Mental Health Community Support Services Evaluation – Summary

Background

The Mental Health, Alcohol and Other Drugs Branch (MHAODB) commissioned the Queensland Centre for Mental Health Research (QCMHR) and School of Public Health at The University of Queensland to evaluate Queensland Health's Mental Health Community Support Services (MHCSS). These are non-clinical, holistic recovery-focused psychosocial wrap around support services delivered either one to one, peer to peer or within a group. The four core MH CSS programs in scope of this evaluation project included:

- **Individual Recovery Support Program (IRSP)**: An individualised program where psychosocial support is tailored to meet specific recovery needs and goals.

- **Group Based Peer Recovery Support Program (GBPRSP)**: Group-based peer-led activities intended for individuals linked from the IRSP. Activities are led and self-managed by peer workers and aim to support the person by working through group processes and sharing life experiences with others who have similar experiences.

- **Transition from Correctional Facilities Program (TCFP)**: Delivered to individuals about to be released from a Queensland adult correctional facility who have been referred to the MH CSS program by a Prison Mental Health Service.

- **Individual at Risk of Homelessness Program (IRHP)**: Tailored specifically to individuals residing in a boarding house, crisis accommodation or hostel and focused on breaking the cycle of homelessness.

Overall, the results were positive. Almost all consumers interviewed for the evaluation reported a positive experience and a portion of consumers could speak to the importance it had played in their recovery journey. Consumers reported that participating in the programs improved their functioning, mental health, relationships, confidence and overall quality of life. Profoundly, some even attributed their survival to engaging in the program.

Areas for further work

Data collection

- There is a lack of consistency across NGOs in the use of standardised outcome measures to track the effectiveness of the programs and recovery outcomes of individual consumers. Across the 38 separate programs, there were 17 different outcomes tools being used. Some NGOs used outcome measures throughout a consumer's time on the program, others used them only at the point of exit, and others did not routinely use them at all. Moreover, the results were not used to inform the ongoing delivery

of the program. The report recommends that all NGOs use the same outcome measures to determine effectiveness of the programs.

- Currently, it is unclear how hospital readmission data is captured at the NGO/HHS levels, which impacts the ability to determine overall effectiveness of the MH CSS programs. It is recommended that hospital re-admittance and emergency department presentation data be collected in the future.

- There is no long-term follow-up of consumers who have exited programs. It is recommended that NGOs follow up with consumers at time points post exiting to assess the long-term effectiveness of the programs. This could also be used as an opportunity to address potential isolation or a decrease in mental health functioning through referrals back into clinical care, alternative community support programs or back into a MH CSS program.

Referrals

- NGOs reported receiving a number of referrals for people who are either not eligible (due to referring staff misunderstanding) or that they have incomplete information to enable triage and risk assessment. Missing information is particularly concerning, as it delays the referral process, missing the window of opportunity for engaging a consumer. The report recommends that the relationships between HHSs and NGOs be strengthened with clear governance processes, regular meetings and co-locating NGO staff within HHS facilities so they attend weekly case management meetings and reviews. In addition, it is recommended that the HHSs and NGOs embed regular NGO-delivered psychosocial support education/training for referring teams to ensure HHS staff are aware of the suite of psychosocial services available, their important role in mental health intervention, and appropriate referral processes.

- Concerns were raised by many consumers as to the distress and discomfort caused by having to present at the HHS prior to being referred onto the program. The report recommended reviewing the feasibility of extending the opportunity for GPs and private mental health clinicians to be able to refer directly into the MH CSS programs. This extension recognises the episodic nature of severe and persistent mental illness and would enable earlier intervention and possibly avoid a crisis that results in an emergency department presentation.

Targets

- Only 58% of programs are meeting their client targets (which are based on only 20% of population need). This suggests that some programs are not able to reach the number of people intended, despite there being significant need. This is likely due to systemic issues related to the referral process noted above. It is recommended that regular reporting and review of this data could help HHSs to identify when referral numbers fall short of what would be expected and prompt them to identify blockages to referral and deploy strategies to increase them.

- Some programs are exceeding their target, however these NGOs tend to have small target numbers and it is likely that the targets in these areas should be reviewed at a local level to better understand the need and capacity.

NDIS

It was noted that while the purpose of the MH CSS programs is to support consumers' recovery, much of the time can be spent assisting consumers to access the NDIS. It was noted that when consumers were identified as potentially eligible for NDIS supports, and their time on the MH CSS program became focused on progressing this application, recovery became a secondary goal.

Individual Recovery Plans (IRPs)

There is evidence IRPs are not being completed or, if they are, not within the two-week timeframe and not reviewed regularly. The report recommends that all NGOs should be implementing clear IRPs within the first few sessions with the consumer, they should follow a recovery-oriented framework and be guided by the consumer's goals and needs. The IRPs should be regularly reviewed and updated, and consumers should play a collaborative role in the management of the plan.

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

A common response from consumers and staff across the programs is that few of the consumers are serviced in line with the contract criteria of a higher intensity recovery support phase (up to 3 months) followed by a lower intensity recovery support phase (up to 9 months). The intended goal of the two-phase approach is to prioritise the consumer's recovery needs and stabilise their supports (phase 1) in order to address longer term recovery goals, develop and utilise psychosocial skills and increase community support networks (phase 2). The report noted that this aspect of the MH CSS program is not being implemented consistently and recommends a review in order to deliver the program as intended and in line with consumer needs.

IRHP

It was acknowledged that it is really difficult to improve mental health outcomes when there is a lack of access to appropriate and secure housing. Given the complex nature of the IRHP consumer group, and their risk of homelessness it followed that they often experienced financial distress and issues meeting their basic living needs. It was therefore recommended that NGOs would benefit from additional discretionary funding that focused on supporting the needs and engagement of consumers (i.e. access to mobile phone, essential needs like food and clothing).

TCFP

It was acknowledged that specific difficulties were encountered by this group including:

- Access to housing due to the complex nature of some of the offences
- NGO requiring security clearances which was often delayed, meaning staff couldn't enter the prison to establish rapport with consumers before release

- Unplanned lockdown and security issues occurring regularly which prevented NGOs entering the prison
- The lack of discretionary funding for the TCFP consumer group to buy essential goods such as bikes for transport or crisis food
- A disconnect between location of prison and place of residence after release, meaning they may not be linked in with an NGO available to support their referral prior to release

GBPRSP

The referral of consumers into the group-based programs are designed to come from any one of the individual programs via the 'parent' NGO. A clear finding throughout the evaluation was that the GBPRSP referrals are not being guided by a consumer's recovery goals, rather they are predominantly related to the delivery of the service at the NGO level.

It was recommended that there was more guidance to all stakeholders around referrals into GBPRSP, including facilitating relationships between NGOs where different NGOs deliver the programs. It was also recommended that a review be undertaken of the feasibility, acceptability, and need for the same NGO to be delivering the IRSP and GBPRSP at each location across the state to facilitate referrals and simultaneous delivery.

Rurality

Problems were identified that were unique to rural and remote areas including: Support workers having to devote large amounts of travel time to access consumers (which is not captured in the current resourcing model); increased stigma; decreased mental health literacy; and fewer clinical services being available leading to many people from rural areas missing out on referrals into the program.

Peer work

The importance of the peer workforce was noted by consumers as integral to their recovery. Consumers valued shared common understandings and experiences between themselves and peer workers and found engaging with peer workers helped to normalise mental illness. It also provided an example of recovery and hope.

The lack of standardised formal qualifications in peer work was highlighted. Peer workers interviewed through the evaluation indicated varying degrees of both training and support across the NGOs in which they were employed. Some peer workers highlighted extensive training opportunities available to them through their NGO. However, a number of peer workers described a dearth in training and support, which significantly impacted upon not only the delivery of the service but also had the potential to impact upon the peer worker themselves. This highlights the importance of developing a community mental health workforce framework which embeds appropriate supervision and professional development.