	1	1	100%
	General Practice	Internal	1	0	0%
	Education services	Internal	2	0	0%
	Psychiatrist	Internal	1	1	100%

As part of the survey, participants were requested to identify the services which they undertook the following activities with within the 6 months period prior to the completing survey:

- Communication about clients and enquiries- giving or receiving information about service/enquiries, corridor conversations about relevant topics, correspondence about client care (not formal case management). This information could be about specific clients or about services or issues more generally.
- Referrals (formal and informal) - sending or receiving a client referral.

- Case planning and management - communication about the management and planning of services/care coordination regarding individual clients, including sharing of case notes, client progress/status, and planning/care coordination meetings.

The survey did not ask about the frequency of the relationship link. Apart from this information, the survey also collected qualitative feedback about experiences of working together with other agencies.

Initial contact with the listed services that the CMHRS already had links with was done by each Team leader who informed the services about the evaluation and their role in it.

The following inclusion criteria were adopted for the SNA:

- the services/agencies which provide support for people with a mental illness:
    - aged 18-65 years
    - required support to live independently in the community; and
    - were a client of the CMHRS
- services or functional unit of a large service/department were considered as actors for the purpose of the SNA survey

Method

The SNA survey was administered using two methods:

- face-to-face interview or using telephone with the Evaluation Team member completing the survey form
- self-administered mail survey in which the survey pack was emailed to participants with a request to complete and return using the same electronic means

Response rate

Overall, the survey returned a response rate of 50%. Ten (53%) out of a possible 19 services were surveyed in Mount Gambier and 10 (48%) out of 21 services were surveyed in Whyalla (Table 1). The services that could not be mapped either did not respond to the invitation to participate in the survey or the relevant person could not be contacted. No service declined outright the invitation to participate in the survey.

Data analysis

The quantitative data was analysed using Microsoft Excel software (www.microsoft.com) and UCINET version 6 software (www.analytictech.com). The qualitative data was manually analysed for themes.

Limitations

The following limitations were experienced:

- the list for Whyalla could not be confirmed with an independent adviser due to time constraints
- overall, only 53% of the services were mapped. This has an effect of strength and quality of maps produced
- one key service in Whyalla was not included in the list of those surveyed. At the time the service was not represented in the town
- the section of the survey that was meant to collect demographic data was mostly left incomplete. This makes it difficult to understand the background of the survey participants.

Results

The network maps below present the results of the survey. Each service in the network is represented by a circle and relationships between the services are indicated by lines (called links) with arrows. The direction of the arrow denotes the direction in which information flowed. The services that were surveyed are shown in black ink and those that were not in white ink.

The size of the circle is determined by the number of other services that reported that they were linked to a particular service. Maps with larger overall circle sizes indicate more linkages in a network than maps with predominantly small circle sizes.

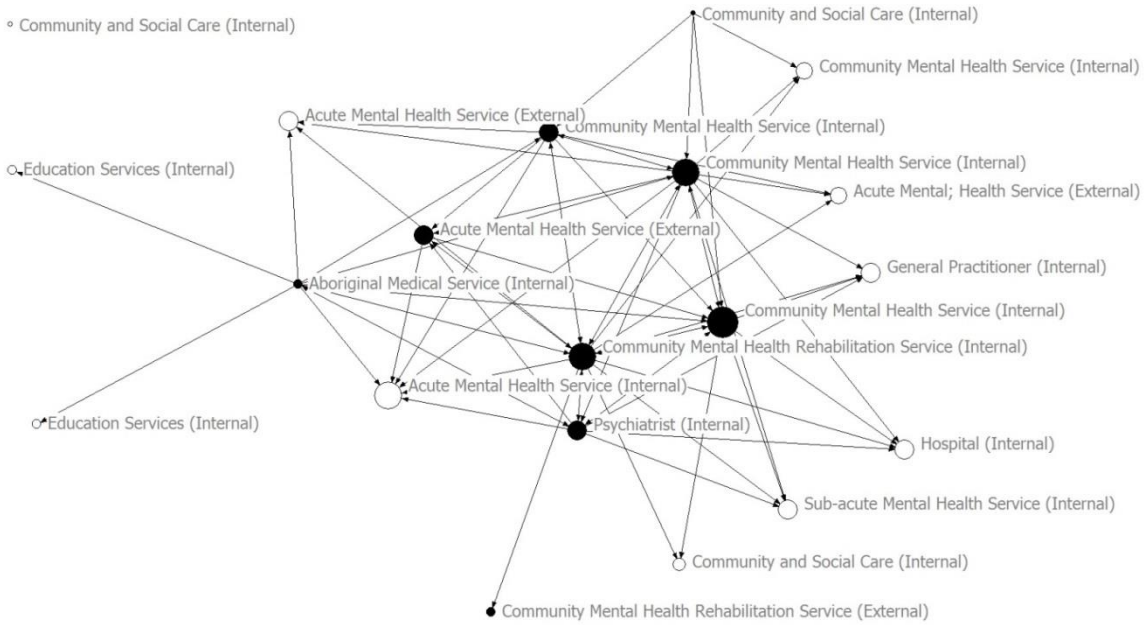
For the purpose of this report and the evaluation, it is sufficient to identify and compare which maps overall reflect higher or lower links as indicated by the size of the circle and the number of lines.

Case planning

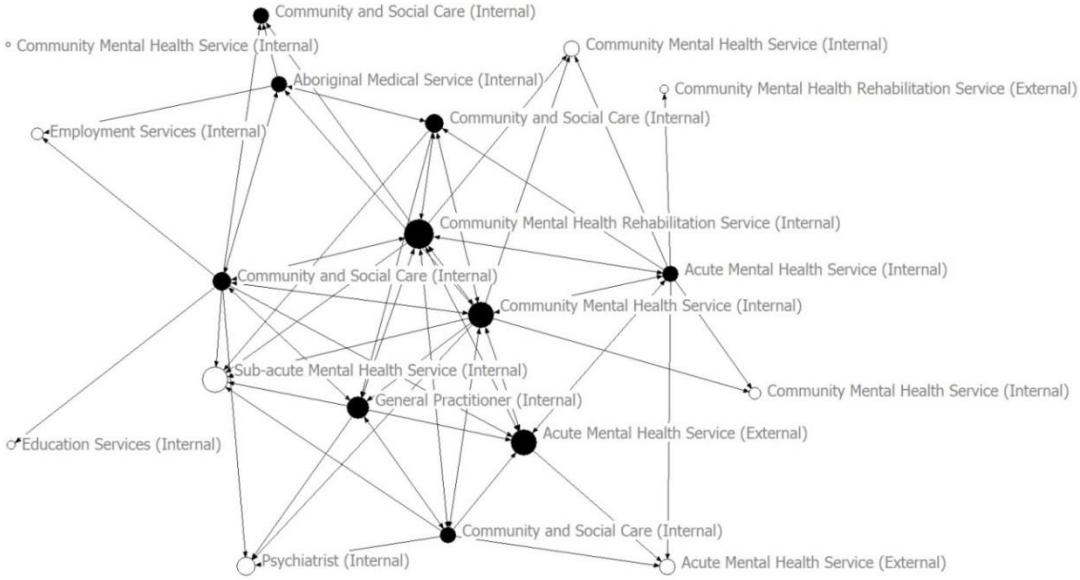
Whyalla - The most linked services in Whyalla included an acute mental health service, the community mental health rehabilitation service and two community mental health services. One community mental health rehabilitation service is low linked whilst one community and social care organisation was not linked with any other service in the network (Map 1).

Mount Gambier – The most linked services were the sub-acute mental health service, one community mental health rehabilitation service, one community mental health service and one acute mental health service. One community mental health service was not linked with any other service in the network (Map 2).

Map 1: Case planning-Whyalla



Map 2: Case planning- Mt Gambier

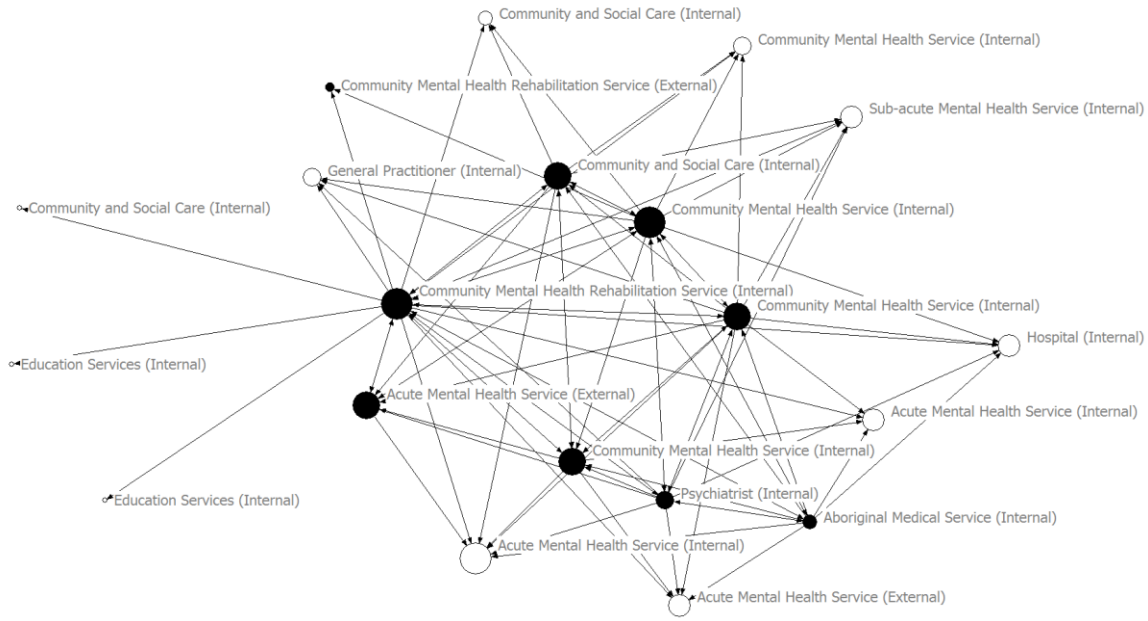


Information sharing

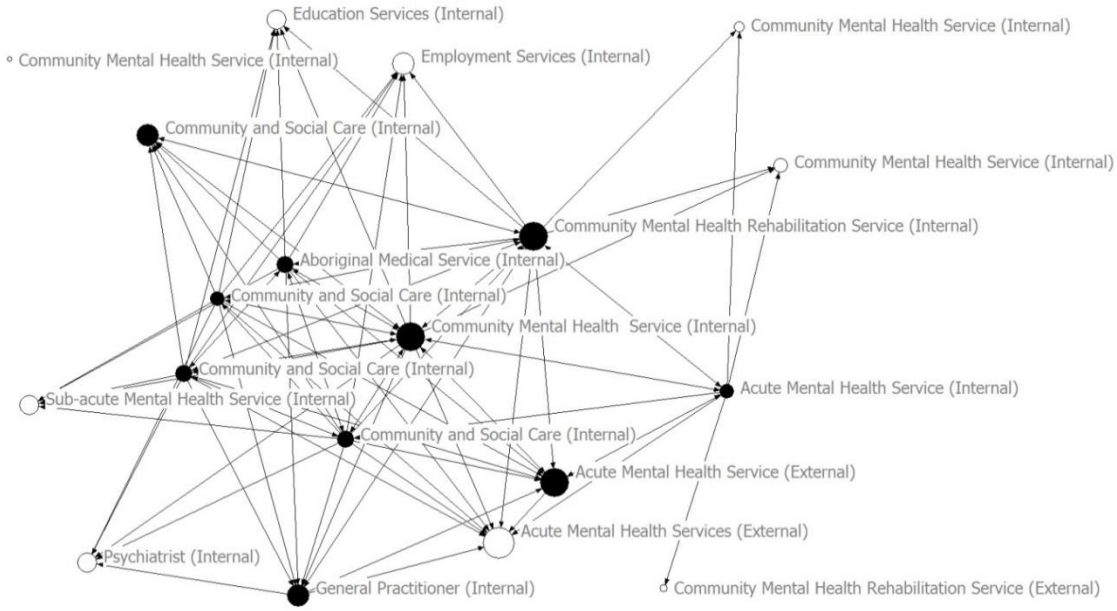
Whyalla - The most highly linked services in relation to sharing of information about consumers of the mental health services needing support to live independently included an acute mental health service, one community mental health rehabilitation service, two community mental health services and one community and social care organisation (Map 3).

Mount Gambier- Two acute mental health services, one community mental health rehabilitation service and one community mental health service were the most linked services in the network. One community mental health service was not linked with any other service in the network (Map 4).

Map 3: Information sharing- Whyalla



Map 4: Information sharing – Mt Gambier

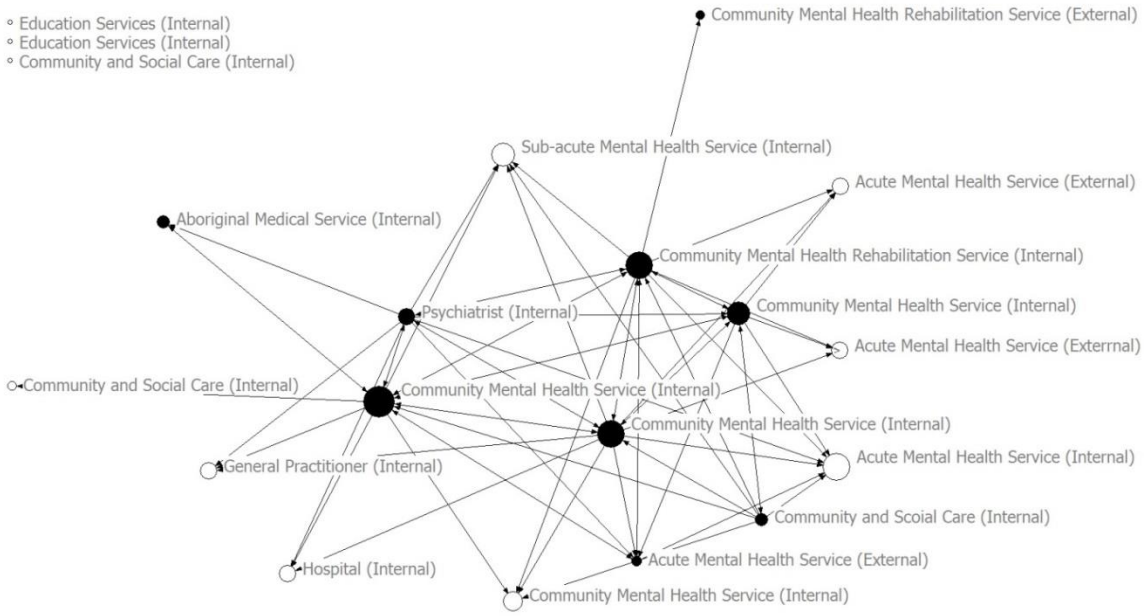


Receiving referrals

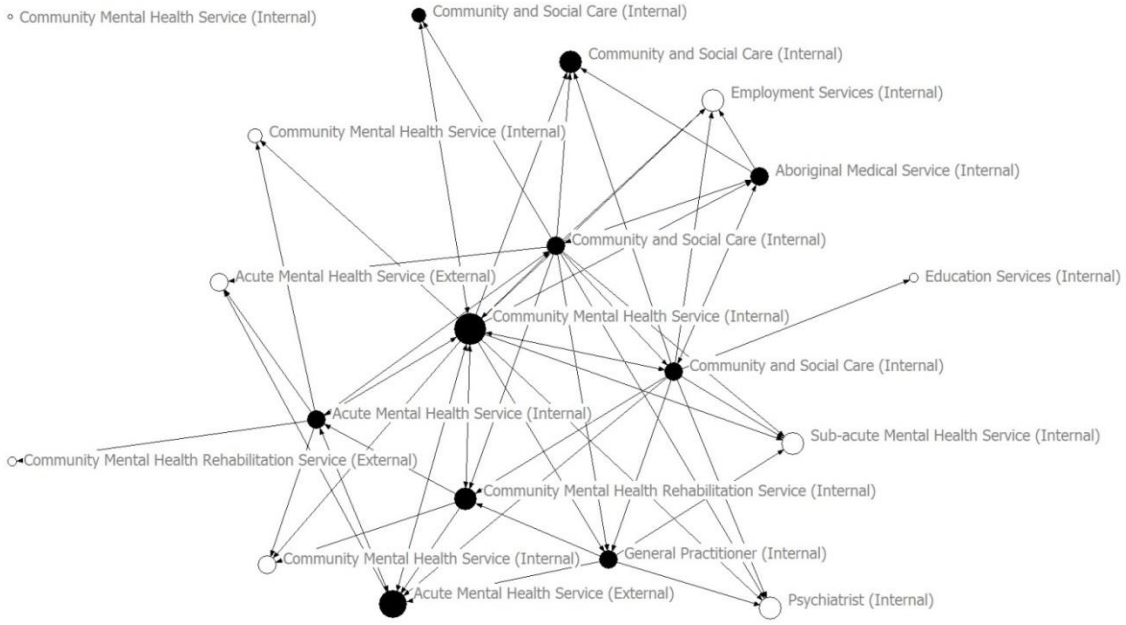
Whyalla - The most highly linked services in Whyalla were two community mental health services, one community mental health rehabilitation service and one acute mental health service. Two education services and one community and social care organisation were not linked to any other service in the network (Map 5).

Mount Gambier – One acute mental health service and one community mental health service were the most highly linked services in network. One community mental health service was not linked with any other service in the network (Map 6).

Map 5: Receiving referrals- Whyalla



Map 6: Receiving referrals – Mt Gambier

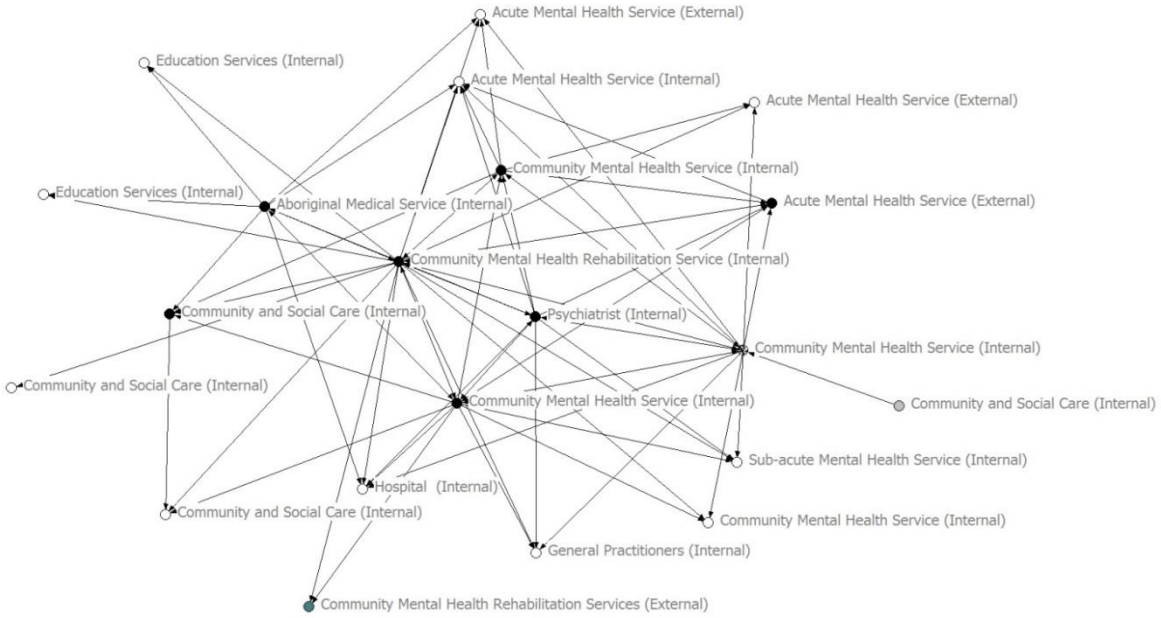


Sending referrals

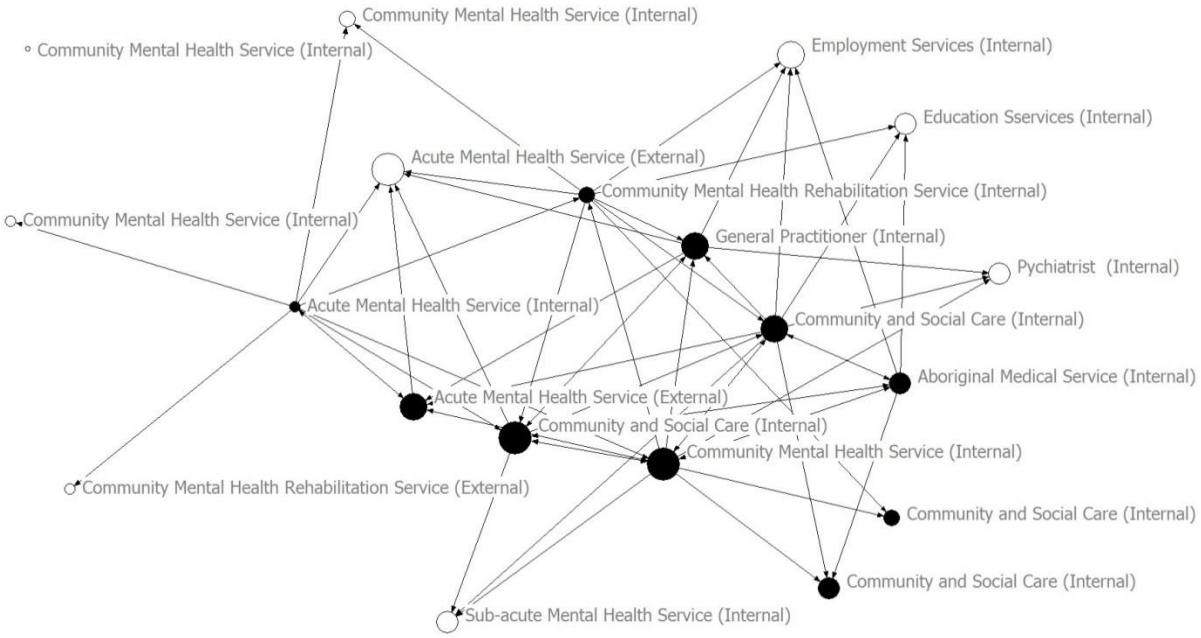
Whyalla – One acute mental health service, one community mental health rehabilitation service and hospital were the most linked services in the network (Map 7).

Mount Gambier – One acute mental health service, a mental health service and a community mental health service were the most linked services within the network. One community mental health service was not linked with any other service in the network (Map 8).

Map 7: Sending referrals - Whyalla



Map 8: Sending referrals – Mt Gambier



Qualitative component

The qualitative section of the survey showed that formal and informal service links existed at both sites and these were mainly concerned with sharing of information and resources. The formal arrangements were characterised by written service agreements and protocols exchanged with other agencies or the non-government sector.

Examples of collaborative work include different health disciplines from different organisation attending regular clinical meetings to address a common health issue, shared training or providing relationships, housing or financial counselling support.

Barriers include to partnership work include:

- fluctuating attendance at meetings
- poor role clarify in terms of the agencies or organisations not knowing what the other does and also who to contact with a problem
- poor representation of key agencies and organisations at local level, thus creating a service delivery gap. Examples were mentioned as being the drug and alcohol services and psychiatrists
- staff shortage and high staff turn-over
- perceived fragmentation of services as well as service overlap

Discussion

Overall, the SNA has demonstrated that across both CMHRS sites and across all four service domains links were generally between and amongst the traditional mental health services than with the organisations outside this realm. This is contrary to the expectation of the service model which envisaged linkages being established to vocational education, employment and housing sectors. Even within the traditional mental health services, variations were observed in relation to the number of the other services linked to them with some services being completely isolated.

In Mount Gambier, the number of links was greater for information sharing followed by case planning, receiving referrals and sending referrals, in that order whereas in Whyalla, the number of links was greater for information sharing followed by sending referrals, case planning and receiving referrals, consecutively. Overall, the number of links was marginally higher in Whyalla than Mount Gambier.

Links between the two metropolitan and rural-based community mental health rehabilitation services were minimal with negligible referrals, care coordination or information sharing occurring between them. In qualitative feedback the metropolitan service felt that there was need for sharing of information and care planning and coordination in order to share experiences as well as to improve health outcomes for the occasional common consumer.

In both Whyalla and Mt Gambier, the acute, sub-acute and to a lesser extent the community mental health services were the predominant sources of referrals. The finding is consistent with the service utilisation data provided by CHSALHN-MH.

There is opportunity to improve links to the Aboriginal medical services, especially in Mt Gambier.

Conclusion

The SNA survey has shown that across the two CMHRS sites there is opportunity to improve service linkages with the services and organisations identified in the service model including the employment, vocational education and housing sectors. Collaborative links to the metropolitan community rehabilitation services may

be beneficial in terms of exchange of experiences and service delivery protocols aimed to improve the quality of services provided to the mental health consumer. Poor role clarity, poor local representation and staff shortage were identified as some of the barriers to effective collaboration.

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APPENDIX 11. SOCIAL RETURN ON INVESTMENT

Executive Summary

Our spreadsheet shows an overall SROI of the two rehabilitation services of a ratio of 1:1 which suggests that the intervention produces social outcomes greater similar to cost. This report is tentative as it is difficult to evaluate while a project is still continuing. We lack the data on the long-term outcomes of the customers and therefore use inadequate proxies. The much more sophisticated analysis of mental health interventions by Fujiwara and Dolan (2014) of London School of Economics provides a template of where this analysis could go. The Table below illustrates the way they have valued the elimination of different health conditions. To do this analysis we would need a longitudinal data collection approach, which we could not possibly do here. A further caveat is that result is limited by a range of assumptions within the time and resource constraints of this evaluation. The result is therefore an attachment to the report as an Appendix as we are still developing and proving the application of SROI as an evaluation tool for mental health interventions. This analysis should give confidence that this is a positive direction for the future in terms of evaluation.

Table 4
Monetary equivalent costs associated with different health conditions

Health condition	Monetary equivalent
Depression, anxiety	-£44,237
Stomach/liver/kidneys or digestive problems	-£5,556
Migraine or frequent headaches	-£3,336
Difficulty in seeing (other than needing glasses to read)	-£2,791
Epilepsy	-£2,698
Chest/breathing problems, asthma, bronchitis	-£2,052
Heart/blood pressure or blood circulation problems	-£1,422
Problems connected with: arms, legs, hand, feet, back	-£1,201
Skin conditions/allergies	-£895

Note: Values estimated at around UK median income of £23,000

Introduction

Social Return on Investment (SROI) has been used in examining the social impact of mental health interventions (e.g. Washenfelder & Hoeber, 2012; Gardner, 2014). The method was developed by the Roberts Enterprise Development Fund as an extension of the well-known approach of cost-benefit (Emerson 2003). SROI is seen as a form of blended value accounting combining known financial values with a monetized value of the social impact (Nicholls 2009). Usually expressed as a ratio, SROI compares the social value relative to the cost of the inputs (Rotheroe & Richards, 2007). The SROI approach is becoming better known with the UK cabinet office putting out a guide in 2009 later updated in 2012; principally for third sector organizations. Yet there are still many critics of SROI who believe the methodology is too complex and often badly done.

It is based on cost-benefit analysis with some significant differences. "SROI is a form of stakeholder-driven evaluation blended with cost-benefit analysis tailored to social purposes". (SVA, 2012, p.3). While it is blended with cost-benefit, there are some clear distinctions:

- SROI is strongly focused on the stakeholder all through the analysis and seeks to understand the stakeholder's view which may be very different to the funder

- It seeks to identify the outcomes and create financial proxies for them in as rigorous a process as possible.

The most vexed issue is finding suitable financial proxies for outcomes.

Methodology

The evaluation team met at Whyalla on 15th December 2015 at the Department of Rural Health. While most members of the team had some ideas of SROI there was not a particularly thorough knowledge of the process. The day was led by Dr Bruce Gurd from the University of SA Business School who conducted training and worked with the team to define the approach and do some preliminary analysis including a Theory of Change.

By that time, some interviews had been done. During December to February the rest of the interviews were conducted. The research team met again on January 22nd in Adelaide to redefine the Theory of Change and to check on the data needed to complete the Social Impact Map.

Our analysis underestimates the SROI as there are still customers leaving the centres.

Results

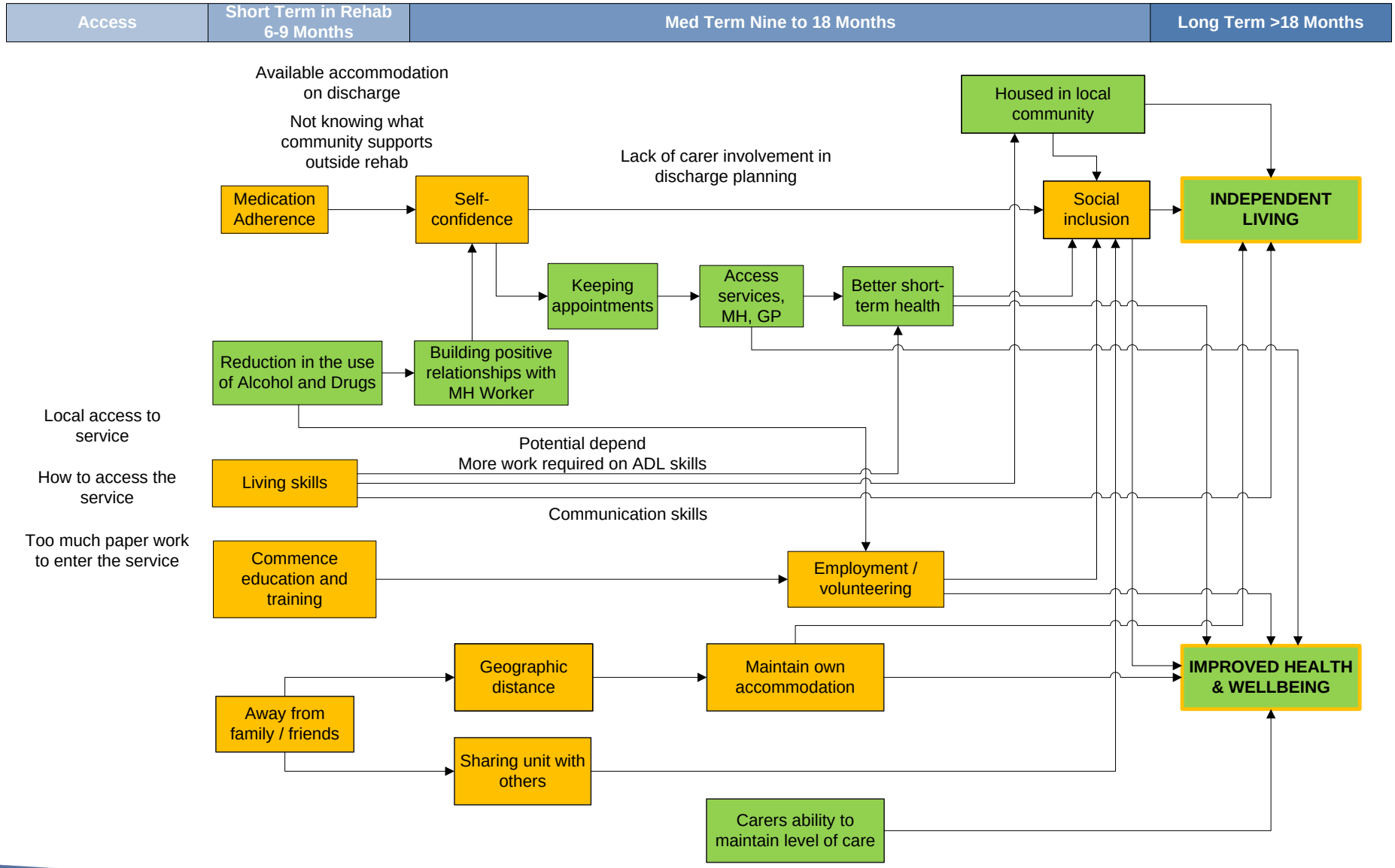
The first analysis is the Theory of Change on page 4. This has been developed by the project team out of the interview data and we are relatively confident in its explanation of the final outcomes using causal links. The outcomes have been divided into immediate outcomes from entering rehabilitation, intermediate outcomes in the 9 to 12 months after leaving and the final outcomes. We have identified two final outcomes: - Independent Living and Improved Health and Well-being. We believe that these are the two final outcomes that the rehabilitation service was based on. Independent Living is a critical outcome as the customer has learnt the skill to live in their own accommodation. While many had lived with carers before rehabilitation they were now confident enough and sufficiently skilled to live alone. Improved well-being is also a critical outcome – the customer's health and satisfaction with life has been enhanced.

There are four major golden threads – these are sequences of outcomes which are the core of the outcomes of the rehab services. The first has a focus on self-confidence. We have connected Medication Adherence to building Self-confidence although Reduction in the use of Alcohol and Drugs is also influential. Self-confidence impacts on both of the final outcomes through Social Inclusion.

Our second golden thread is based on the outcomes of the living skills developed in the rehabilitation centres. These skills, developed during rehabilitation have direct impact on the Independent Living outcome.

The third golden thread relates to commencing education and training. For some customers, this leads to the ability to volunteer or work in paid employment. Being in paid employment or volunteering leads to greater social inclusion and independent living. It has a direct effect on personal well-being. The last golden thread starts with Being Away from Family and Friends. While this might seem a negative, it does appear to have positive outcomes in encouraging the customer to be independent and share with others.

Outcome Mapping



This leads into the major analysis in the Impact Map on the next pages. We note each of the key stages:

(1) Identification of the stakeholders – There are four key stakeholders:
    - The consumers – this is the core stakeholder group who are the beneficiaries of the service
    - Carers – they are a group who are concerned about the outcomes and important volunteer supporters of the process
    - Other NGOs – these are affected by offering complementary services to support the services or by being replaced as a service provider
    - Country Health SA – the funder is not usually counted as a stakeholder but it does offer alternative services
(2) The inputs – the major provider is CHSA which put in $4,000,000 per annum to the two facilities.
(3) The outputs – 52 customers have been through the two services at Mt Gambier and Whyalla or are currently still receiving the services. The activity is important as it tells us what has happened with the resources.
(4) The outcomes – these are observable from the Theory of Change. In the impact map we identify indicators of the outcomes. Then we estimate the level of outcomes and the duration. We have tended to use a 5 year duration but have quick "drop off" of the benefits. The toughest part is to find financial proxies for each outcome. There are various ways to arrive at proxies but we have tended to use the value of resource allocation rather than revealed preference. This is where we present our analysis in a fairly tentative way because we are not sure yet of the proxies. We have not done any work with consumers to put their values on the outcomes.
(5) The filters:
    - Deadweight – would this have happened anyway without the intervention
    - Displacement – is some other activity displaced by what we are doing. Initially we imagined that the rehabilitation might impact on Uniting Care Wesley. However there is some level of complementarity.
    - Attribution – did someone else contribute to the change
    - Drop –off – how quickly will the benefits fall away? Our analysis suggests that this might happen relatively quickly.

Then we have calculated the Net Present Value of the outcomes.

Conclusion

This is a first cut of an SROI analysis of for a mental health intervention in South Australia. While incomplete it starts to evolve a model which can be used for the future.

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