

Evaluation of the Integrated Rehabilitation and Recovery Care Program

David Abelló, Karen R. Fisher and Tomasz Sitek

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Social Policy Research Centre, UNSW

Karen Fisher, David Abelló, Tomasz Sitek, Robyn Edwards, Megan Griffiths and Kristy Muir

School of Psychology, Victoria University

Heather Gridley, Jenny Sharples and Pauline Clement

Authors

David Abelló, Karen R. Fisher and Tomasz Sitek

Contact for follow up

Karen Fisher, ph 02 9385 7813, email karen.fisher@unsw.edu.au

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Abbreviations

AMHS	Area Mental Health Service
ARAFEMI	Association of Relatives and Friends of the Emotionally and Mentally Ill
CCT	Continuing Care Team
CCU	Community Care Unit
Consumers	People using mental health services, also referred to as clients
DHS	Department of Human Services, Victoria
EACH	Eastern Access Community Health
ERMHA	Eastern Regions Mental Health Association
HACC	Home and Community Care
H&CB	Housing and Community Building
HASI	Mental Health Housing and Accommodation Initiative NSW
IRRCP	Integrated Rehabilitation and Recovery Care Program
IRRCS	Integrated Rehabilitation and Recovery Care Service
MHS	Mental Health Service
MSTS	Mobile Support and Treatment Service
PDRSS	Psychiatric Disability and Rehabilitation Support Service
SECU	Secure Extended Care Unit
SPRC	Social Policy Research Centre
UNSW	University of New South Wales
WRHC	Western Region Health Centre

Executive Summary

Introduction

This is the Executive Summary of the evaluation of the Integrated Rehabilitation and Recovery Care Program (IRRCP) pilot undertaken by Social Policy Research Centre, University of New South Wales (July 2009). The services provided in the program are referred to as IRRCS. This report uses that convention.

The IRRCS is a transition program for consumers from Secure Extended Care Units (SECU) and Community Care Units (CCU), who need a higher level of combined clinical and community treatment and support than is usually available to become reintegrated into the community. IRRCS was piloted in three metropolitan consortia in Melbourne from 2007.

Evaluation

The evaluation of the IRRCS pilot aimed to:

- assess whether the appropriate consumers were targeted by the IRRCS;
- identify program implementation consistency across the three providers;
- assess early impacts of the project on system practices, such as resolving consumer flow and consumer outcomes; and
- identify applicability of the service model to other types of consumers of mental health services.

The evaluation used mixed quantitative and qualitative methods to address questions of appropriateness, efficiency and effectiveness in meeting the evaluation aims. Data sources included:

- output and key performance indicators (KPI) datasets;
- financial data;
- administrative data;
- consumer, worker, manager and other stakeholder interviews and observation (2008, repeated in 2009);
- program documentation; and
- descriptive and outcomes data.

It did not evaluate the performance of individual consortia.

The evaluation project was approved by the DHS Human Research Ethics Committee (HREC no: 100/07), health regional committees and UNSW Human Research Ethics Committee.

Design of IRRCS

IRRCS is a new program for consumers in SECU and CCU, who need a higher level of combined clinical and community treatment and support than is usually available to consumers for them to become reintegrated into the community. IRRCS aims to improve consumer outcomes through:

- providing more targeted and time limited, high level psychosocial rehabilitation and clinical support;
- facilitating access to appropriate housing or other accommodation options; and
- increasing opportunities to participate in community activities such as recreation, education, vocational training and employment.

IRRCS also aims to embed system improvements through:

- strengthening collaborative practice between Psychiatric Disability and Rehabilitation Support Service (PDRSS) services, extended care clinical services (SECU and CCU) and local Mobile Support and Treatment Services (MSTS);
- improving the continuity of care for consumers across these service components, particularly at critical transition points;
- increasing the capacity for the PDRSS sector to support high needs consumers; and
- increasing the response capacity of clinical, bed-based services. The pilot targeted a specific subset of consumers to improve throughput in bed-based services.

The IRRCS pilot was established to target consumers who meet the following criteria:

- Who because of their severe mental illness and enduring psychiatric disability face difficulties transiting back into the community with currently available levels of psychosocial rehabilitation and clinical mental health support.
- Can be managed on a Community Treatment Order (CTO), if involuntary treatment is required, and do not require active inpatient treatment and care.
- Are assessed as being able to live in the community if provided with high levels of multidisciplinary psychosocial and clinical treatment and support, and access to stable and affordable housing or other accommodation.
- Are assessed as having potential for achieving a level of daily living skills and social functioning such that, after an extended period of community based high level and focused rehabilitation support, they could be successfully maintained in the community, with a lower level of ongoing psychosocial support and clinical care.
- Do not pose an unmanageable risk to themselves or the community if they were discharged from SECU or CCU.

In practice, a further criterion was that after discussion and negotiations that included family, friends or other carers or representatives, the consumer indicated a willingness to move from the clinical, bed-based service.

The model has three phases: preparation for transition to the community; high level support in the community; and transition to ongoing support responses in the community.

IRRCS planning has three elements:

- care coordination, liaison between relevant support staff and monitoring of the integrated plan;

- the individual's support plan which identified personal goals and what would be provided; and
- an exit plan to move the consumer from the IRRCS, with staged support withdrawal, reducing the number of hours or workers that visit, transfer to a MHS Continuing Care Team (CCT), and transfer to a PDRSS home-based outreach program or other relevant exit option for example a Supported Residential Service (SRS).

IRRCs is delivered by consortia of PDRSS in three regional clusters. The consortia work in partnership with area mental health services including the regional SECU, a number of CCUs and the relevant community mental health teams including MSTs and CCT.

The individual consortia that participated in the pilot and evaluation were:

- Southern IRRCS – Eastern Regions Mental Health Association (lead agency), Prahran Mission, Peninsula Support Services, Reach Out and Richmond Fellowship Victoria.
- Western IRRCS – Western Region Health Centre (lead agency), North Western Mental Health, Norwood Association, Doutta Galla Community Health Service, Werribee Mercy Mental Health Program, Richmond Fellowship Victoria, Dianella Community Health and Moreland Community Health Service.
- North Eastern IRRCS – including Richmond Fellowship Victoria (lead agency), Eastern Access Community Health (EACH) and ARAFEMI.

The program aims to address some of the contextual changes that have an impact on the rehabilitation and care of people with severe mental illness and associated disability, including service demands, PDRSS expansion, workforce availability and system blockages (Mental Health Branch, 2006).

Findings

The IRRCS delivered a service that was consistent with the program aims. The IRRCS undertook the:

- provision of targeted and time limited, high level psychosocial rehabilitation and clinical support;
- facilitation of access to appropriate housing or other accommodation options; and
- activity to increase opportunities for participation in community activities.

The design and implementation of the program achieved outcomes in terms of appropriateness, effectiveness and efficiency described below.

Appropriateness

The IRRCS targeting of SECU or CCU consumers met the program eligibility criteria guidelines. The IRRCS consumers had lived in a SECU or CCU on average for approximately six years. The majority of consumers (72 per cent) had an 'involuntary' mental health legal status. For most consumers the primary mental health diagnosis was schizophrenia (89 per cent).

One third of consumers had multiple disabilities, including psychiatric, physical and/or intellectual disabilities. Three consumers had diagnosed drug and/or alcohol disorders. All consumers at entry into the IRRCs were assessed as having restrictions in core activities of daily living. These consumers had, because of their severe mental illness and enduring psychiatric disability, faced difficulties transiting back into the community with currently available levels of psychosocial rehabilitation and clinical mental health support.

The gender, age, ethnicity and marital status of the IRRCs consumers were consistent with that of the SECU and CCU population. Their ages ranged from 22 to 64 years, with an average age of 39 years. Most consumers were men (72 per cent), none were currently married and 78 per cent had always been single. Most consumers (75 per cent) were primarily Anglo-Australian or with a mixed heritage (Anglo-Australian with another nationality). The proportion of consumers in IRRCs from a culturally or linguistically diverse background was greater than the general population and is probably due the locations in which IRRCs operates. No consumers were from an Indigenous background.

Effectiveness

The program was effective in achieving the following goals, each described below:

- Consumer outcomes required for reintegration into the community – improved mental health; improved living skills; improved health and wellbeing; transition to sustainable housing and discharge from IRRCs;
- Cost effectiveness; and
- System impacts.

Consumer Outcomes

Outcome goals for the IRRCs were:

- maximised symptom control;
- maximised engagement in the community; and
- reduced intensity and frequency of demand for public mental health services.

Improvement in mental health, living skills, physical health and wellbeing was required for these goals to be achieved and was attained by most consumers in IRRCs as described below.

Mental health

The IRRCs model was effective at reducing psychiatric inpatient and emergency admissions. Changes in health service use showed a trend towards regular and less frequent service use as would be expected with planned service use as part of recovery and relapse prevention plans.

Consumers and staff reported that consumers' mental health improved. Consumers gained greater insight into their own mental health management and demonstrated greater compliance with medication.

Living skills

Consumers' living skills, measured in terms of personal care, domestic skills and community skills, gradually improved. Patterns of slow improvements towards independence indicate that some consumers will require long-term support from other human service programs to maintain the gains.

The assessment and transition process revealed a link between independent living skills and length of stay in a SECU or CCU. The living skills capacity of many consumers in IRRCs was reported as negatively affected by their prolonged time in a SECU or CCU and their earlier institutionalisation.

The greatest living skill gains were in personal care. The move to a less structured living environment with greater emphasis on self-management required more initial support whilst these skills developed. Some consumers' independence in exercise, diet and taking medication, for example, decreased. This may be an effect of consumers moving away from more structured environments where meals are provided, self-care and health are monitored, and for some consumers, supervised taking of medication is mandated. Increased levels of support in these areas, as consumers transition towards independence, are reflected in the data.

Social and economic participation

Significant social and economic participation gains were made. Most consumers had begun to make friends and reconcile with family members. Over half the consumers were engaged in paid or voluntary work or education or had plans to do so.

Health and wellbeing

Consumers reported their physical health improved (46 per cent) or remained the same (54 per cent). Overall wellbeing tended towards the population norm but was still low in all domains except in personal relationships.

Transition to sustainable housing

Consumers were housed in a range of accommodation options, the largest proportion being housed in transitional housing stock. The expected pathway of a move into permanent and affordable housing eventuated for only a minority of consumers due to a range of reasons. At June 2009, nine of the 30 consumers on the program remained in Phase 1 in-reach into the SECU or CCU, either because they had recently entered the program or they needed a longer period of in-reach to prepare for living independently in the community.

Fifty-eight per cent of consumers moved into community housing. Most consumers were allocated accommodation in transitional housing because appropriate and affordable social housing was not readily available. A number of consumers moved into other models of accommodation that better met their assessed needs, including SRS.

The shortage of permanent and affordable public housing stock was a significant barrier to the IRRCs model. Housing allocation resolution worked best where IRRCs providers developed links with the Office of Housing at the local level to facilitate

appropriate and timely housing and to allow for consumer input into housing preferences.

Discharge from IRRCs

Most consumers were discharged from the CCU or SECU and received support to develop their capacity to exit the program. Only a minority of consumers had left the program by the end of the evaluation because of delays identifying the appropriate consumers, delays identifying available suitable housing, variation in the time they needed in each Phase and delays identifying ongoing housing and support to facilitate sustainable exit plans. It is expected that over time the processes will become more efficient so that some of these delays can be addressed.

Cost effectiveness

The annual cost of implementation of IRRCs was less expensive than anticipated in the design and significantly less than the cost of remaining in a SECU or CCU. The cost effectiveness analysis identified expenditure and consumer outcomes associated with IRRCs.

IRRCs funded packages of \$100,000 comprised \$90,000 package per consumer per annum and an allocation of up to \$10,000 per consumer to be used, if required, to support a higher level clinical response than usual from MSTs, for an individual consumer.

The IRRCs provided support to 30 consumers, well above the notional target of 12. For most consumers, the cost of their IRRCs support was less than anticipated in the program design and minimal costs associated with additional clinical support were used.

Consortia reported costs of \$52,000 per consumer including project management, care coordination and care delivery costs. Comparative costs for consumers who remain in a CCU are \$114,610 per person per year (2008-09, \$314 per day) and SECU \$166,805 (\$457 per day).

The average and range of cost per person remains unresolved because it is too early to draw conclusions about the range of time consumers are likely to remain in the program and their range of support needs as the processes continue to be modified over time.

System impacts

The IRRCs has established effective systems for supporting consumers to successfully move out of a CCU or SECU into sustainable housing and support in the community, eventually exiting IRRCs.

In addition the IRRCs has also had wider benefits for discharge processes and coordination in other parts of the mental health system. An improved capacity of the mental health system to respond to shared clients was supported by the development of positive PDRSS and MH relationships, experience in multi-disciplinary care planning, clarification of roles and responsibilities (initially problematic) and the development of communication mechanisms.

Efficiency

The efficiency of the systems, processes and relationships integral to the IRRC model was developmental. Growing efficiency was identified in the following areas described below:

- partnership development;
- systems and processes development; and
- responsiveness to consumer needs.

Partnership development

The IRRC is necessarily a complex model because it aims to generate working relationships between all parts of the mental health system and the wider human services system. Key processes in establishing, implementing, operating and maintaining IRRC included coordination activities to create and maintain the partnerships, agree on goals and establish processes to achieve the goals. These included coordination at the policy management, local and consortium levels. For this reason explicit mechanisms to facilitate communication between the partners were critical to establish and operate the program.

The establishment of these processes took a long time. By the end of the evaluation period strong professional relationships between the organisations, managers and staff and a willingness to engage in a multidisciplinary approach were evident. These relationships had a direct impact on the functioning and efficiency of the IRRC program and its effectiveness in supporting consumers.

The involvement of organisations already integral to the mental health system was a strength of the IRRC model. The impact of this approach was that the consortia were able to build on existing relationships, allocate experienced managers and staff to the program and manage transition out of IRRC into sustainable housing and support within other community services.

Systems and processes development

Very detailed screening and selection processes supported the IRRC. These processes, whilst taking longer than expected, enabled the accurate identification of consumers well suited to the IRRC transitional support model despite great variability in their individual needs. The matching of the level of support consumers required for discharge out of the SECU or CCU with the intensity of the IRRC support available was enabled by the clearly defined eligibility criteria.

The individual support planning was a dynamic individualised process that appeared responsive to the changing needs of the consumer. Monitoring of the individual support enabled support levels and activities to be modified according to changes in consumers' needs.

Exit from IRRC was found to require early planning due to the capacity implications for other parts of the mental health, PDRSS, housing and a range of other generic community-based support services.

Procedures and consumer-related program documentation established by the consortia were modified during the evaluation period to reflect the lessons from implementation. The immediate impact was to more efficiently assess the suitability of consumers, prepare them for discharge from the CCU or SECU and arrange suitable housing and support. In addition, as the program matured, fewer meetings were required to establish and modify the processes.

Responsiveness to consumer needs

The program was able to support more consumers to enter the program than expected due to variation in the levels of support consumers needed at any particular time and in the time they needed in each phase of the program. The intensity of support required by consumers varied within, rather than between, the phases of preparation for transition to the community; support in the community; and transition to ongoing support responses in the community. High levels of support were required at the beginning of all three phases. This required constant responsive change from the workers and high levels of interaction with workers in other parts of the system.

Time lines for consumers moving through the various stages were highly individualised based on the degree of their disability, the types and levels of support needed, the rate of mental health improvement or recovery and the availability of support and housing in the community – some consumers required more time than others. This required the IRRCs to be responsive to individual needs through the design of specific and changing combinations of integrated mental health and psychosocial rehabilitation support.

Applicability of the IRRCs model to other types of consumers of mental health services

By the end of the evaluation period workers recommended that the program model should be expanded to enable other consumers to participate. The combination of high levels of mental health support, psychosocial rehabilitation support and housing had already built service capacity through collaboration and was suitable for addressing the needs of people with chronic severe mental illness and on-going support requirements.

Barriers and facilitators that might influence wider implementation of IRRCs in Victoria include the availability of suitable housing in the short-term so that consumers can leave the SECU or CCU and in the long term to exit IRRCs; the capacity of PDRSS to absorb more consumers exiting IRRCs; and the availability of experienced staff to manage the complex relationships between service providers in the mental health and other human services sectors.

1 Evaluation Methodology

This is the final report of the evaluation of the Integrated Rehabilitation and Recovery Care Program (IRRCP) pilot. The services provided in the program are referred to as IRRCS. This report uses that convention.

The IRRCS is a transition program for consumers from Secure Extended Care Units (SECU) and Community Care Units (CCU), who need a higher level of combined clinical and community treatment and support than is usually available to become reintegrated into the community. IRRCS was piloted in three metropolitan consortia in Melbourne from 2007.

The evaluation of the IRRCS pilot aimed to:

- assess whether the appropriate consumers had been targeted by the IRRCS;
- identify program implementation consistency across the three providers;
- assess early impacts of the project on system practices, such as resolving consumer flow, and consumer outcomes; and
- identify applicability of the service model to other types of consumers of mental health services.

The evaluation utilised mixed quantitative and qualitative methods to address questions of appropriateness, efficiency and effectiveness in meeting the evaluation aims. Data sources included:

- output and key performance indicators (KPI) datasets;
- financial data;
- administrative data;
- program documentation;
- descriptive and outcomes data; and
- consumer, worker, manager and other stakeholder interviews and observation (2008, repeated in 2009).

These data sources were collected by IRRCS providers and transferred to DHS except for the interviews and observation data collected by the SPRC and Victoria University researchers. It was not the purpose of this project to evaluate the performance of individual consortia.

The evaluation project was approved by the DHS Human Research Ethics Committee (HREC no: 100/07), health regional committees and UNSW Human Research Ethics Committee.

The evaluation methods are detailed in Abelló & Fisher (2008). Appendix A includes the evaluation questions. The data framework applies these data sources to the evaluation objectives (Table 1.1).

Table 1.1: Data Framework

Data	Source	Data applied to evaluation objectives			
		Appropriate consumers targeted	Implemented consistently	Impact on system practices	Applicability to other consumers
Outputs and KPIs	IRRCs providers	x	x	x	
Financial and administrative data	IRRCs providers		x		
Interviews – consumers	SPRC	x	x		x
Interviews – service providers	SPRC	x	x	x	x
Observation data	SPRC	x	x	x	x

Consumer samples

Three samples of consumers were included in the evaluation (Table 1.2). Some administrative data were available about all consumers (29 to February 2009 and 30 to June 2009). The IRRCs providers provided other descriptive and outcomes data about 18 consumers. The evaluators interviewed 11 consumers in 2008 and repeated interviews with nine of them in 2009.

Table 1.2: IRRCs Consumers and Evaluation Samples

	Total to February 09	Evaluation client dataset		Interview sample	
		2007-08	2009	2008	2009
Northeastern	10	6	5	4	4
Southern	11	6	4	4	3
Western	8	6	4	3	2
Total	29	18	13	11	9

Evaluation consumer database sample

IRRCs providers transferred evaluation data about all consumers in the pilot to DHS. The baseline data were measured between October 2007 and April 2008. It was updated in May 2009. The different transfer dates means that comparisons between consumers are limited. Some data were missing and this is indicated in the report where relevant.

Interview samples

The evaluators interviewed IRRCS managers and staff, IRRCS consumers, their clinical services case managers, PDRSS care co-ordinators and PDRSS support workers in 2008 and again in 2009 (Table 1.3).

The samples were selected from the first four consumers to enter IRRCS in each location who agreed to participate in the evaluation. The staff who supported the consumers were then asked if they would agree to be interviewed. Two consumers were not available for the repeat interview. The number of PDRSS staff interviewed is greater than other workers because most consumers in the evaluation sample had more than one PDRSS worker or staff changed during the evaluation.

Table 1.3: Evaluation Interview Samples

	Numbers of interviews				Total
	Consumers	MHS staff*	PDRSS staff	Managers and staff	
First contact 2007-08	11	7	14	12	44
Second contact 2009	9	5	8	-	22
Total	20	12	22	12	66

Note: *Staff of SECUs, CCUs, MSTs and CCT

Consumer interviews were about their experiences and satisfaction with their transition from SECUs and CCUs to living in the community and the psychosocial and clinical support they receive. These discussions included the consumer's interaction with the mental health system prior to IRRCS, their relationships with clinical mental health case managers and PDRSS staff, individual support and mental health plans, their housing, neighbourhood, community and social involvement, any relationships with friends or family, interests and wishes for the future. The topic guide for consumer interviews is at Appendix B.

Interviews with agency staff were about the intake of consumers to IRRCS, individual support planning, mental health planning for transition to living in the community, housing, clinical mental health and psychiatric disability support required to sustain consumers in the community (Appendix B).

Program implementation data are from program documents, meetings, discussions, interviews (above) and observation with the consortia and DHS. In 2007, 12 interviews were conducted with the stakeholders from the three consortia (2 North Eastern; 3 Southern and 7 Western). Most respondents had been involved in the IRRCS since its inception in early 2007. The stakeholders were from various agencies, including representatives from the lead agencies in each consortium. Roles of the stakeholders range from daily responsibilities to being involved in more consultative roles (Governance, Purchasing and Client Selection Committees).

2 Design of IRRCs

IRRCs is a new program for consumers in SECU and CCU, who need a higher level of combined clinical and community treatment and support than is usually available to them to become reintegrated into the community. IRRCs aims to improve consumer outcomes through:

- providing more targeted and time limited, high level psychosocial rehabilitation and clinical support;
- facilitating access to appropriate housing or other accommodation options; and
- increasing opportunities to participate in community activities such as recreation, education, vocational training and employment.

IRRCs also aims to embed system improvements through:

- strengthening collaborative practice between the Psychiatric Disability and Rehabilitation Support Service (PDRSS) services, extended care clinical services (SECU and CCU) and local Mobile Support and Treatment Service (MSTS);
- improving the continuity of care for consumers across these service components, particularly at critical transition points;
- increasing the capacity for the PDRSS sector to support high needs consumers; and
- increasing the response capacity of clinical, bed-based services. The pilot targeted a specific subset of consumers to improve throughput in bed-based services.

The IRRCs pilot was established to target consumers who meet the following criteria – those who:

- because of their severe mental illness and enduring psychiatric disability face difficulties transiting back into the community with currently available levels of psychosocial rehabilitation and clinical mental health support.
- can be managed on a Community Treatment Order (CTO), if involuntary treatment is required, and do not require active inpatient treatment and care.
- are assessed as being able to live in the community if provided with high levels of multidisciplinary psychosocial and clinical treatment and support, and access to stable and affordable housing or other accommodation.
- are assessed as having potential for achieving a level of daily living skills and social functioning such that, after an extended period of community-based, high level and focused rehabilitation support, they could be successfully maintained in the community, with a lower level of ongoing psychosocial support and clinical care.
- do not pose an unmanageable risk to themselves or the community if they were discharged from SECU or CCU.

In practice, a further criterion was that after discussion and negotiations that included family, friends or other carers or representatives, the consumer indicated a willingness to move from the clinical bed-based service.

The model has three phases indicative of the consumers' pathway to recovery: preparation for transition to the community; high level support in the community; and transition to ongoing support responses in the community (Table 2.1).

Table 2.1: Indicative Phases of Consumer Pathways through IRRCs

Phases	1. Preparation for transition to the community	2. High level support in the community	3. Transition to ongoing support response in the community
Timeframe	Up to 3 months:	12-15 months	Up to 3 months
Tasks	-Identification of consumers -Development of care plan, housing options -Consumer engagement through PDRSS 'in-reach' support	-Intensity of rehabilitation support decreasing as living skills improve	-Transit to ongoing PDRSS response (Home-based Outreach Support) and clinical case management services (MSTS or CCT) and generic community support
Goal	Move to the community	Support in the community	Support in the community
Key stakeholders	-PDRSS providers -MSTS provider -Lead worker – SECU/CCU -Housing service -Consumer and carers	-PDRSS providers -MSTS provider -Generic community support	-PDRSS providers -MSTS/CCT provider -Generic community support
Source: Department of Human Services			
Notes: MSTS - Mobile Support and Treatment Services; PDRSS - Psychiatric Disability and Rehabilitation Support Services; SECU - Secure Extended Care Unit; CCU - Community Care Unit; CCT – Continuing Care Team			

IRRCs planning has three elements:

- care coordination, liaison between relevant support staff and monitoring of the integrated plan;
- the individual's support plan which identified personal goals and what would be provided; and
- an exit plan to move the consumer from the IRRCs, with staged support withdrawal, reducing the number of hours or workers that visit, transfer to a MHS Continuing Care Team (CCT), and transfer to a PDRSS home-based outreach program or other relevant exit option for example a Supported Residential Service (SRS).

IRRCs is delivered by consortia of PDRSS in three regional clusters. The consortia work in partnership with area mental health services including the regional SECU, a number of CCUs and the relevant community mental health teams including MSTS and CCT. The consortia that participated in the pilot and evaluation were:

- Southern IRRCs – Eastern Regions Mental Health Association (lead agency), Prahran Mission, Peninsula Support Services, Reach Out and Richmond Fellowship Victoria.

- Western IRRCS – Western Region Health Centre (lead agency), North Western Mental Health, Norwood Association, Dousta Galla Community Health Service, Werribee Mercy Mental Health Program, Richmond Fellowship Victoria, Dianella Community Health and Moreland Community Health Service.
- North Eastern IRRCS – including Richmond Fellowship Victoria (lead agency), Eastern Access Community Health (EACH) and ARAFEMI.

The program aims to address some of the contextual changes that have an impact on the rehabilitation and care of people with severe mental illness and associated disability, including service demands, PDRSS expansion, workforce availability and system blockages (Mental Health Branch, 2006).

The evaluation found that the IRRCS delivered a service that was consistent with the program aims. The IRRCS undertook the:

- provision of targeted and time limited, high level psychosocial rehabilitation and clinical support;
- facilitation of access to appropriate housing or other accommodation options; and
- activity to increase opportunities for participation in community activities.

The design and implementation of the program achieved outcomes in terms of appropriateness, effectiveness and efficiency as described in the next sections.

3 Appropriateness

The first aim of the evaluation was to assess whether the appropriate consumers were targeted by the IRRCS pilot. The evaluation found that the IRRCS targeting of SECU and CCU consumers met the IRRCS eligibility criteria guidelines.

This section provides information about the characteristics of the consumers who participated in IRRCS to February 2009 (29) (Table 1.2). It describes the consumers in the evaluation dataset (18) and interviews (11). Most information is from late 2007, with additional profile information about three consumers in September 2008 reports.

3.1 Number of Consumers in IRRCS

The IRRCS pilot was expected to have a minimum of four consumers in each regional cluster, with at least one from a SECU (total 12). In practice, the providers were able to assess and support 30 consumers within the IRRCS budget. Additional information on the possible reasons for the number of consumers is provided in Section 5.1 (Table 3.1 and Table 1.2).

Table 3.1: Total IRRCS Consumers, May 2008 to June 2009

	Total	Phase 1 Care plan approved and costed	Phase 1 In reach support completed	Phase 2 Living in community	Phase 3 Exited IRRCS
May 08	15	9	5	5	0
September 08	26	21	18	17	2
February 09	29	22	18	18	2
June 09	30	27	21	20	7

Source: DHS Client Tracker Dataset

As at June 2009, most consumers were living in the community with IRRCS support (20/30) and seven had exited IRRCS to stable community living, including using other community supported living options (Table 4.22). The IRRCS consumers remaining in the CCU or SECU (9/30) were there because they had recently entered the program and were still being assessed; their mental health was unstable; they were receiving in-reach or they were waiting for housing (Section 4.6).

The remainder of the section is about consumers from the evaluation dataset (18) and interviews (11). Information about the consumer characteristics include type and length of stay in bed-based mental health service at time of entering IRRCS, core activity restrictions and their age, gender, eligibility for entering IRRCS. Some of variation in outcomes discussed in the next section might be explained by the diversity in these characteristics.

3.2 Mental Health and Disability Characteristics

Fourteen consumers were living in a SECU and fifteen in a CCU before they joined IRRCS (DHS Client Tracker). One consumer had moved from a SECU to a CCU as

part of his transition. All the Western IRRCs consumers came from a SECU, while the majority from Eastern and Southern came from a CCU.

Consumers had been living in a SECU or CCU for periods ranging from 21 months to up to 20 years. The average length of time since previously living in the community was approximately 6 years. Most consumers reported long involvement with the mental health system; for many consumers this involvement began in their adolescence. Their histories included admission to and very long stays in acute mental health inpatient units, child and adolescent mental health units, rehabilitation units, SECUs and CCUs and living in a SRS. Many consumers had multiple admissions some over decades.

Mental health at entry to IRRCs

Schizophrenia was the primary mental illness diagnosis for 16 of the 18 consumers (89 per cent) (Table 3.2). Of the remaining two consumers, one had a diagnosis of bipolar disorder and the other schizoaffective disorder. The most common secondary mental illness diagnosis was major depression and anxiety, experienced by four consumers. While many consumers had the single diagnosis of schizophrenia, a smaller number also had a secondary diagnosis. One consumer had multiple diagnoses of schizophrenia, Asperger’s syndrome, major depression and psychosis.

Table 3.2: Consumers’ Mental Health Diagnoses, 2007-08

	Primary diagnosis	Secondary diagnosis	Total consumers
Schizophrenia	16	0	16
Major depression/anxiety	0	4	4
Schizoaffective disorder	1	2	3
Bipolar disorder	1	0	1
Asperger’s syndrome	0	1	1
General anxiety disorder	0	1	1
Schizophreniform psychosis	0	1	1
Obsessive compulsive disorder	0	1	1

Source: Evaluation client dataset, n=18

Note: Total is more than 18 because some consumers had more than one diagnosis

When they entered IRRCs, most consumers (13 or 72 per cent) were ‘involuntary’ consumers of mental health services. Only three consumers were voluntary. The legal status of two consumers is unknown. Three consumers were on Community Treatment Orders.

Disability and core activity restriction

In addition to their mental health condition, many IRRCs consumers also had at least one co-existing physical (3/17) or intellectual disability (3/17) or drug and alcohol disorder (3/17) (Table 3.3). Six consumers had multiple disabilities. At the start of the IRRCs evaluation (2007-08), staff rated consumers’ core activity restrictions as a result of disability (Table 3.3).

Table 3.3: Core Activity Restriction by Disability, 2007-08

Restriction*	Psychiatric disability	Physical disability	Intellectual disability	Drug, alcohol disorder
Mild	5	3	1	0
Moderate	2	0	1	2
Severe	7	1	1	1
Profound	3	0	0	0
Total	17	4	3	3

Source: Evaluation client dataset

Note: Missing=1

* ABS 2003 definitions

The four levels of core-activity restriction are based on whether someone needs help, has difficulty performing, or uses aids or equipment with one or more core activities, which are communication, mobility and self care (defined by Australian Bureau of Statistics, 2003). The four levels of restrictions or limitations are profound, severe, moderate and mild:

- Profound: the person is unable to do, or always needs help with, a core-activity task;
- Severe: the person sometimes needs help with a core-activity task and has difficulty understanding or being understood by family or friends;
- Moderate: the person needs no help but has difficulty with a core-activity task; and
- Mild: the person needs no help and has no difficulty with any of the core-activity tasks, but [has minimal restriction(s) and may use] aids and equipment [or other support].

Psychiatric disability

The level of core activity restriction associated with psychiatric disability ranged from mild through to profound. Most consumers (10) had severe or profound restriction, which was similar across the consumers in the three consortia. One of the SECU consumers who had not lived in the community for the last 20 years has a 'mild' restriction.

Physical disability

Four of the 18 consumers had a physical disability. Of these four, one had a severe core activity restriction associated with the impairment and the remaining three a mild restriction.

Intellectual/cognitive disability

Three of the 18 consumers had an intellectual disability. Of these three, one has a severe restriction associated with the impairment, one was moderate and one was mild.

Multiple disabilities

Six consumers experience multiple disabilities (psychiatric disability, physical disability and/or intellectual disability). One older consumer experiences all three disabilities and his level of core activity restriction was recorded as severe for each.

Drug and alcohol disorder

Only three of the 18 consumers had a co-existing diagnosed drug and alcohol disorder. While this is a lower number than may have been typically expected, given the links between mental illness and drug and alcohol misuse it probably reflects the length of time the consumers had been in the SECU or CCU. Of the three consumers, their core activity restriction was severe or moderate

Justice system

Only one consumer spent time in prison in the year before entering IRRCS, again this is probably due to the length of stay in the SECU or CCU of the consumers.

Demographic characteristics

The age range is 22 to 64 years old, averaging 39 years (Table 3.4).

Table 3.4: Age of Consumers, 2007-08

	Consumers	Per cent
<20 years	0	0
20-29 years	4	22
30-39 years	6	33
40-49 years	5	28
50-59 years	1	6
60 years and over	2	11
Total	18	100

Source: Evaluation client dataset

More men (72 per cent) than women are in the program (Table 3.5). Each area has at least one woman. This is similar to the mix of consumers living long term in SECUs and CCUs.

Table 3.5: Gender of Consumers

	Consumers	Per cent
Female	5	28
Male	13	72
Total	18	100

Source: Evaluation client dataset

Consumers' cultural and linguistic background is primarily Anglo-Australian (8), with an additional four consumers identifying as Australian with another nationality (Australian-Indonesian, Turkish-Australian, Greek-Australian, Polish-Australian) (Table 3.6). The remaining four consumers identify as German, Turkish, Indonesian and Spanish. The proportion of consumers in IRRCs who had a CALD background is greater than the general population. No one is known to have had an Indigenous background.

Table 3.6: Cultural Background of Consumers, 2007-08

Ethnicity	Consumers	Per cent
Anglo-Australian	8	50
Both CALD and Anglo-Australian	4	25
CALD	4	25
Indigenous Australian	0	0
Total	16	100

Source: Evaluation client dataset

Note: Missing=2

3.3 Summary of the Consumer Profile

The IRRCs targeting of SECU or CCU consumers met the IRRCs eligibility criteria guidelines. The IRRCs consumers had lived in a SECU or CCU on average for approximately six years. The majority of consumers (72 per cent) had an 'involuntary' mental health legal status. For most consumers the primary mental health diagnosis was schizophrenia (89 per cent).

One third of consumers had multiple disabilities, including psychiatric, physical and/or intellectual disabilities. Three consumers had diagnosed drug and/or alcohol disorders. All consumers at entry into the IRRCs were assessed as having restrictions in core activity of daily living. These consumers had, because of their severe mental illness and enduring psychiatric disability, faced difficulties transiting back into the community with currently available levels of psychosocial rehabilitation and clinical mental health support.

The gender, age, ethnicity and marital status of the IRRCs consumers were consistent with that of the SECU and CCU population. Their ages ranged from 22 to 64 years, with an average age of 39 years. Most consumers were men (72 per cent), none currently married and 78 per cent had always been single. Most consumers (75 per cent) were primarily Anglo-Australian or with a mixed heritage (Anglo-Australian with another nationality). The proportion of consumers in IRRCs from a culturally or linguistically diverse background was greater than the general population and is probably due the locations in which IRRCs operates. No consumers were from an Indigenous background.

4 Effectiveness – Consumer Outcomes

The second evaluation aim was to assess the program's effectiveness of achieving consumer outcomes, cost effectiveness and system impacts, discussed in the next three sections. This section reports on outcomes experienced by consumers since participating in the IRRC pilot. Outcome goals for the IRRC were:

- maximised symptom control;
- maximised engagement in the community; and
- reduced intensity and frequency of demand for public mental health services.

Improvement in mental health, living skills, physical health and wellbeing was required for these goals to be achieved

First measure data were available for 18 consumers (to March 08) and follow up data for 13 people in April 2009, enabling some longitudinal outcome analysis. In addition, 11 consumers participated in first measure interviews, with follow up interviews for nine consumers in February and March 2009. Because the samples are small, only general conclusions can be drawn from the outcome data.

Outcomes measured are mental health, living skills, social and economic participation, health and wellbeing, transition to sustainable housing, finances and goals. Instruments used to measure the outcomes are described in each section and in more detail in Abelló & Fisher (2008).

4.1 Mental Health

The first consumer outcome is mental health. Central to the success of the IRRC is its capacity to provide the psychosocial rehabilitation and clinical support in the community that helps consumers avoid or minimise the effects of mental illness relapse. The evaluation relies on clinical mental health data and the longitudinal interview data with consumers and staff about mental health changes.

Consumers and staff reported that consumers' mental health had improved from participating in IRRC as evidenced by:

- remaining living outside a CCU or SECU;
- fewer hospitalisations;
- compliance with medication; and
- greater insight into their own mental health management.

One PDRSS worker reflected on the gains of the consumers assisted:

The idea was to give them a run, to see if they could do it with enough support. It's been a good investment. It's been a great thing to give them the opportunity. Even three out of four for our program is a good outcome. They've realised more independence. They've had a run at freedom to a degree and realised their own level of it.

Mental health records

Comparative clinical mental health records were available for 11 consumers with repeat scores for HONOS (Health of the Nation Outcomes Scale), LSP (Life Skills Profile) and Focus of Care. None of the measures showed significant change (Table 4.1 and Table 4.2). The number of participants for whom data was available is too small to be certain of the explanation for that result. Explanations could include that their mental health as measured by these instruments did not change; the measures are insufficiently sensitive to measure change over this period; the measures might have been repeated at times of unstable mental health, such as inpatient admissions; or the variation between the consumers in such a small group was too wide to make generalised conclusions. It is also possible that the differences on items within the instruments that have the potential to be influenced by IRRCs (e.g. activities of daily living) were masked by items that were not expected to be influenced by IRRCs (e.g. cognitive problems).

Table 4.1: Clinical Mental Health Measures HONOS and LSP, 2007-2009

	Consumers	Minimum	Maximum	Mean	Std. Deviation
HONOS time 1	10	8	31	14.0	7.7
HONOS time 2	11	7	30	14.7	6.8
HONOS time 3	11	8	21	14.6	5.1
LSP time 1	10	4	32	16.4	8.8
LSP time 2	11	3	25	14.5	6.5
LSP time 3	11	9	22	14.3	4.1

Source: Evaluation client dataset

Notes: Time one = Sep-Dec 06 (Prior to entry to IRRCs); Time two = May-June 07 (entry to IRRCs)
Time three = Dec 08-Jan 09 (repeat in IRRCs). No significant change

Table 4.2: Clinical Mental Health Measures Focus of Care, 2007-2009

	Acute N	Functioning gain	Intensive extended (prevent deterioration) N	Maintenance
Time 1	1	4	1	5
Time 2	0	6	3	2
Time 3	0	3	6	2

Source: Evaluation client dataset

Notes: Time one = Sep-Dec 06 (Prior to entry to IRRCs); Time two = May-June 07 (entry to IRRCs)
Time three = Dec 08-Jan 09 (repeat in IRRCs). No significant change

Relapse prevention plans

Workers and consumers attributed the successful mental health outcomes for most consumers to active relapse prevention plans. These plans enabled the consumers to recognise and participate in managing changes in their mental health. They reflect cooperation between the consumer, PDRSS worker and clinical workers. For example, two clinical case workers said,

I am able to work through that cognitively with him, and reflect on what some of the symptoms were and what might some of the stressors be, what are some of the contributing factors in terms of the influence of drugs and his compliance with medication. So taking step-by-step through, and for him to be able to identify what the early warning signs would be and what that means to him and why it is causing it, and what resources are available to him if he needed to deal with it.

[Consumer] has been very proactive which surprised me, doing a relapse management plan and was able to identify some early warning signs. I thought he would be resistant. He has a copy as well as [PDRSS worker] and [Care Coordinator]. In case any signs or symptoms are identified, we're able to put that plan into place to prevent a relapse (MSTS case manager working with a consumer with an acquired brain injury).

Even in cases where the relapse resulted in hospitalisation, the workers reflected that the relapse prevention plan still managed to lessen the effects of a consumer's relapse. A PDRSS worker said,

She has had a relapse. It was so sudden that the MST became involved. The plan did help in the early identification of symptoms, but didn't stop it. She is now in hospital.

Relapse prevention strategies included:

- Monitoring medications and a consumer's mental state;
- Providing support around new stressors arising from their transition to community life, neighbour relations, work and education, changes in family relationships and friendships and being alone;
- Assistance with medication such as depo injections, Webster packs and dosettes, delivering medications, and coordinating medication with staff in the housing setting (SRS, CCU);
- Monitoring the effects of the behaviours of other CCU or SRS residents that may impact on the consumer's stability;
- Encouraging insight around relapse signs such as obsessive, depressive, paranoid, suicidal or delusional thinking, elevated hearing of voices, drug and alcohol use, panic attacks, rage and aggression;
- Having strong support relationships that encourage open discussion about any symptoms the consumer may be experiencing that are early warning signs;
- Forward planning so that consumers are prepared with achievable goals and are neither fatalistic or overly impatient;
- Building plans onto strategies from former settings (SECUs and CCUs) and including former case managers; and
- Managing health conditions and improving physical wellbeing.

IRRCs workers recorded that implementing relapse plans was more difficult if the consumer had co-existing disabilities that affected memory and motivation, for

example acquired brain injury or intellectual disability. They gave examples that illustrate their strategies for managing the consumers' additional needs,

There is a lot of discussion about medication treatment and possible changes. I wouldn't go as far as saying the consumer has relapsed although it is clear she is psychotic. If the team decides to change the medication routine ... then as case manager I would be doing a file search to learn more about her relapse pattern.

Consumer insight into mental health

IRRCs enabled some consumers to gain insight into their mental health condition, managing their mental health and contributing to preventing a relapse. This is in contrast to their reflections about an absence of such insight before participating in IRRCs. Examples from consumers are, 'I was sick since 1992 though I only realised this in the last two years when I got insight into my condition.' 'I've been sick all the time since 1984 when my mental illness came.' 'I have had a lot of psychotherapy which has given me a lot of insights.'

Some of the insights into mental illness expressed by consumers later in the evaluation related to acknowledging their long-term condition, and recognising and managing short-term changing symptoms. Consumers said,

Some days I have good times and sometimes I've had bad times. I'm pretty bad sometimes I get up, have something to eat and watch something on TV or go back to bed.

It's just the cycle, that's how I think of it, of well and sick. I don't know if I'll be cured.

I've been up and down. I haven't done many of the things I used to. I haven't played sport because I've got no one to play with. Sometimes I feel very paranoid.

Although most consumers seemed to gain insight over time, some had not achieved that yet. Workers gave examples of how they work creatively to support consumers to work towards gaining insight. One PDRSS worker said,

He's got much more insight into his condition. There's a lot of thought that this may not move. It could work but we've just got to see and support him rather than not support him.

Having recognised their long-term condition and short-term symptoms, consumers reflected that they were able to receive support to manage these changing symptoms, so as to minimise the degree to which the symptoms disrupt their lives. For example, four consumers said,

My voices? It's not a constant conversation. It's much, much better. My mind is falling into place. It's not so fragmented and I hardly hear any voices.

I don't get angry anymore. It takes me a lot to get angry. I haven't been angry, not even an outburst, not since the new medication. I feel like a bit of a blob, I can't get angry.

I still have a bit of an anxiety problem. I saw a psychologist for the first time last week, I got a referral from my GP on the request of the [MSTS] psychiatrist.

I've been not taking the medication too. Before I was not a good guy then I went to [psychiatric rehabilitation service]. I was depressed I know. I didn't know what was wrong with me, but now I do.

Medication support

Most consumers were complying with their medication and reflected on their understanding about how medication contributes to managing their mental health so that they can avoid hospital admissions and continue living in the community. A consumer and PDRSS worker said,

I was arguing with [PDRSS worker]. She said I was rude. Then she found out I didn't drink the medication. She always tells me, 'You don't drink the medication, you have to go to hospital.'

His health has been up and down, not so compliant with medication is a bit up and down. Other than that he's been okay, no physical health problems. He hasn't ended up in hospital so that's positive. It's been a constant battle to keep the medication going. MST started monitoring him, then that dropped off when he was compliant.

Some consumers were no longer on CTOs and were managing their medication with support. While willingness to comply is important, some consumers did not have the capacity to manage medication alone without structured support. Identifying this capacity was part of the assessment and review processes. A PDRSS worker said,

I think he would manage his medication given his structure and rigidity. If it was in a dosette box he could manage that. He's very aware of how important it is to take his medication.

Acute inpatient hospital admissions

The IRRC model based on individual support and care plans (Section 8.2) has been effective at reducing psychiatric inpatient and emergency admissions (Section 4.4). According to one PDRSS worker, in their area, 'None of them have ended up in hospital.' Consumers were aware of the link between managing their mental health and avoiding acute inpatient hospital or CCU/SECU admissions and losing their housing in the community. They were positive about having stayed out of bed-based clinical services during their time in IRRC. Consumers said,

The main goal is to keep out of hospital because of the long admission I had last time, three years. Since I last saw you I haven't gone in. Not since I got out in August, I haven't gone back.

No psychiatric admissions, I've been here all the time, since June last year. So it's eight months I've been here and I haven't been in the hospital.

4.2 Living Skills

The second consumer outcome is living skills. Staff rated consumers on their independence in aspects of the living skills domain in early 2008 and a year later. Living skills relate to self care, domestic skills and community living skills. The assessment and transition process revealed a link between independent living skills and length of stay in a SECU or CCU. Support workers and consumers spoke about how the living skills capacity of many consumers in IRRCs is negatively affected by their prolonged time in a SECU or CCU and their earlier institutionalisation. For some consumers, IRRCs Phase 1 in-reach activities were targeted at developing or re-establishing activities of daily living skills required to live in the community.

Self care

At March 2008 IRRCs staff rated consumers' level of independence in five self care tasks: bathing, dressing, diet, exercise and taking medication (Table 4.3).

Table 4.3: Self Care Skills during IRRCs, 2007-08

	Bathing	Dressing	Exercise	Diet	Taking medication
Independent	13	12	10	5	0
Supported less than half the time	1	3	4	7	8
Supported more than half the time	3	3	3	4	3
Fully dependent	1	0	0	2	7
Don't know	0	0	1	0	0
Per cent who are independent more than half the time (first interview)	78	83	78	67	44

Source: Evaluation client dataset

Note: n=18

Consumers were most independent in bathing and dressing and most dependent in taking medication. The dependence level for taking medication partly reflects that the majority of consumers were involuntary consumers of mental health services or under CTOs, which require the supervision of medication by a mental health service case manager. It is also consistent with their prior admission in the SECU or CCU.

Table 4.4: Change in Self Care Skills, 2007-08 and April 2009

	Bathing	Dressing	Exercise	Diet	Taking medication
Increased independence	1	2	3	5	3
No change	1	1	0	2	5
Decreased independence	0	0	7	4	5
Independent	11	10	3	2	0

Source: Evaluation client dataset

Note: n=13

For all the consumers for whom longitudinal data were received, independence remained high and increased for bathing and dressing (Table 4.4). Independence declined for exercise, diet and notably medication. This might be an effect of consumers moving to transitional and independent housing and away from more structured environments where meals are provided, self-care and health are monitored and supervised taking of medication is mandated for some consumers. Increased levels of support in these areas by PDRSS and MHS, with the consumer's transition towards independence are reflected in these data.

Domestic skills

Domestic skills include cooking, cleaning, shopping and laundry. Consumers at the first point were more dependent in relation to domestic skills than self-care skills (Table 4.5). They were most independent in cooking and laundry, and least independent in shopping and cleaning skills.

Table 4.5: Domestic Skills during IRRCs, 2007-08

	Cooking	Laundry	Shopping	Cleaning
Independent	7	7	5	5
Supported less than half the time	5	5	5	4
Supported more than half the time	2	3	1	3
Fully dependent	4	3	7	6
Per cent who are independent more than half the time	67	67	56	50

Source: Evaluation client dataset

Note: n=18

A year later the proportion of consumers fully independent had increased in cooking and laundry and more consumers were moving towards independence in shopping and cleaning (Table 4.6). Some consumers (2/13) also lost some independence during the year.

Table 4.6: Change in Domestic Skills, 2007-08 and April 2009

	Cooking	Laundry	Shopping	Cleaning
Increased independence	2	3	4	6
No change	5	2	4	2
Decreased independence	0	2	2	2
Independent	5	6	3	3

Source: Evaluation client dataset
Note: n=13

The acquisition of the skills of daily living was common to all individual support plans. PDRSS workers were pragmatic, in the main, about consumer's cleanliness in their homes. One PDRSS expressed this view,

As far as neatness and tidiness is concerned I think people have a right to independence – there may be personal dangers in this though relating to health, hygiene and fire risks. We can only support the person to make informed choices in respect of this. If consumers have an ongoing issue with this we can get home help to help keep them living independently ... sometimes we see a sudden and uncharacteristic change in the neatness/tidiness/cleanliness of their home and this may be indicative of an episode of unwellness.

Skills in cooking also relate to shopping and affect diet and health. A case manager noted,

Cooking is one of the things that he's needing to work on. He says to me sometimes, 'I'm just eating junk. I just can't be bothered, I'm eating pizza and all that.' I said I will discuss it with [PDRSS worker] and he said he would look into it, and then make a plan that he can start work on. Because of the medication he's on it's more likely that he will put on weight.

PDRSS workers found it difficult to support some consumers where their psychiatric disability posed challenges for helping to move them towards greater independence in domestic activities. A PDRSS worker said,

It's hard to say if he could live independently. It's mainly motivating him and his OCD just doesn't allow him to do certain things. It's still a problem, so it would be a massive problem if he had to cook and clean for himself, it just wouldn't happen. He has insight about this. I think it's why he prefers to keep his life quite simple too. The simpler it is the less he has to think things through.

Several consumers were dealing with their skill gap as a consequence of never having lived alone and difficulties with being alone. One consumer's treatment-resistant mental illness and long-term institutionalisation produced a high level of psychiatric disability. A very structured support and assertive case management, with boundary

setting and rules enabled this consumer to live successfully and safely in a community setting.

Community skills

Community living includes getting to places, using public transport, banking, budgeting, use of community services and making appointments. In March 2008 consumers were least independent in this set of skills (Table 4.7). They were most independent using public transport and getting places and least independent on making appointments, using community services, budgeting and banking.

Table 4.7: Community Skills during IRRCs, 2007-08

	Getting around	Use public transport	Banking	Use community services	Make appointment	Budget
Independent	4	5	4	2	2	1
Supported less than half the time	9	6	3	3	3	4
Supported more than half the time	2	0	2	2	1	5
Fully dependent	3	6	9	10	12	8
Don't know	0	1	0	1	0	0
Per cent who are independent more than half the time	72	61	39	28	28	28

Source: Evaluation client dataset

Note: n=18

Some consumers were moving towards greater independence in community skills a year later (Table 4.8). This also reflects that MHS and PDRSS staff particularly focused on this aspect of consumers' transition and addressing the loss of skills as a result of living in a SECU or CCU for an extended time.

Table 4.8: Change in Community Skills, 2007-08 and April 2009

	Getting around	Use public transport	Banking	Use community services	Making appointments	Budget
Increased independence	5	7	4	6	6	6
No change	1	2	5	3	4	5
Decreased independence	4	0	2	2	2	1
Independent	2	4	2	1	1	0

Source: Evaluation client dataset

Note: n=12/13

After the profound effects of institutionalisation, learning to take advantage of the greater personal freedom of living in the community was part of the skill development for some consumers. A PDRSS worker said,

His freedom is important to him. It has grown from going to the shopping centre to buy something because we told him to, to him going by himself and he might get other stuff that he needs. He's starting to realise how much freedom he has. He used to always tell a staff member where he was going and what time he'd be back. Now he doesn't feel he has to tell them. He knows he is free to come and go. He can go home for the weekend and come back when he wants. I'd say coming from [a psychiatric facility] a year ago, that's a very big move.

Aspects of community living skills (e.g. socialising, moving around the community and skills like cooking) were addressed not only within individual support relationships but also within the centre-based programs that some PDRSS provide. While some consumers accessed these groups and resources, some did not want to. The example below from a consumer raises questions about whether PDRSS workers offered sufficient individualised choices for a range of community-based activities. Alternatives that could be appropriate for some consumers for example are skills development programs at a Neighbourhood House or TAFE. A consumer said,

Sometimes I go to [PDRSS centre-based activities], not very often, every two or three weeks. I do nothing there. I don't want to join a group. I'd have to go every week, just talking and talking all the time.

Consumers' intellectual and cognitive disability also had an impact on their capacity to learn skills. Workers commented on the difficulties some consumers faced in acquiring skills if they had Asperger's Syndrome, drug and alcohol related brain damage or a brain tumour. A PDRSS worker said,

My client has done really well, better than anyone expected but his [disability] needs remain the same. No change is possible at the moment. His memory has been severely damaged by his use of alcohol and drugs. There has been no change in the hours of support needed. He had increased support after living at the CCU for many years. He has made no connections with other programs.

These examples illustrate the need for staff training and support to design and implement individualised assessment, planning and skill development for consumers with co-existing disabilities.

Financial skills

Managing finances or support to do so is an essential requirement of transition to independent living in the community. Most consumers were not independent in their budgeting and banking skills by April 2009, although budgeting was the one skill area where everyone had progressed towards achieving greater independence (Table 4.8).

Most consumers rely on the Disability Support Pension for income. Some consumers had additional, very small, occasional income from supported employment. Some consumers had not managed their own finances for years with their affairs under the

control of a trustee. A trustee has granted one consumer a bank account with a small income to manage. Two consumers had a guardian before they started IRRCs. Both consumers still had a guardian at the time the data were recorded. Several consumers are under financial guardianship. Some consumers disliked having no control of their affairs (e.g. 'I feel like a prisoner'). Some consumers were planning towards managing their own affairs. A PDRSS worker said,

He wants control of his money and I and the MST staff think he should have control but we'll have to work around budgeting and managing his money for that to happen. Shopping and all that will come into it.

At a later interview this consumer, still with an administrator, was doing more himself, saying,

I pay my bills. I had gas and electricity bills and I paid them. So I had to get a new address on my pension card to get the discount. Once I get a job I'll be right, I'll be able to save more.

Concerns about budgeting and banking delayed transition plans for some consumers. One consumer said,

They were a bit worried that I'm going to manage my finances. I was originally meant to move in really quickly and they decided to do it differently and take it much more slowly.

Interview comments reveal the link between a lack of financial skills and other participation choices. For example, a consumer and PDRSS worker said,

The administrator says he's putting money aside in investments. [PDRSS worker] can't get in touch with him. I'd like to get my full pension like anyone else. He's taking money out and my balance isn't growing when I see the statements. It's confusing and it's been going on for ages.

His money is administered by State Trustees, but PDRSS staff monitor his bank key card, his cash and his cigarettes, as he will still go out and drink and use all the funds in his bank account if he can access his money.

Managing a small income means limited capacity for social and leisure activities. One consumer said,

I can go out of here, that's one thing you can do. But that's not much enjoyment because what can you do out there if you haven't got much money. Walk the street, pace up and down and do nothing else. I'm on the pension [DSP].

Some PDRSS workers use brokerage funds to help consumers participate in social activities.

4.3 Social and Economic Participation

The third consumer outcome is social and economic participation. A goal of IRRCs is to increase opportunities to participate in community activities such as recreation,

education, vocational training and employment. Social and economic participation after a prolonged time in SECU or CCU was a big challenge for many consumers. This section discusses social networks, family, friends, neighbours, community activities and economic participation. Information is from the Evaluation Client Dataset collected by IRRC providers and fieldwork interviews by the researchers.

Social networks and family

In 2007-08 most consumers (14/18) were single and never married (Table 4.9). Two of the 18 consumers were in an intimate relationship. A year later, for those for whom longitudinal data were provided, the situation was unchanged, except for one person who began a relationship.

Table 4.9: Relationship Status of Consumers, 2007-08 and April 2009

	Consumers		Change 2007-08 to 2009
	2007-08	April 2009	
Partner, married	0	1	One person started an intimate relationship
Divorced or separated	4	2	No change
Never married	14	9	No change
Current relationship	2	1	No change
Total consumers*	18	12/13	

Source: Evaluation client dataset

Note: * Consumers could have more than one response.

In 2007-08 the most common regular social contact by consumers was with parents and siblings (Table 4.10). Most IRRC consumers had family connections. Thirteen (72 per cent) consumers saw their parents at least weekly. Most consumers (12/18) also had contact with their siblings. Three female consumers had contact with their children; one had contact more than once a week and two only had yearly contact. Most notably though is that most consumers did not have friends or see them.

Table 4.10: Social Contact, 2007-08

	Frequency of contact			
	More than once per month	1-3 times per quarter	Yearly	Never, N/A
Parents	14	0	2	2
Siblings	8	3	1	6
Friends	5	3	0	10
Children	1	0	2	15
Carer	2	0	0	16
Other	6	0	0	12

Source: Evaluation client dataset

Note: n=18

By April 2009, contact with parents remained frequent for some consumers and most consumers had increased the frequency of their contact with friends and siblings (Table 4.11).

Table 4.11: Change in Social Contact, 2007-08 and April 2009

	Regularity of contact with family members		
	Increased contact	N/A or Contact the same	Reduced contact
Parents	3	9	1
Siblings	6	6	1
Friends	8	4	1
Children	1	11	1
Carer	3	9	1
Other	4	8	1

Source: Evaluation client dataset

Note: n=13

Reductions in family contact might indicate improved family relationships and independence of consumers. One consumer for example was visiting and staying over less often with family because he was feeling much better. Parents were in one case caring for the children of one consumer. ‘I don’t see my parents every week. My younger children are living with them (consumer).’

At the first interviews with consumers, some consumers said they were estranged from family members. For example, one woman was separated from her partner and did not see her children, parents, siblings or relatives (Table 4.9).

For the consumers who have sustained family relationships and contact, there was an opportunity for PDRSS and MSTs staff to support consumer’s family relationships. Some consumers enjoyed happy relationships with family members. Some talked about strained family relationships and reconciliations now being supported through IRRCS. They said that the individual support contributed to improvements in family relationships. For example, one consumer said,

My relationship with my family is excellent, couldn’t be better. I have a positive attitude with them. I have turned my life around and I’m still doing that. It took a bit of work to get back with them.

Later interviews showed improvements for some consumers in their family relationships, which the PDRSS workers had facilitated. They spoke of having more contact and better quality family relationships. One PDRSS worker observed,

His family relationships are still good, He goes there every weekend. Because of his brain impairment he is unable to say what happened when he returns.

One PDRSS worker observed that a consumer’s family had a moderating effect on symptoms, ‘He goes home to his parents every weekend. He has regular panic attacks but that doesn’t seem to happen when he’s with mum and dad.’

For others, family dynamics had negatively affected the consumers' capacity for appropriate social interaction and in reconciling with estranged family members. An MSTS case manager said,

From such a young age his mother and father were both unwell and he never had the childhood that most people have had, so he never did have friends. From a young age he was put into care and in and out of institutions. So he's never had the chance to develop any friendships. He's got real trust issues as well.

Family relationships also presented conflict for some consumers. For example an MSTS worker noted, 'The relationship is still very rocky. His parent is his official administrator and there are always problems there.' In addition, contact with family did not always reinforce recovery strategies used in IRCSS support. For example an MSTS case manager said,

My client knows what he can and can't get away with, with his family. I think at times he gets away with a lot. So he knows he can push and often he'll get his way.

Dynamics within families could create unrealistic or reduced expectations of their members with severe mental illness. This was true for several consumers. A CCT case manager and PDRSS worker said,

My client won an award for achievement in his study. When I went to visit him he showed me his award. He still plays it down. It's an effect of his brothers and sisters who are high-achievers. I say: 'you're being too hard on yourself, you're in a completely different situation to them. Given the limited support you have, and being away from home, this is a big achievement. It's a small step, but a big achievement for you.' And he's still doing it well.

I think some of the cultural issues are difficult to work with too, with this consumer in particular, family and religion. They're high achievers he has brothers who are health and legal professionals.

Friendships

In 2007-08, eight of 18 consumers had some (mostly occasional) social contact with friends (Table 4.10). Not far into the program one consumer had made a new friend (Table 4.12). That trend continued so that one year later over half (seven of 13) the consumers had new friends. This is an unusual achievement compared to the similar program, the Mental Health Housing and Accommodation Support Initiative NSW (HASI), where consumers reported remaining lonely (Muir et al 2007). It might reflect the positive contribution of the intense support provided by the PDRSS in the community that concentrated on assisting consumers to develop skills and provided the opportunities to engaging in activities that were likely to result in the development of friendships. Most of the IRRCSS consumers lived alone so developing and maintaining friendships was an important part of their recovery.

Table 4.12: New Friends since Starting IRRCS, 2007-08 and April 2009

	Consumers	
	2007-08	April 2009
Yes	1	7
No	16	3
Don't know	1	3
Total	18	13

Source: Evaluation client dataset

Early in the program, consumers reported having no friends or being unable to make friends. Some of them were not interested. Some had friends that they had lost contact with while in acute inpatient care, SECUs and CCUs. And some were making new friends in their new surroundings and in activities like voluntary work or study, for example. Consumers said,

My skills are pretty poor there. It also may be because sometimes you don't want to be around other people and you want your privacy. On the other hand you need support when you're broken.

I'd like to have other people in my life. It helps against my mental illness, to communicate with others.

At later interviews some consumers remain uninterested in friendships or unsuccessful in making them. They said, 'I'm not really interested in having friends male or female. I'm happy to be alone. I get books from the library and I have TV and DVDs.' 'I haven't made any new friends since I left the CCU.' For other consumers however, they had positive accounts of new friendships or associations which had broadened their social lives and increased their opportunities for meeting other people. Two consumers and a MHS worker said,

I've actually got a friend at the moment and we've spent time hanging out and it's actually fun. I'm not a socialite or anything but I've got a friend, a good quality friend. It's a friendship that happened by chance.

I've made some new friends. One will be a good mate I reckon. We go to the pub and poker nights. It's good fun, I like playing poker. I met some guys down there and I talk to them now.

His friend is living with him now who is a student doing the same course at another institution. They seem to get on extremely well. There's a lot of humour in their relationship. They both cook.

Generally workers were positive about consumers' relationships but they also had some concerns about some friendships having destabilising effects on consumers, such as relationships with friends who were not discharged from CCUs and who might encourage risky behaviour. In addition, some consumers had not yet developed the social skills to successfully engage with other people. A PDRSS worker said,

His social skills are really poor. He's able to negotiate his needs with people at the bank or Centrelink, to go in there and say what he wants or

why he's there and get what he needs but to actually have a conversation with someone, he doesn't have those skills. It's something he's spoken about, that he's never had a friend before and that's something he really wants.

Neighbours

In 2007-08, most consumers (14) were getting on well with their neighbours (Table 4.13). Most of these neighbours were other residents in SECUs and CCUs. A year later neighbours were more likely in properties adjoining their transitional or permanent housing, and most consumers continued to get on with these new neighbours.

Table 4.13: Relationship with Neighbours, 2007-08 and April 2009

	Consumers	
	2007-08	April 2009
Yes	14	9
No	0	1
Don't know/ not applicable	4	3
Total	18	13

Source: Evaluation client dataset

Consumers who had moved to transitional or permanent housing were fairly happy with their housing, and the neighbourhood in which they were living. They mentioned shopping facilities, friendly neighbours and having friends nearby. Some consumers had met or visited neighbours and 'say hello to them.' For some consumers, PDRSS workers had been facilitative of consumer-neighbour relations. A PDRSS worker said,

He has no contact with the neighbours. They keep to themselves but there is no friction. He has good relationships with his housemates. He originally wanted to live on his own but the positive experience has led him to be willing to move on to shared accommodation.

Consumers in congregate settings such as CCUs and group transitional housing had a range of experiences of neighbours and co-residents. Some relationships were largely positive but others were not. In particular they found living with 'very ill' people difficult and disturbing to managing their own mental wellbeing. A worker said,

At the CCU he tends to isolate himself from the other residents. He speaks to one a little bit. We try to get him down to some of the [PDRSS] group programs as well in order to meet people.

Social and community activities

In 2007-08, over half the consumers (10 of 18) were involved in social and community activities (Table 4.14). In the interviews, most but not all consumers expressed a willingness to socialise and become socially involved. They gave examples of sporting clubs, local events, bush care and church activities. The other

consumers were still in CCUs and SECUs without these opportunities. A year later most consumers (nine of 13) were engaged in social and community activities.

Table 4.14: Social and Community Activities

	Consumers	
	2007-08	April 2009
Yes	10	9
No	8	4
Total	18	13

Source: Evaluation client dataset

In first interviews consumers and PDRSS workers discussed the difficulties for many consumers making new social networks after such a long time in SECU or CCU care. They attributed this to a lack of previous experience with the opportunities. The workers felt that it would take long-term support to rebuild this confidence and familiarity with the rewards of social activities. A consumer, PDRSS worker and MSTs worker said,

I go to the shopping centre with [the PDRSS worker]. I don't like going out on my own. I'm old; I like to stay at home. Going out doesn't appeal to me. People say I should go out more, but I like it indoors.

Underlying his social skills are big problems with self-esteem and his confidence needs considerable building up. One problem of being in a CCU is that it's not a place you'd invite your friends to.

He goes out to shopping centres and coffee shops. He likes being out but doesn't interact with other people. He is concerned that bad things are going to happen to him.

Many of the ISPs included goals to address particular social needs that may arise during consumers' move to community living, such as building insight into drug and alcohol use. PDRSS workers also advocated for consumers and their access to community and services. A worker said,

We have intervened in one situation where [a program provider] refused our client without an assessment and on the basis of being familiar with that client many years earlier. After we did, the client was given an assessment for the program.

At later interviews the social situation was unchanged for some consumers. Some consumers remained unable, uninterested or unwilling to engage in social programs and community activities. Some chose not to attend PDRSS centre-based social programs. Tiredness and mood affected their willingness and ability to participate in community events, even in favoured activities. Some consumers found being in groups in the community challenging. A consumer said,

If I join a club I feel like people overpower, overwhelm me. For instance I joined a club, everyone that goes there is really good. It happens all the

time. Then I feel down, I think 'I'm not really good'. I'm really stressed sometime I have really high expectations of myself.

The fieldwork examples suggest that IRRCs workers require skills to assist consumers to develop social connections appropriate to individual needs and circumstances. In some cases, PDRSS and MHS staff needed to use culturally competent responses to support consumers from CALD backgrounds. Some older consumers did not want to develop their social life. They preferred not to go out or socialise. One consumer said,

Social life? No not really, not really. I like to go for walks, look at people's gardens and that. I talk to some people down the street, when I'm going to the shop, ask them how they're going, nice weather, nice day. They talk back to me about it.

Social stigma was a problem for some consumers. Some consumers commented about the willingness or otherwise of other community members to accept them. One said,

I'm still trying to match it [myself to the community's expectations]. Like everyone knows that I have a mental illness. When it comes to looking somebody dead in the eye and smiling and saying thank you when I buy my lunch, people from the supermarket and the shopping centre are like that. I'm trying to maintain my illness and I'm still not there, getting it covered (consumer).

In contrast other consumers had found social settings where they are more likely to be accepted. One person said, 'There were a fair few [people with mental illness] at my [church-based] men's group. It was all right. We all got on.'

Paid work, volunteering, education and training

In 2007-08, one IRRCs consumer was in paid work (Table 4.15). It was casual work, classified as supported work. Another was engaged in voluntary work and also enrolled in education. The consumer was studying part-time at TAFE. Near the beginning of the program, with these two exceptions, IRRCs consumers were not engaged in work, volunteering or education/training. But by April 2009, other consumers were gradually moving into work and education activities. By the end of the evaluation period over half (seven of 13) of the consumers were engaged in work or education.

Table 4.15: Education and Work Participation, 2007-08 and April 2009

	Consumers		Average hours*** April 2009
	2007-08	April 2009	
Working	1	4	8
Volunteering	1	2**	8
Education	1	3	7
No participation	16	6	-
Total consumers*	18	13	-

Source: Evaluation client dataset

Notes * Consumers participate in more than one activity so total is greater than 18.

** One consumer has recently begun volunteering.

*** average of clients engaged in activity

Consumers discussed their education and work history in the interviews. Many consumers experienced the onset of mental illness in their adolescence and early adult life. Mental illness disrupted their education. One person moved between school and an adolescent mental health unit. Others were regularly hospitalised in their early to late teens. Mental illness disrupted some consumers' efforts to establish themselves in the labour force. One consumer said,

I left school in Year 10 and got a job at a factory in a trade I didn't finish. I tried others but I couldn't do the study. I lost the jobs. It [mental illness] affected jobs. They'd say 'you're no good'.

Work and education were goals in most ISPs either in the short or long-term. PDRSS workers and mental health case managers supported consumers to participate in these activities with transport, travel training, orientation to new locations or premises and management of workplace and education stresses to which the consumers are new.

Some consumers had become involved in education, voluntary work and supported employment or had been involved in the programs in the past. Others had long-term goals for work and education, while acknowledging limitations from their education and work history. They identified a range of occupations they were aiming for and knew to some extent the path through education and training they would need to follow. Some consumers were also clear that they had to be 'well enough' to cope with work and this was an incentive to manage their mental health. Two said,

My mental health is still the same as it's always been, but there's something that keeps me hanging on and that's work, waiting to get a job. I'm hoping I'll stick with it and it's everything I thought it would be. I'll see what happens, stay focused and think positive, see how I go.

[The CCU case manager] sent me to see a guy who brought me back on the positive side [after drug use]. I got to the point where I wanted to get a job for the first time. I still haven't cleaned up my act yet but I'm on the right track – trying to see the light – reaching out for it.

Some consumers were not considering work or study, either because of their age, physical health or they did not see employment or study as a realistic option. One person said,

I'm not prepared for it, I haven't got the skills to organise it. I can't organise it all. That's why I'm seeking other people's support to organise things for me, arrange things for me 'cos I can't do it myself.

A number of consumers were engaged with Job Network and Disability Employment Network organisations. They were either actively looking for a job or working in supported employment. Several consumers were engaged with voluntary work which they valued highly, one travelling an hour each way to get there. He said, 'There's a similar organisation nearby but I've got a good situation there and I'm very comfortable working there.'

Some consumers were doing TAFE or other community courses. These included computer engineering, hospitality, life skills and employment preparation. Some were intending to enrol in courses when they were ready. One consumer had found good support within TAFE, saying,

The TAFE teachers are pretty lenient which is great. Someone said that moving here I should move to a closer TAFE but I really don't want to because I have a good relationship with the TAFE, with the teachers. They're very supportive. They are flexible with me, lenient on me. It's hard work though, I've got to put a lot of energy into it.

Employment presented some consumers with new or difficult pressures. This was a risk to their mental health that they faced during the transition in IRRCs. An MSTs worker said,

He had a job that only lasted a week and a half and he had to resign. That stalled things and he hit a flat spot for a while. He went back to the CCU full-time for a month.

4.4 Health and Wellbeing

The fourth consumer outcome is health and wellbeing. A primary outcome goal of IRRCs is to provide targeted, time limited, high level psychosocial rehabilitation and clinical support to achieve improvements in the consumer's health and wellbeing.

Physical health

The consumers reported health ranging from excellent to poor (Table 4.16), with a larger proportion than the general population reporting lower health levels (50 per cent compared to 15 per cent). This is not surprising given their history of mental health related hospitalisation.

Table 4.16: Self Assessed Health, April 2009

	Consumers		Adult Australians
	Number	Per cent	
Excellent or very good	1	8	56
Good	5	42	29
Fair or Poor	6	50	15
Total	12	100	100

Source: Evaluation client dataset. National Health Survey 2007-08 (ABS)
Missing=1

Nearly half (six of 13) consumers reported improvements in health while receiving IRRCs, the remainder reported no change (Table 4.17). No consumers reported worse health outcomes. Improvements in health could be related to increased functioning and confidence due to living in the community. If so, this is especially relevant to conditions such as depression and schizophrenia, which include loss of functioning as key diagnostic criteria.

Table 4.17: Self Assessed Health Compared to One Year Ago, April 2009

	Consumers
Much better	2
Somewhat better	4
About the same	7
Somewhat worse	0
Much worse	0
Total	13

Source: Evaluation client dataset

Most consumers described themselves as overweight (Table 4.18). This finding is expected given that most consumers had schizophrenia which is associated with greater obesity risk due to low levels of self care, difficulty making dietary choices, inactivity and side effects of medications (Wu et al, 2008).

Table 4.18: Self Perception of Weight, April 2009

	Consumers		Adult Australians
	Number	Per cent	
Acceptable weight	2	15	42
Underweight	0	0	3
Overweight	11	85	56
Total	13	100	100

Source: Evaluation client dataset. National health survey 2007-08 (ABS).

Note: Perception of weight was recorded as subjectively self reported by IRRCs consumers. Australian data were obtained from self reported height and weight which was converted to Body Mass Index data. Overweight and obese BMI categories were combined into 'overweight' for the purpose of comparison. See NHS 2007-08 ABS for more detailed description of BMI.

Other health problems mentioned by consumers included poor physical fitness, tiredness and sleepiness, high cholesterol and epilepsy. Measures to address these concerns were elements in individual support and treatment plans.

Health service use

Part of the health outcome goal is that IRRCs aims to increase appropriate service use, such as primary and allied health services e.g. community health services and general practitioners, and to minimise inappropriate or unplanned service use, such as hospital, emergency and criminal justice services IRRCs staff were asked about how frequently consumers used different health service types (Table 4.19).

Table 4.19: Health Services Used, 2007-09

	Frequency of contact							
	More than once per month		1-3 times per quarter		Yearly		Never, N/A	
	2007-08	2009	2007-08	2009	2007-08	2009	2007-08	2009
Psychiatrist	2	3	11	7	0	0	0	3
GP or medical officer	10	2	1	8	0	0	2	3
Allied health	5	1	5	7	0	1	3	4
Community mental health	7	8	0	2	1	0	5	3
Psychologist or counsellor	3	2	0	7	0	0	10	4
Other specialist	0	0	0	5	2	0	11	8
Emergency or hospital	0	0	0	2	1	0	12	11

Source: Evaluation client dataset

Note: n=13

At the early measure (2007-08) in the SECU or CCU, most consumers regularly saw a psychiatrist, medical officer and allied health practitioners. Very few services were reported as used in the community because at the baseline data collection point, most consumers still resided in the SECU or CCU.

Changes in health service use from the baseline to 2009, shows a trend towards regular and less frequent service use as would be expected for consumers with

planned service use as part of recovery and relapse prevention plans (Table 4.19). For example, frequency of contact with GPs, allied health professionals and public mental health moved towards quarterly contact rather than weekly or monthly contact. Consistent with this trend, quarterly contact with professionals associated with stabilising mental health management, such as psychologists, counsellors and other specialists increased.

Hospital use data provided was not available for all consumers. However, the hospital data that were received for IRRCs consumers show a history of multiple admissions to acute mental health inpatient units prior to entry to IRRCs. The frequency and periods of hospitalisation reflect their mental health status (Section 4.1). Hospital data in one regional cluster showed that admissions to inpatient facilities before IRRCs were as high as 35 admissions for one consumer, over a number of years. The lowest number of admissions was two, followed by 14 (for two consumers) and 28 admissions for another. These figures need to be treated with some caution as the data show high rates of consumers leaving the facilities and being re-admitted on return.

Hospital data about consumers in a second regional cluster before IRRCs show evidence of multiple hospital admissions over substantial periods of time, again indicating the severity of psychiatric disability experienced by IRRCs consumers. Data for one consumer show a total of 17 admissions from 1992-2005. Similarly, in the third area data about one consumer showed 22 admissions from 1995 to entering IRRCs.

Wellbeing

The longitudinal sample of consumers who participated in IRRCs for at least one year reported how they feel about life as a whole, taking into account the past year and the future. All consumers reported feeling at least ‘satisfied or mixed’ with no consumers reporting feelings in the bottom half of the scale (Table 4.20). Two consumers reported being either ‘delighted’ or ‘pleased’ about their life overall.

Table 4.20: Satisfaction with Life as a Whole, April 2009

	Consumers		Adult Australians*
	Number	Per cent	
Delighted, pleased or mostly satisfied	11	85	76
Satisfied or mixed	2	15	~18
Mostly dissatisfied, unhappy or terrible	0	0	<6
Total	13	100	100

Source: Evaluation client dataset
 Note: * National Health Survey 2001 (ABS)

Most consumers reported satisfaction slightly above the neutral or middle score/scale degree. IRRCs consumers reported overall life satisfaction levels similar to the broader Australian Population.

In addition, consumers were asked about their personal wellbeing, using the Personal Wellbeing Index (PWI; Cummins & Lau, 2005) (Table 4.21). The PWI measures

consumers' overall life satisfaction by indexing subjective assessments of satisfaction on various life domains including: standard of living, personal health, achievement in life, personal relationships, personal safety, community connectedness and future security. The PWI has been used extensively in Australia, with established normative scores for the broader population and subgroups of interest having emerged.

Unlike the satisfaction with life as a whole question above, IRRCs consumers show substantially lower personal wellbeing scores than both the broad Australian population and a Victorian sample of persons with mild to moderate intellectual disability (Table 4.21). Comparison data for people with mental illness are not available.

Table 4.21: Personal Wellbeing, April 2009

	IRRCs consumers (n=12)	Australian normative data 2008*	Intellectual disability normative data**
Personal Wellbeing Index	58.5	74.8	77.1
Standard of living	60.8	76.7	75.2
Personal health	48.3	74.8	70.5
Achievement in life	59.2	72.5	79.3
Personal relationships	66.7	78.7	82.1
Personal safety	67.5	79.3	79.3
Community connectedness	51.7	70.4	81.8
Future security	55.0	71.1	72.4

Source: Evaluation client dataset

Notes: * Cummins (2008).

** McGillivray et al (2008) People with mild/moderate intellectual disability, Victoria 2008.

For detailed description see International Wellbeing Group (2006).

Wellbeing scores were below the normative range of 73.4-76.4 and lower than the life as a whole question above. Consumers scored substantially higher on 'personal relationships' compared to other domains, approaching (but not meeting) Australian normative means.

The theory of subjective wellbeing homeostasis (International Wellbeing Group, 2006) suggests that personal wellbeing scores should return to this range of 73.4-76.4 over the long term, even in the presence of short term (e.g. death in family, relationship breakdown) or long-term (e.g. disability, poverty). While no longitudinal PWI data exists for the IRRCs consumers, their participation in the program for at least one year suggests that IRRCs consumers had not yet subjectively adapted to their new circumstances.

4.5 Transition to Sustainable Housing

The fifth consumer outcome is transition to sustainable housing. At February 2009, out of the 29 consumers on the program 12 remained in Phase 1 (in-reach). The remaining consumers were housed in a range of accommodation options, the largest

proportion being housed in transitional housing stock (Table 4.22). The range of housing and accommodation support is consistent with the options considered in similar housing support programs for people with a history of mental illness (Hanrahan *et al.*, 2001; Tsemberis, 1999).

Table 4.22: Housing, February 2009

	Consumers
Transitional housing	8
Supported Residential Service	5
Social housing	2
Residential Rehabilitation Services	1
Private rental, owner	1*
Phase 1 consumers**	
SECU	8
CCU	4

Source: DHS Client Tracker Dataset n=29

Note: *private housing was being considered for two consumers still in a SECU as at February 2009

** information about whether consumers are waiting for other housing was not available

The expected pathway – a move into permanent and affordable housing eventuated for only a minority of consumers due to a range of reasons including:

- Suitable public housing takes time to locate and allocate to IRRCs consumers. IRRCs consumers must compete with other people who are also eligible for public housing;
- Transitional housing was identified as a suitable temporary option while awaiting the allocation of permanent public housing;
- Some consumers needed a longer period in the SECU or CCU to prepare for living independently in the community; and
- Some consumers because of their disabilities needed higher and longer levels of support than could be provided in single occupancy housing models. For a number of consumers the Supported Residential Services option, which provides onsite 24 hour low level support was more suited to their needs.

At the first evaluation interviews, comments by consumers, PDRSS and MSTs staff about accommodation focused on the amenity and location of properties, relationship with neighbours and the neighbourhood, convenient access to community facilities, work or shopping, gardens or a pleasant aspect, quiet, comfortable temperature and having an extra bedroom. A match between the neighbourhood and the consumer was also well-regarded by some people. Further to this consumers were very positive about moving out of the CCU and the greater personal freedoms they could enjoy.

Other consumers were waiting to move from shared transitional housing to single occupancy transitional housing and one to an SRS. One consumer in a CCU was

considering moving to a Supported Residential Service option because of his level of disability. The PDRSS worker said,

We've been talking about supported housing as an option for him, which could mean he still gets support and we link him into other services, meals on wheels or café meals and I think he could sustain that, as long as there were those support structures in place, like anyone in those properties has to have.

At the first interview some consumers were accommodated in a Supported Residential Service. PDRSS workers considered this the best option for them because their assessed needs would require high levels of on-site support. This option presented a range of risks including 'regimented hospital-like conditions, fixed and ... early meal times and set medication times ... [and the effects of] 'living in close proximity with so many unwell people.' One consumer said he was happy to be there.

PDRSS workers were considering an SRS for another consumer, because, 'He needs the constant reminder to get up in the morning, take medication, to shower and to make his own food'. With this level of support need, his care team thought he would not ever be able to live independently.

While the intent of IRRCSS is to house consumers within the community following Phase 1 a three month 'in-reach' program of support, most consumers waited up to six months to be allocated housing in the community (for some consumers Phase 1 was prolonged because of their support needs to prepare to leave rather than because of housing delays). At the time of the baseline data, none of the consumers from Eastern or Western consortia had housing allocated. Southern collected the data later in 2008, by which time four consumers had community accommodation options (Table 3.1).

At the first interview PDRSS and MSTs workers were concerned about the Office of Housing problems finding suitable housing that matched the consumers' identified support requirements and the negative effects that the delay had on consumers (Section 7.2). This comment from a worker was typical,

It could have been planned to have the accommodation available when the person is ready to move. It was on [consumer]'s mind for six months. It affected the consumer's confidence in us. I don't think having a dual diagnosis was taken into account. We have worked on transferring her skills from the CCU. When she has to move again we will have to do that again.

Staff also related concerns about to the quality of neighbourhoods with available housing stock and the possibility of some neighbourhoods not being conducive to consumer's recovery, particularly consumers with past drug use problems.

At the second interview some consumers were still on waiting lists for public housing and expecting waits of 12 to 18 months. Some consumers dealt with Office of Housing themselves. One person was organising to move to a higher priority list (from segment two to segment one).

Timely access to suitable housing continued to be the biggest problem with the IRRCS model. Situations where workers could not access permanent or even temporary housing at the time when the consumer was ready to leave the SECU and CCU weakened consumers' trust of the capacity of the IRRCS workers to fulfil their undertakings and interrupted their momentum in skill development and mental health recovery. Interim options also created some problems.

While transitional housing can be a suitable step for some consumers leaving hospital based care (Rog, 2004), several consumers expressed anxiety about transition housing. One person in permanent housing said, 'I don't have to worry about where I'm going to end up anymore. Now I can settle down. I've got nothing to worry about, or not much anyway.' At the second interview one consumer had moved from transitional housing into a permanent Office of Housing unit, about which he was very happy, an improvement on his transitional housing. About his transition he said,

Funny, thinking about moving here, the transition was smoother than from the CCU to the transitional housing. It happened quickly, was organised quickly, no mucking about. It happened quite seamlessly. All the utilities companies and the relocation transfers happened quickly. I'm very grateful for the program that I could be a part of it.

For a majority of consumers with mental illness, the use of transitional housing stock was not considered an ideal option as the transitional tenancy creates stress for the consumer at the time of moving on. Stress can cause relapse of the consumer's mental illness. Living in transitional housing also interrupted the setting and achievement of goals about community integration. In some cases OOH and the agencies negotiated to change the status of the property from transitional to permanent so that the consumer would not have to move.

The transition model from SECU to CCU, to transitional housing, to permanent housing, while disruptive for some consumers, also had some benefits. Consumers could learn from their transitional settings without jeopardising their permanent housing. PDRSS workers were able to minimise the stress of transition for some consumers with gradual moves. The transitional aspect of the program meant that consumers' needs changed with their housing setting and these were instructive to consumers and workers, requiring adaptation of ISPs and case management and support activities and producing new insights. The weakness of the model was that the timing of permanent housing provision was critical. After long preparations for transition to the community some consumers went backwards and lost some of the gains they had made when waiting times slipped from a couple of months to up to two years.

4.6 Discharge from IRRCS

Consumers preparing for exit from IRRCS made considerable gains towards independence or moved to a less restrictive housing and support setting (Table 3.1). They changed to CCT case management and lower levels of support provided by generic PDRSS programs and other community providers.

It is difficult to assess how long consumers need to remain in IRRCS or even remain in each phase, because of the variation in individual needs, the combined effect of

their mental health stability and independent living skills, and the delays finding suitable housing. On average most consumers remained in IRRCs for longer than anticipated in the program design, however, this probably does not reflect any long-term pattern, since workers were establishing effective processes for working with each part of the mental health, housing and generic service systems.

Consumer goals

At interviews, consumers were asked about how they saw their future. Case managers and PDRSS workers were also asked to reflect on this. Some consumers and their workers were confident about their future prospects. Typically they were the younger people and they talked about a more normalised future with elements like work, study, having a driver's licence, permanent housing, having love, intimacy and friendship, staying well and out of hospital. They linked articulating and wanting to achieve their goals to the motivation to manage their mental health. Workers reinforced their need for insight into their mental illness to set a path towards longer-term goals. Consumers said,

The future? Hopefully I'll get a stable job, living in my new place from the Office of Housing, own a nice car. Way down the track, get a girlfriend and get married, kids way down the track and have a normal life, not be in and out of hospital any more. That's what I want to do. I'm not going to do anything to jeopardise going back into hospital.

I want to have a car again. I see myself living in my own house, with a dog or cat. I'll get my licence back. [PDRSS worker] will help with that process but I haven't done much yet. I've got to sit the test. I don't know how long I'd be there because I want to buy my own place.

In the future I think my life will be much better. I'll still be living here. I'll be doing voluntary work in aged care. In the longer-term I want paid work, working in a packaging place.

Consumers who still lived in CCU and with higher levels of disability had greater uncertainty about the future and where the program might assist them in the longer-term. One person said, 'I can't say about the future. The immediate future is pretty good.' They tended to be less certain about either their ability to manage their mental health or the capacity of IRRCs to help them achieve that. For example, a consumer and worker said

I don't know I've never seen the future. Sometimes I think it's going to be really bad for me because of my manic talking and all that. I know I can stop it but sometimes I feel I need to talk to myself [consumer].

I don't see it changing much. I think he'll still be in the SRS. I don't think he'll move out to his own place. Ideally that's what he'd want but I don't know how realistic that is.

Workers agreed that the long-term goals remained a long time off for cases where the consumer had a high level of psychiatric disability. However, other workers did not dismiss the possibility that in the longer-term, even these consumers could achieve greater independence than they currently enjoy, especially if they can access disability

support and receive appropriate community mental health support as their needs change. For example, PDRSS workers said,

Given the time he's been in the program he's made some huge achievements and it's possible that he could leave the program at some stage.

My client has left the IRRCP and is on the Intensive Support Program. The future for him is good if he continues to get support to get up, shower and take medications.

I think that he will always be a longstanding client of mental health services. I don't see him staying with the MSTS for another 12 months. He'll move on the Community Treatments Program to the less intensive team.

For older consumers, asking them about future goals raised issues for them about their longevity, deteriorating health, reduced independence, ageing of parents or changed needs due to ageing. Workers considered that some consumers with very high support needs were not suitable for exit from IRRCs and that exiting the consumer would jeopardise the gains they made within the program. For example, two workers said,

Currently, if my client was to leave the program I think it would be disastrous. [PDRSS worker] is a constant source of support to her. I doubt if she would cope with the social isolation.

I'd say her future is bleak if she doesn't get more support. I think she's going to need more hours than she's getting. She's starting to develop some insights. I'd like to see some more psychosocial rehabilitation and more PDRSS time.

This suggests that these staff were not fully aware of the aims and objectives of the IRRCs pilot and the role of staff in assisting consumer's to participate in social activities to reduce social isolation and to transit to other PDRS programs such as home-based outreach support which could continue to support the consumer.

4.7 Summary of Effectiveness for Consumer Outcomes

Outcome goals for the IRRCs were maximised symptom control; maximised engagement in the community; and reduced intensity and frequency of demand for public mental health services. Improvements in mental health, living skills, social and economic participation, physical health and wellbeing were required for these goals to be achieved and were attained by most consumers in IRRCs as described below. Longer term goals of transition to sustainable housing and successful discharge from IRRCs had not occurred for most people within the short period of the evaluation, but were being gradually addressed within a timeframe suitable for each person.

Mental health

The IRRCs model was effective at reducing psychiatric inpatient and emergency admissions. Changes in health service use showed a trend towards regular and less

frequent service use as would be expected with planned service use as part of recovery and relapse prevention plans.

Consumers and staff reported that consumers' mental health improved. Consumers gained greater insight into their own mental health management and demonstrated greater compliance with medication.

Living skills

Consumers' living skills, measured in terms of personal care, domestic skills and community skills, gradually improved. Patterns of slow improvements towards independence indicate that some consumers will require long-term support from other human service programs to maintain the gains.

The assessment and transition process revealed a link between independent living skills and length of stay in a SECU or CCU. The living skills capacity of many consumers in IRRCs was reported as negatively affected by their prolonged time in a SECU or CCU and their earlier institutionalisation.

The greatest living skill gains were in personal care. The move to a less structured living environment with greater emphasis on self-management required more initial support whilst these skills developed. Some consumers' independence in exercise, diet and taking medication, for example, decreased. This may be an effect of consumers moving away from more structured environments where meals are provided, self-care and health are monitored, and for some consumers, supervised taking of medication is mandated. Increased levels of support in these areas, as consumers transition towards independence, are reflected in the data.

Social and economic participation

Significant social and economic participation gains were made. Most consumers had begun to make friends and reconcile with family members. Over half the consumers were engaged in paid or voluntary work or education or had plans to do so.

Health and wellbeing

Consumers reported their physical health improved (46 per cent) or remained the same (54 per cent). Overall wellbeing tended towards the population norm but was still low in all domains except in personal relationships.

Transition to sustainable housing

Consumers were housed in a range of accommodation options, the largest proportion being housed in transitional housing stock. The expected pathway of a move into permanent and affordable housing eventuated for only a minority of consumers due to a range of reasons. At June 2009, nine of the 30 consumers on the program remained in Phase 1 in-reach into the SECU or CCU, either because they had recently entered the program or they needed a longer period of in-reach to prepare for living independently in the community.

Fifty-eight per cent of consumers moved into community housing. Most consumers were allocated accommodation in transitional housing because appropriate and

affordable social housing was not readily available. A number of consumers moved into other models of accommodation that better met their assessed needs, including Supported Residential Service.

The shortage of permanent and affordable public housing stock was a significant barrier to the IRRCS model. Housing allocation resolution worked best where IRRCS providers developed links with the Office of Housing at the local level to facilitate appropriate and timely housing and to allow for consumer input into housing preferences.

Discharge from IRRCS

Most consumers were discharged from the CCU or SECU and received support to develop their capacity to exit the program. Only a minority of consumers had left the program by the end of the evaluation because of delays identifying the appropriate consumers, delays identifying available suitable housing, variation in the time they needed in each Phase and delays identifying ongoing housing and support to facilitate sustainable exit plans. It is expected that over time the processes will become more efficient so that some of these delays can be addressed.

5 Effectiveness – Cost Effectiveness

The second measure of effectiveness in the evaluation is cost effectiveness. This section describes the costs and benefits of the program.

5.1 Costs

The cost effectiveness analysis identifies the expenditure and outcomes associated with IRRCs. The focus is what is the IRRCs recurrent cost and what are the benefits of IRRCs to the consumers. The evaluation quantified the expenditure associated with the IRRCs as a basis for budget decisions. It addressed the following questions:

- What is the IRRCs expenditure in terms of establishment and recurrent costs?
- What is the average cost per person while they are receiving IRRCs?
- What are the benefits to the person during IRRCs?

The hypothesis is that while consumers are in the IRRCs, and after they exit, government costs are less than the costs before they entered the IRRCs; and outcomes and sustainable service support for the person improve. Comparative costs for consumers who remain in a CCU are \$114,610 per person per year (2008-09, \$314 per day) and SECU \$166,805 (\$457 per day).

The DHS service specifications document identified the following budget parameters for IRRCs.

\$1.2m is available for the initiative, \$400,000 per SECU and CCU cluster. Twelve packages of \$100,000 each represent the total quantum of funds available to deliver IRRCs to a minimum of 12 consumers (or four consumers per cluster). The funding is made up of:

- A nominal amount of up to \$90,000 package per consumer per annum.
- An allocation of up to \$10,000 per consumer to be used to support a higher level clinical response than usual from MSTs, if this is required by an individual consumer. The selected provider(s) are the fund holders of this clinical funding and will need to negotiate a purchasing agreement with individual MSTs.

Not all consumers will require packages up to \$90,000. As part of the development of IRRCs plans it is expected that existing community supports will be identified and accessed. This may result in IRRCs supporting more than 12 consumers (or four consumers per cluster) with the available funding.

The funding was to supplement, rather than replace, existing PDRSS and clinical service already funded by DHS within the regional cluster catchment. As this was a new program it was envisaged that consortia would utilise a portion of the available funds for establishment, such as establishing system processes.

The IRRCs funding was to cover all costs associated with delivering the program, including direct service delivery, coordination, assessment and care planning. It also covers the administration/management costs to run the program. Other data about

management costs to IRRCs providers that they did not expend against the contract price was also recorded by the consortia. The evaluation does not have information about why consortia did not apportion available funding on these costs. Only two consortia recorded consumer costs (Table 5.1) and these were housing related costs.

The funding provided by DHS described above allocated up to \$100,000 per consumer per year inclusive of management and consortium operating costs. The cost reported by the consortia is approximately \$52,000 including project management, care coordination and care delivery costs covered in their IRRCs budget and other consortia budget (Table 5.1).

Table 5.1: IRRCs Average Annual Total Ongoing Cost per Consortia (\$)

	Average annual ongoing cost	
	Annualised January-June 08	Annualised July 07-June 08
Project management		
Management and governance	21508	24219
Establishment	7609	11310
Operating	2167	2383
Care coordination		
Staff, coordinators, PDRSS workers	21982	23395
External consultants	1600	800
Operating	3565	4381
Care delivery		
Staff, coordinators, PDRSS workers	61548	46676
Operating and consumer brokerage	8526	6792
Housing		
Rent, repairs, property maintenance ^b	1713	1406
Total IRRCs expenditure	128505	119956
Average annual ongoing cost per consumer^a	53430	51402
Total project management costs	31284	37912
Total care coordination and delivery costs	98933	83451
Proportion of costs on project management	0.24	0.31

Notes: Annualised cost from average total costs to the consortia (IRRCs contract funding and other expenditure on IRRCs).

Project management – not specific to serving individual consumers

Care coordination – consumer costs that are not direct service e.g. identifying consumers, screening, assessment, care planning, arranging services, finding housing

Care delivery – direct services to consumers

Housing – ongoing housing costs

Cost to IRRCs is the contract funding to the consortia. Cost to consortia is additional consortia expenditure to run IRRCs not covered by the contract funding

a. Consumers July 07 to June 2008 (4-6 per NGO). Actual costs ranged from \$31,831-65,272 per consumer per annum, depending on the consortia and data from which it is annualised

b. Southern and Northeastern had no housing costs to IRRCs or the consortia. Western (\$11,651) and Southern (\$2628) reported annual housing costs to consumers.

The IRRCS provided support to 30 consumers, well above the notional target of 12. A possible explanation for the difference between the contracted cost and actual cost could reflect effective selection practices and well developed and costed care plans. The eligibility criteria for participation in the pilot phase of IRRCS were very specific and the period of in-reach may have supported good assessment of needs which resulted in individualised care plans and program costs that were below the notional \$100,000 per place budget. A further factor could be the skill of the staff. A number of PDRSS providers indicated that they had utilised existing experienced psychosocial rehabilitation support staff to deliver the direct support to IRRCS consumers.

The cost in the establishment months included establishing governance structures, recruiting, training, protocols, consultant fees and assessing the suitability of consumers. The initial project management costs borne in the consortia other budget is very high – over one third of project management costs in the first six months (Table 5.1 and Table C. 1).

It is unclear why the providers did not include this in the IRRCS budget costs since the contracted funding was available to cover these costs during this time. A possible explanation is the level of input required to establish the consortia partnerships, such as the senior management input required to get agreements between the partners and the good will of the consortia members.

Ongoing project management costs average \$35,000 per consortia (28 per cent of annual IRRCS and consortia other budget, Table 5.1). This is high compared to other community services, which are usually approximately 15 per cent of contract budget. It might be because it includes the high proportion of costs covered by consortia's other budget. It also reflects the complex service obligations of the PDRSS to negotiate between multiple human service agencies in all three phases of the program.

Future funding models would need to take account of the restricted eligibility criteria during the pilot and the particular way that the IRRCS providers selected consumers. It could be that in future implementation of the model providers would target other consumers from SECUs with more complex needs that would require more intensive support for longer periods than the 30 consumers in the pilot.

5.2 Benefits

Outcome data were gathered from the interviews and case studies and presented in detail in Section 4. The data were compared to before and during IRRCS or to population norms (Table 5.2).

Table 5.2: Measures of Effectiveness for Consumers Supported by IRRCs to April 2009

Outcome	Explanation
Health and wellbeing	Physical health and wellbeing trended towards the population norm. 'Personal relationships' was the personal wellbeing domain that moved closest to the population norm.
Mental health	Mental health improved as evidenced by: remaining living outside a CCU or SECU; fewer hospitalisations; compliance with medication; and greater insight into their own mental health management
Living skills	Living skills such as personal care, domestic skills and community skills and financial management are gradually improving towards greater independence. Most gains were in personal care skills.
Social and family relationships	Most consumers had begun to make friends and reconcile with family members. However, contact with children decreased. For others it remained a long-term goal to gain friendships.
Community participation	Most consumers were more likely to now participate in social and community activities and have positive relationships with neighbours.
Employment and education	Nearly half the consumers were engaged in paid or voluntary work or education or had plans to do so.
Stable housing	Most consumers were allocated accommodation in transitional housing because appropriate and affordable social housing was not readily available. A number of consumers moved into other models of accommodation that better met their assessed needs e.g. Supported Residential Service.

Source: Evaluation client dataset, consumer and worker interviews
 Note: Comparison is between before and during IRRCs or a population norm.

In summary, in the best cases it is likely that the return on investment cost of between \$52,000 and \$100,000 per person who uses the program per year includes:

- improved physical health, wellbeing and mental health;
- trends towards independence in living skills;
- increased social contact with friends and family; and
- participation in community activities, employment and education.

The financial program cost of IRRCs per consumer is low compared to the alternative higher financial cost of continuing to remain in SECU and CCU support, and in addition generates these favourable benefits for most IRRCs consumers in a community setting over time.

6 Effectiveness – System Impacts

The final measure of effectiveness is the system impacts. This section describes the consortia, governance and staffing aspects of the design and establishment of the program that had an impact on the mental health system.

6.1 Consortia

DHS advertised for IRRCs providers in 2006. Three consortia were appointed based on geographical areas: Western, North Eastern and Southern. The consortia are local PDRSS providers and other local agencies that support mental health consumers, and work in partnership with specialist mental health services and nominated SECUs and CCUs in the catchment area.

Each consortium of PDRSS and clinical services is specific to a geographical location. They had an historical relationship between the consortia members and with the local SECU and CCU, which varies between the regions. Some consortia members had existing working relationships through earlier initiatives. For other consortia, much of the establishment period was spent developing common professional understandings in order to implement the intention of the IRRCs.

6.2 Governance

Department of Human Services and Advisory Group

The Director of Mental Health Branch was the sponsor of this project. The IRRCs was developed and supported by officers of the Mental Health Branch.

The Advisory Group membership is comprised of Department of Human Services staff, Area Mental Health Services, PDRSS representatives and an academic. The membership is:

- Sue Brennan the then Director, Service Improvement Unit, Miriam Segon, David Carey and Rod Mann, Mental Health Branch, DHS
- Tony Newman and Robb McGregor, Housing and Community Building, DHS
- Robyn Duff, MIND
- Peter Waters, ERMHA
- Clare Amies, Western Region Health Service
- Dr John Farhall, La Trobe University
- Gary Monkley, Mid West Area Mental Health Service, North Western Mental Health
- Frances Blyth, North East Mobile Support and Treatment Service
- Robyn Humphries, Eastern Health
- Matthew Somerville, Danny O’Kelly and Cathy Keenan, DHS regional representatives
- Barbara Hill, Western Region Health Centre
- Maria Malic, Werribee Mercy
- Dr Tim Rolfe, Southern Health

The group met two-monthly in the early stages of the implementation. The Advisory Group provides steering and monitoring of the IRRCs, had agreed on assessment domains for consumers and monitored the evaluation plan and activities.

Consortia managers

Managers of the three consortia meet monthly to share information, knowledge, expertise, processes and experiences. This was seen by stakeholders as particularly beneficial because it allowed consortia to discuss any questions and compare implementation strategies. From this common point they had developed different models based on shared principles.

Housing

Housing and Community Building (H&CB), DHS is a member of the Advisory Group. The H&CB official has met with the consortia as required to discuss the expected procedure when a consumer is identified as requiring public housing. The officer responsible is also involved in the related High Risk Tenancy project.

Representatives of the Office of Housing had different involvement in each local consortium. For example, the Office of Housing representative in the West IRRCs participated in decision making processes and the development of local policy and protocol. In the North East, local housing providers, including Yarra Housing, Supported Housing and Community Housing were consulted, however the Office of Housing was only involved peripherally in the development of the local initiative.

Families and carers

Families and carers are offered opportunities to participate in the program in all three phases of the program, as relevant to their relationship with the consumer and at the request of the consumer. At minimum they received information about the program and had been asked to contribute their opinion about the suitability of the program to support the consumers' needs. Some families and carers are more actively involved in supporting the consumers' transition from their current place of care. Others were more concerned about the impact of such a change.

Effectiveness of the governance arrangements

The IRRCs model is very complex, as evident in the governance arrangements described above. Despite frequent meetings, targets and reporting, some respondents in the initial interviews criticised the lack of relevant communication between the service providers and lead agency in each consortium and DHS. Presumably, this is due to the large number of people involved in establishing a new integrated initiative that requires the participants to change the way they provide services. The prolonged establishment period probably reflects this complexity. By the end of the evaluation, questions about setting up the program had been resolved and respondents were more positive about how the relationships were contributing to both the implementation of IRRCs and wider system improvements (Section 7.1).

6.3 Consortia Staffing and Supervision

Arrangements for consortia staffing and supervision are specific to each consortium. DHS was involved in requiring particular clinical arrangements. Supervision is conducted internally by the consortia members. The regularity of these supervision

meetings varies across regions and between members, which presents risks in terms of consistency of expectations within and between consortia.

The IRRCSS staff tend to be experienced PDRSS staff because of the complexity of coordinating services from agencies within and outside the mental health system to meet the changing needs of consumers as they transition out of the SECU or CCU, through IRRCSS and finally into ongoing support in the community.

6.4 Summary of System Impacts

The IRRCSS established effective systems to supporting consumers to successfully move out of a CCU or SECU into sustainable housing and support in the community. Facilitators and achievements in the program establishment included:

- establishment of the Advisory Group;
- establishment of the three consortia, each with a lead agency;
- development of assessment tools, where the content of the tool is common to the three consortia;
- funding allocated according to each consumer's individual plan, up to \$90,000 per consumer; and
- systems of care coordination are in the process of being established.

Barriers included:

- the complexity of the IRRCSS model and the consequent protracted nature of the establishment phase;
- delays in selecting consumers for IRRCSS; and
- difficulties and delays securing suitable housing for IRRCSS clients.

Keeping the momentum of implementing the model was initially a problem. The commencement of the first IRRCSS phase, preparation for transition to the community, took longer than the anticipated three months from allocation of funding to lead agency. This was primarily due to the need to establish governance processes and agreed assessment including sharing client information and developing joint care plans. The program responded to the complexity of the IRRCSS governance model, both at program and consortia levels, and considering where opportunities may exist to streamline processes. Some organisations changed communication processes within the consortia, and across the program to consolidate the IRRCSS model, together with a consideration of key aspects of the model for example the role of the lead agency.

In addition the IRRCSS has also had wider benefits for discharge processes and coordination in other parts of the mental health system. An improved capacity of the mental health system to respond to shared clients was supported by the development of positive PDRSS and mental health service relationships, experience in multi-disciplinary care planning, clarification of roles and responsibilities (initially problematic) and the development of communication mechanisms.

7 Efficiency – Partnership Development

The third aim of the evaluation was to assess the efficiency of the program in relation to the development of partnerships, systems and processes and responsiveness to consumer needs. The following two sections discuss the findings in relation to efficiency, beginning with partnership development. Partnerships were developed with PDRSS, specialist mental health services and housing providers.

7.1 Collaboration between PDRSS and Specialist Mental Health Services

The IRRC design integrates delivery of psychosocial rehabilitation and mental health support. PDRSS and mental health clinical staff reported that IRRC has positively contributed to both worker cooperation and the improved capacity of the mental health system to respond to shared clients.

There were some difficulties in early implementation of IRRC in the collaboration between mental health services (MHS) and PDRSS staff. Lack of clarity about responsibilities between staff at MSTs, PDRSS, SECUs and CCUs had the potential to jeopardise the success of consumers' transition through IRRC and risk the stability of their mental health. A MST worker discussed an example where the responsibilities had not been resolved in the interests of the consumer's transition out of the CCU to the community. He had previously been in a SECU. The MST worker said,

There was a period that he was doing well. He was on a certain regime with his medication when he was discharged from the SECU to the CCU and I think he was complaining of some side effects and then at the very start of his time at the transitional unit that time they decided to alter his medication a bit which didn't have a good result. He expressed delusional ideas that resurfaced and he was a little bit more elevated. So he had a setback then and the medication was changed back somewhat. There was some disharmony between services about medication as well as the timing for his transition. I think the problem was due to changes in medication as well as the stress of moving to the transitional unit. The CCU changed his medication and was keen to get him out. They had the final say.

IRRC represented a higher level and extent of engagement between MHS and PDRSS than pre-existing arrangements. As the program progressed and questions about respective responsibilities were resolved, relationships normalised and improved.

Worker cooperation

At the first interview perceptions and statements about cooperation were mixed. Most staff members were positive about their partnership counterparts and the importance of having good relationships. They had a clear understanding of their roles and boundaries in relation to consumers, and each other's organisations. Good communication, regular case meetings, consistency in approach and role clarity were some of the qualities of good relationships. Some workers acknowledged the opportunity for change that IRRC represented. The differences in approach (clinical and support) were articulated clearly and the difference was positively valued. A PDRSS worker said,

I find that clinical and PDRSS have different ways of thinking, different processes and focus. The clinical mindset contrasts with the person-centred mindset. Different constraints and reporting requirements create a much more analytical mindset. We're more lateral, problem solving – how to solve problems rather than systematised thinking, for example, the focus on medications before all else. If we respect each other we cover more ground. The two approaches when married well, take off. You must have both.

Problems with collaboration that IRRCs, SECU and CCU staff mentioned at the first interview included communications breakdowns, mixed messages, not having a full picture of what was going on with a consumer, or what the consumer was being told. Delays in getting case manager input in ISPs was mentioned by one PDRSS worker and a view that CCU staff had particularly negative views about consumers by another. Other IRRCs staff reported perceptions that MSTs were unwilling to resource the program and that SECUs were 'dumping' consumers on IRRCs.

One set of workers discussed how their MSTs-PDRSS relationship improved with the reduced number of workers involved. On the other hand not all relationships were regarded so positively. The example below indicates that the integration could benefit from explicit reflection on how to improve communication between the many partners. One PDRSS worker said,

The working relationships with other professionals involved in the client's care (psychiatrist and case manager at the CCU) are not so good. Their clinical decision making is not shared with non-clinicians, who have lower status. PDRSS has no contact with the CCU. I have some struggles with inpatient units – difficulties in working with two teams.

Negotiating control over the case plan budget was a point of tension between clinical and PDRSS workers, although generally well resolved. Tension was experienced during the case plan negotiations and during the implementation, when it became clear that the person's needs had changed or were different to needs anticipated through the development of the case plan. Usually this change was an increase in support needs. However, it also included more stable mental health than anticipated, resulting in a lower need for clinical support.

Very few negative comments were made a year later. Generally comments about collaboration were positive from IRRCs and clinical staff at the end of the evaluation, for example,

Our relationship is good. We meet every month to discuss what we've been doing with our client and what the gains have been and then we make sure we have clear guidelines on who's going to do what. Our client is very good at asking all of his carers the same question, to see if he gets a different answer, so we're clear about who does what.

I think we have a good team in place. We all communicate regularly on any updates or things we need to know with what's going on with the client. We have monthly case conferences so we're all up to date on

what's happening. It works really well. We have a good relationship with each other and it works, it makes it much easier.

Relationships in the mental health system

Early in the evaluation some MHS and PDRSS commented on how IRRCSS and its partnerships extended the capacity of the mental health system in the interaction between its components (SECU, CCU and MSTs) and with the psychiatric disability support system. Workers made several comments on this theme,

[Consumer] is getting better care than he would have without IRRCP. It's a good idea to get out of the institutional mindset. [Consumer] was in there for such a very long time. If you look at what he's capable of, it would have been lost if he'd stayed there.

PDRSS and MHS staff identified a generalised improvement in the relationship between their organisations that translated to providing support to consumers who did not require an IRRCSS response,

My relationship with the mental health case manager is now good. At the start there was poor communication. I was not informed of decisions about my client, but now I not only have a good working relationship with his case manager, but with the members of the team who replace him when he is not available.

It's improved my relationship working with MST with other clients. The good thing is that it made them have a relationship with us and I've picked up other clients of the MST worker and no problems, it's been good.

Two MSTs case managers made similar comments on the benefits of the IRRCSS in the quality of care teamwork and broader relations.

I find we have at the moment quite a coherent approach. We're working closely together, we meet to have conferences with all the teams every two weeks where we make major decisions and then in between time there's lots of emails back and forward to various services involved and so everyone's on the same page and it needs to be that way because with this client we all have to be consistent.

For us to be able to delegate certain things within the care team makes things much easier and we respond more consistently.

Another benefit of care teams was the capacity of the team to accommodate changes in membership and support individual staff as this PDRSS worker experienced.

Actually I didn't have a handover with the previous worker. So I only had access to the file and the current care team and that was it, which despite not having a formal handover with former PDRSS worker was quite easy because the care team was very supportive, with frequent conferences and accessing information.

7.2 Housing Collaboration

A key partnership process in the IRRCS was the identification of appropriate and affordable housing in the community. Housing and Community Building (H&CB) DHS was involved in the working group to support the implementation of IRRCS. Their role was to provide advice to facilitate access to social housing where appropriate.

Demand for low cost and affordable housing is growing rapidly in Victoria. In addition, private rental market affordability and the rates of entry to and exit from Victorian public housing are both falling, affecting the capacity H&CB to meet new demand for affordable housing quickly. Access to public housing is through a segmented waiting list introduced in early 2000 to prioritise scarce housing resources to people most in need by targeting groups for early housing allocation based on need. The groups are:

- Segment 1 – Recurring homelessness
- Segment 2 – Supported Housing Segment – people receiving designated types of mental health support are usually included in this category. Recognised Mental Health support agencies include PDRSS home-based outreach providers.
- Segment 3 – Special Housing Needs – currently in unsuitable housing for a variety of personal, health or family needs.
- Segment 4 – Would benefit from living in public housing.

IRRCS consumers make applications for public housing via Segment 2 of the early housing waiting list. Segment 2 includes people with disabilities or long-term health problems, whose current housing is unsuitable and who cannot find suitable housing to rent privately.

The average statewide wait time for public housing through Segment 2 is six months. The length of time between the application for public housing being approved and a property being allocated varies considerably across the state and can range from a few months to over 12 months especially in localities that had high demand and unaffordable private rental.

A person must meet the public housing eligibility criteria and register for public housing with the relevant Office of Housing (OOH) regional office. The evaluation identified that the level of knowledge and understanding of this application process varied among the consortia members. Procedures were put in place to reduce the potential waiting periods for the consumers. As soon as an IRRCS provider identified that an IRRCS consumer required public housing they were listed for public housing as Segment 2 applicant. The OOH allocated a regional housing officer to advise IRRCS provider on the best location and the stock type application to make, that balanced the consumer's housing requirements with best potential waiting period.

If appropriate public housing stock was not available, other options were to be considered. Solutions that were used were transitional housing stock instead of permanent housing and widening the range of housing options suitable to the person's support needs – public housing, social housing managed by community housing associations and Supported Residential Services (SRS). In some areas the IRRCS provider had a direct relationship with the local housing officials, which facilitated

more direct problem solving, including access to transitional or temporary opportunities.

7.3 Summary of Partnership Development

The IRRCS is necessarily a complex model because it aims to generate working relationships between all parts of the mental health system and the wider human services system. Key processes in establishing, implementing, operating and maintaining IRRCS included coordination activities to create and maintain the partnerships, agree on goals and establish processes to achieve the goals. These included coordination at the policy management, local and consortium levels. For this reason explicit mechanisms to facilitate communication between the partners were critical to establish and operate the program.

The establishment of these processes took a long time. By the end of the evaluation period strong professional relationships between the organisations, managers and staff and a willingness to engage in a multidisciplinary approach were evident. These relationships had a direct impact on the functioning and efficiency of the IRRCS program and effectiveness of the program support for the consumers.

The involvement of organisations already integral to the mental health system was a strength of the IRRCS model. The impact of this approach was that the consortia were able to build on existing relationships, allocate experienced managers and staff to the program and manage transition out of IRRCS into sustainable housing and support within other community services.

8 Efficiency – Systems and Process Development and Responsiveness

The second aspect of efficiency evaluated was systems and process developments. This section discusses the development and responsiveness of the IRRC processes including:

- selection of consumers and intake into the IRRC;
- Individual Support Plan and Mental Health Plan process and responsiveness;
- preparing for exiting from IRRC; and
- support responsive to consumer needs.

8.1 Screening and Selection of Consumers into IRRC

The content of the assessment tools is common to the three consortia, but the tools themselves differ, depending on the local practices and existing tools. The assessment fields are: risk factors; housing requirements; social support requirements; living skills; family and care support; clinical history (including co-morbidities, substance abuse); health; and history of prior effort.

The Advisory Group agreed that it was not necessary that the same tool was used in all areas but that common fields for assessment were needed. A small subgroup of consortia members met to review the assessment tools that were being considered by each consortia and to ensure that common assessment fields were included.

The assessment process took longer than expected. Delays were due to:

- processes such as establishing a relationship with SECU and CCU staff;
- ensuring an understanding of IRRC and buy in by staff;
- communication with the SECUs and CCUs, consumers, families, carers;
- consumers withdrawing interest from participating in the IRRC or being diverted to alternative options;
- discussions confirming suitability of the IRRC for individual consumers; and
- reaching agreement whether the consumer required a different service response model to the IRRC transitional model and whether the notional individual funding allocation was sufficient to support the consumer's needs.

Once SECU and CCU consumers were assessed, a selection panel in each region made up of staff from the PDRSS, SECU, CCU and OOH agreed upon which consumers would be selected. The same panels also approved and monitored the implementation of care plans.

At the first evaluation interviews the intake process was described by most workers as smooth and involving close collaboration between PDRSS and MSTs staff as well as workers in the CCUs, SECUs and staff of SRS. Some PDRSS and MSTs staff had had no direct involvement in the intake of their IRRC consumers. Workers that had been involved in the process were generally positive about it and felt that appropriate consumers were selected to the program. Workers raised cautions that:

- some potential consumers were excluded, such as people who were high functioning, with low support needs but with fixed delusions that may present a danger to themselves or others). These consumers do not meet the IRRC pilot eligibility criterion;
- consumer needs could be unpredictable and likely to change. It was difficult to predict how consumers will respond in the community and how their reaction might change, for example, when they were exposed to illicit drugs again.

At the second evaluation contact some MSTs and PDRSS staff reflected on the intake criteria in the light of what they had learnt from consumers in the IRRC pilot program and its suitability for some consumers. One worker recommended that the selection process address the consumer's willingness to comply with activities such as, 'to attend a group once a week, or participate in an activity.' Another questioned the suitability of using the level of illness as a criterion when a consumer presents as low risk but may have very high support needs, poor social skills and severe disability. The comments seem to indicate that some workers were unclear about the aim of the pilot and the eligibility criteria. Some workers reflected on the suitability of IRRC pilot for some consumers selected for it, for example,

I think this first group has ... given me the framework to be able to identify what level they need to be at to make use of this program. I think the program really needs to be seen as a stepping stone to more independence, rather than just getting people out of SECUs and CCUs who've been there a long time. If they've been in a SECU or CCU for a long time they're not going to be able to do it.

The dynamic of high levels of disability, long periods living in psychiatric institutions and poorly developed social abilities posed challenges for workers. Some staff proposed more social and community living skills development in Phase 1 before they leave SECUs and CCUs. Some said that the person's willingness to participate in these aspects of a support plan should be taken into account in selecting consumers. A PDRSS worker said that the consumer's motivation had reduced since intake, saying,

I'd say his mental health has been quite stable over the time. I will say when with IRRC pilot he was first removed from the [psychiatric facility] he was perhaps more willing to do things that we asked him to do because he knew there was that threat that if he didn't work out he might have to go back in.

The intake process seems to be effectively identifying consumers who can leave SECU or CCU care, develop their skills for living in the community and transition into sustainable existing community levels of support. At entry many consumers had low levels of independence in some self care, domestic and community skills, which needed to be addressed in their IRRC pilot plan, either while they were still in the SECU or CCU or when they moved into the community.

Preparation for discharge from the CCU or SECU required intensive liaison between workers in the community and facility. The relationships generally worked well, but some disagreements arose, for example conflicting opinions about consumers' capacity, safe transition and responsibilities for preparing the person to leave.

8.2 Individual Support Plans and Mental Health Plans

Once a consumer was confirmed as suitable for IRRCs they were allocated a care manager from one of the consortium members. Initially the care managers worked with the consumers in the SECU or CCU for an average of three months. The consumers then moved into the community and eventually worked towards exiting IRRCs onto other sustainable mental health and other community support (Table 2.1).

Planning process

Discussions with PDRSS workers showed that ISPs were developed in a collaborative and consumer-centred manner and allowed the necessary time to engage with consumers in a meaningful planning process. Where it was relevant to the consumers, in some cases family members were also engaged in the process. Planning began in Phase 1, while consumers were in SECUs or CCUs and involved clinical staff in those settings. Most ISPs employed problem solving to identify major goals of consumers and help them plan. With changes of support personnel, handovers were sometimes limited to a review of written case notes and working with the consumer to write their ISP and timetable.

Preparing the initial plan for the basis of funding, took weeks or months in most cases, while the workers gained the consumers trust and became familiar with the consumers' needs. As intended, plans changed once the person left the SECU or CCU.

Individual support plans

The ISPs of consumers were unique to each person. They addressed all life domains and addressed the changes brought by transition. As some consumers progressed through their plan, new elements were added to address issues in their new, more independent situations or changed circumstances.

IRRCs planning had three elements:

- care coordination, liaison between relevant support staff and monitoring of the integrated plan;
- the individual's support plan which identified personal goals and what would be provided; and
- exit plan to move the consumer from the IRRCs– staged support withdrawal, reducing the number of hours or workers that visit, transfer to a MHS Continuing Care Team, and transfer to a PDRSS home-based outreach program or other relevant exit option for example a SRS.

The effective delivery of an integrated care plan required regular meetings with the PDRSS, MSTs or CCU, consumers and perhaps family members. IRRCs staff also liaised with consultant psychiatrists and trustees or administrators.

Individual integrated care plans included:

- Establishing a home - including brokerage funding to purchase furniture and equipment;
- Physical health plan – supporting the consumer to look after physical health such as assistance managing diet and medical conditions including diabetes and

epilepsy, developing strategies and rules around non-prescribed drug use or alcohol;

- Mental health Plan – including monitoring the consumer’s mental state, strategies for keeping someone safe when they are a risk to themselves or others; checking and providing medications; mental health relapse prevention plan; support to comply with the terms of a Community Treatment Order;
- Psychosocial rehabilitation – formal or informal skills training in a range of activities of daily living e.g. managing finances and spending, and/or helping with problems; shopping, laundry, cleaning and cooking; getting or recovering a drivers licence; support with leisure and community activities; preparing for work or studying, and practical help like reminding consumers to go to work; learning to use an ATM; travel training and orientation to medical and related services where consumer has moved to a new area, including doctors, specialists, chemists, pathology services

The plan also identified strategies to address new and more stressful circumstances from living in the community, such as working or studying, managing social or family relationships, access to illicit drugs and managing mental illness symptoms.

The individual needs assessment process was also used to identify the range of supports required from generic health and community support services. The IRRC support workers assisted consumers to access services that met their needs by making referrals and advocating on behalf of the consumers (e.g. accessing ongoing Medicare funded psychological services or finding a private psychiatrist; men’s groups, women’s groups); day activity programs, independent living skills (e.g. cooking, literacy, assertiveness training) recreation and social programs, vocation and employment support services.

Planning for exit from IRRC

Planning for exit was part of the assessment and planning against goal attainment. Staff gave examples,

For the last six months I felt she made significant improvement and I had evidence from family members, about how much more easily she was able to communicate. The plan changed slightly in focus, but stayed fluid. Her support needs stayed pretty much the same. She has now been transferred to the Intensive Support Team. She’d say, ‘I don’t need to see you today.’

The way I look at it, it’s a graduation for him, coming to us from the MSTs. My work with [consumer] will be more about normalisation in the community, and where he will be taking a lot more responsibility for himself, part of his independence. We’ll be responsible for his treatment, managing his treatment and then him having a life out there.

I think there have been a few things change, some of it is that he does want to do things by himself but at the same time there are things we’re not prepared to support him around or do with him and that’s pushed him to do them by himself and learn these new skills.

The ISP was reviewed and modified as consumers continued on their transition, which could involve a transfer to a new community service or mental health provider. Consumers exiting the program were referred to a Continuing Care Team, and the planning process began again. The intention of the program model is to facilitate a smooth transition from SECU and CCU to living in the community with intensive IRRCS services and finally into usual levels of PDRSS support. For CCT case managers the intake process was the same as for other consumers, as one commented,

What they do is a normal process. They fax me all the information and talk to me over the phone and this is like a normal referral. So I got all that stuff and talked to them [other parties] over the phone. The PDRSS worker accompanied him so I got to meet him.

At last interviews PDRSS and MSTs staff were increasing the intensity of support or accessing additional support in the community to underpin the successful exit and handover to new community-based provider. However, some IRRCS workers anticipated difficulties preparing some consumers for exit from IRRCS. These consumers would require an on-going level of support from alternative sources to plan a sustainable path out of IRRCS and to prevent the risks to their mental health stability. They included people with poor psychosocial skills, brain injury or neurological or intellectual disability that could negatively affect motivation and capacity to acquire new skills.

Some staff members were also concerned that some consumers would not cope with the limited maintenance support available through PDRSS and MSTs; or that access to that support would not be available when the consumer was ready to leave because other consumers living in the community might have higher priority needs. These worker concerns indicate possibilities that:

- some consumers were selected who did not meet the pilot eligibility criteria because their long term support needs are too high;
- some workers need extra training, skills and support to undertake the assessment, design and implement support programs and to understand the range of generic support programs and the referral processes for accessing services for people with dual disabilities; and
- exit planning and negotiation with service providers in the consumer's placement catchment area might not have occurred early enough to facilitate access to the supports in a timely manner.

8.3 Support Responsive to Consumer Needs

A goal of IRRCS was to provide support responsive to consumer needs. This is in recognition of the individual needs and preferences of the consumers involved and the likelihood that their needs would change during their time using IRRCS. The evaluation considered the responsiveness evident in the way care plans were implemented and the relationship between consumers and workers.

Implementation and monitoring of integrated care plans

The level of support provided was responsive to individual needs. This could range from daily contact with a member of the care team to weekly visits. At the most

recent evaluation contact some PDRSS and MSTs staff were increasing the intensity of support or accessing additional support in the community from PDRSS and other sources. Transition involved changes to the amount of support and which case manager and PDRSS workers supported the consumer. These changes required planning by the IRRCS worker to avoid affecting some consumers negatively. One worker said,

Her time was reduced to ten hours and she became a little bit unsettled because she was given a new worker, as it was close to the IRRCP coming to an end. She was moved to the Intensive Support Program with IRRCP offering secondary consultation. She's now down to four and a half hours a week. Though she expressed an interest in being connected to more mainstream things she now finds that overwhelming.

Some PDRSS and MSTs staff reported no significant change in the level of support provided over time in the program, although the focus of the support may have changed (e.g. a lesser focus on medication and treatments). One consumer with high support needs has continued to receive a high level of support. This might reflect transitional high support needs during early engagement in each IRRCS Phase or that the consumer did not meet the eligibility criteria.

In summary, the program design of individualised support targeted at consumers who are likely to be able to transition to standard levels of clinical and community support appears to be appropriate. Consumers and workers spoke about how the initial intensive support has led to gradual changes in the amount and type of support needed over time. It reflects effective screening and selection of consumers (Section 8.1), the development of goals based on individualised need and changes in support as goals are achieved (Section 8.2). Consumers said,

They are reducing the amount of support. The good thing is that they are doing it very slowly, but when I look at being independent I start to get a bit worried as I don't know if I can look after myself. Lucky that they won't take away the props.

Because I'm much better, I find I'm talking to my psychiatrist about little things. I don't really have that much to say. I'm just much, much better.

Consumers experienced positive outcomes from the implementation of their care plans in terms of leaving bed-based clinical services, establishing mental illness relapse prevention strategies; setting up homes and improving the quality of their relationships with their family and friends. A few consumers had also started establishing new social connections, including some economic activities.

Consumer relationship with PDRSS and mental health services

The second aspect of responsiveness was the quality of the relationship between consumers and staff. At the first interview consumers were generally very positive about their relationships with PDRSS workers. They cited the positive personal qualities of workers, their interactions with them and the value of the help they were receiving. Most consumers were also happy with their interactions with MSTs case managers and the help they received from them. At the second interview those relationships continued to be regarded positively. For example, consumers said,

[PDRSS worker] helped me a lot getting this nice little place and put a lot of work into it. I've had this lady come over to do the gardens, weeding and all that she's done there.

I see [MST case manager] about once a week. It's all right. He comes to have a quick chat but then he goes. We talk about how I'm going, the voices I'm hearing, the OCD and if they've changed, you know.

Changes in staffing affected relationships positively and negatively. Relationships changed where the support or case management role had become more limited by boundary setting or reduced contact hours. Workers said,

I don't think he struggled with the staff changes at all. He's had a number of changes since then, he's had three ISP staff changes and he really hasn't struggled with it at all. He's used to staff coming and going in his life.

I think he felt a bit vulnerable initially, coming to a new area, having to come to a new clinic, having to meet new doctors, new case managers. Having to re-establish that link. He initially expressed some stress which tended to exacerbate some of his symptoms initially. That's when I saw the vulnerability in him and he did actually acknowledge that.

The dynamics of relationships were influenced by the level and type of illness or disability of consumers and their willingness or resistance to treatment or support as the following illustrate. Workers said,

With someone who's very rigid and everything's black and white and with not a lot of empathy, it's harder to reason with them, so fixed on what they want. It's harder to get them to listen to your reasons.

Our consultant psychiatrist and I have talked about my client's lack of social skills. A structured social skills program was tried, which he was cognitively unable to do. So PDRSS have put a very basic social skills program within our interactions with him.

Longevity of contact with mental health services also affected relationships, in both positive and negative ways. One case manager had first made contact with the consumer 12 years earlier, which the case manager thought contributed to them working together effectively. Other consumers said they found it difficult to work with the case managers in the MSTs, because they had had a negative history of working with them prior to IRRC.

Some relationships were less equal and more directive where consumers had high levels of psychiatric disability and required very structured support. Consumer satisfaction with PDRSS workers and case managers was harder to establish in these situations. Compulsory orders (such as guardianship or treatment orders) also complicated satisfaction with relationships.

8.4 Summary of Systems and Processes Development and Responsiveness

Very detailed screening and selection processes supported the IRRCs. These processes, whilst taking longer than expected, enabled the accurate identification of consumers well suited to the IRRCs transitional support model despite great variability in their individual needs. The matching of the level of support consumers required for discharge out of the SECU or CCU with the intensity of the IRRCs support available was enabled by the clearly defined eligibility criteria.

The individual support planning was a dynamic individualised process that appeared responsive to the changing needs of the consumer. Monitoring of the individual support enabled support levels and activities to be modified according to changes in consumers' needs.

Exit from IRRCs was found to require early planning due to the capacity implications for other parts of the mental health, PDRSS, housing and a range of other generic community-based support services.

Procedures and consumer-related program documentation established by the consortia were modified during the evaluation period to reflect the lessons from implementation. The immediate impact was to more efficiently assess the suitability of consumers, prepare them for discharge from the CCU or SECU and arrange suitable housing and support. In addition, as the program matured, fewer meetings were required to establish and modify the processes.

The final measure of efficiency was the IRRCs responsiveness to consumer needs. The program was able to support more consumers to enter the program than expected due to variation in the levels of support consumers needed at any particular time and in the time they needed in each phase of the program. The intensity of support required by consumers varied within, rather than between, the phases of preparation for transition to the community; support in the community; and transition to ongoing support responses in the community. High levels of support were required at the beginning of all three phases. This required constant responsive change from the workers and high levels of interaction with workers in other parts of the system.

Time lines for consumers moving through the various stages were highly individualised based on the degree of their disability, the types and levels of support needed, the rate of mental health improvement or recovery and the availability of support and housing in the community – some consumers required more time than others. This required the IRRCs to be responsive to individual needs through the design of specific and changing combinations of integrated mental health and psychosocial rehabilitation support.

9 Applicability of the IRRCS Model to Other Consumers

The final part of the evaluation was to assess the applicability of the IRRCS model to other types of consumers of mental health services in the broader mental health system. By the end of the evaluation period workers recommended that the program model should be expanded to enable other consumers to participate. The combination of high levels of mental health support, psychosocial rehabilitation support and housing had already built service capacity through collaboration and was suitable for addressing the needs of people with chronic severe mental illness and on-going support.

Barriers and facilitators that might influence wider implementation of IRRCS in Victoria include the availability of suitable housing in the short term so that consumers can leave the SECU or CCU and in the long term to exit IRRCS; the capacity of PDRSS to absorb more consumers exiting IRRCS; and the availability of experienced staff to manage the complex relationships between service providers in the mental health and other human services sectors.

Appendix A Evaluation Questions

Appropriateness

1. Have appropriate consumers been targeted by the IRRCs service providers?
2. Have the targeted consumers received appropriate mix and level of services and support?
3. How well does the implementation of the IRRCs align with the current policy directions of associated sectors (e.g. housing, community health etc)?
4. What is the support for the program among key stakeholders?

Effectiveness

5. To what extent have the implemented procedures and consumer-related documentation complied with the guidelines for service provision established during the program implementation?
6. What consumer and carer outcomes and systemic improvements have been achieved through implementation of IRRCs?
7. What are the different models of care implemented by the IRRCs and which key components have had the greatest impact upon consumers and carers and the service system?
8. What unanticipated positive and negative outcomes have arisen from implementation of IRRCs?
9. How do the costs of implementation of the IRRCs individual consumer packages compare to the alternative models of service provision and alternative support packages available to the target consumers in the community at the time of program implementation?
10. What barriers and facilitators exist to influence wider implementation of IRRCs in Victoria?

Efficiency

11. What key processes were involved in establishing/implementing, operating and maintaining IRRCs at organisational and system level?
12. What opportunities exist to simplify or improve implementation over time?

Appendix B Interview Schedules

Psychiatric Disability Rehabilitation Support Service staff

1. How long have you been working with [name of consumer]?
2. Have you worked with [consumer] prior to IRRCS?
3. How long have you been a PDRSS support worker?
4. How long have you provided outreach/in-home support to mental health consumers in partnership with MHS (prior to IRRCS)?
5. How did you find the effectiveness of the intake procedures for IRRCS? Did it provide useful information for engaging with [consumer's name]?
6. How did you go about planning and providing support to [name of consumer]?
7. What are the elements of [consumer's] individual service plan? What goals? What timeframes? What support?
8. How did you negotiate the relapse prevention plan? What is the plan?
9. How do you see [consumer] increasing or improving their social and community participation and in the long-term, their social connectedness?
10. How do you see the immediate neighbourhood and community interacting with [consumer]? What impact do you think the IRRCS will have on this?
11. What do you think of the accommodation provided to [consumer]? What do you think of the process that you and [consumer] went through to secure that accommodation?
12. How is your relationship with [consumer's] mental health case manager?
13. What are the benefits of IRRCS for [consumer] and consumers generally?
14. Are there downsides of IRRCS for consumers?
15. How do you see the future for the consumers?
16. How do you see the future of the program?
17. Do you have any further comments you would like to make about the IRRCS?

Interview schedule: MSTs, CCT, SECU and CCU staff

1. When did you meet [consumer] for the first time? How? When?
2. How did you find the effectiveness of the intake procedures for IRRCS (experience of consumer, suitability of consumer personal and medical information)?
3. How did you go about planning and providing support to [consumer]? Have there been any issues for you in this process?
4. What are the elements of [consumer's] individual service plan? What goals? What timeframes?
5. How have you developed a relapse prevention plan? How do you think [consumer] will go in the short-term / long-term? What are the threats?
6. Do you think the IRRCS will help consumers to increase their social community participation? Can you see this happening with [consumer]?
7. How do you see the immediate neighbourhood and community interacting with [consumer]? What impact is the IRRCS having on this?
8. What do you think of the accommodation provided to [consumer]? Are there advantages of this choice of housing? Do you see any problems arising because of location / neighbourhood / neighbours /configuration of the house or flat /size/ number of rooms /level of independence /any other problems? What choice was the consumer able to express?
9. How is your relationship with [consumer's] PDRSS worker? How satisfied are you with the support they provide to [consumer]?
10. How do you see the future for [consumer]?
11. Generally speaking now, how do you see the benefits of IRRCS for consumers?
12. Are there downsides of IRRCS for consumers?
13. How do you see the future of the program?
14. Do you have any further comments you would like to make about the IRRCS?

Consumer interview topic guide

1. Where have you been living before here?

2. How did you find living there? Was that good living there? Were there good things or bad things about living there?
3. [If lived with others] how were the other people you lived with?
4. Did you get to do your own cooking/housework?
5. Was anyone supporting you then?
6. Where are you living at the moment? (or About living here ...)
7. Do you like living here?
8. [If living in congregate/group house etc] Do you like the other people here?
9. Are there things you don't like about living here? Are there things you do like about living here?
10. What does [MHS Case Manager/Care Coordinator] help you with? How often do you see them? How happy are you with [MHS Case Manager/Care Coordinator]?
11. What does [PDRSS support worker] help you with? How happy are you with what they do? Do you like them?
12. How do you feel about living in this area? Do you have a social life here? What sorts of things do you do? Do you have friends here? Do you have family here?
13. Where would you like to live?
14. Why there? Have you lived there before? Do you know people there? Do you have any interests there (sport or leisure activities, cultural things like art, theatre, etc, social – social groups, special interest groups)?

Health and wellbeing prompts:

15. Have [PDRSS] or [MHS case manager or care coordinator] helped you to see doctors or have any health problems looked into?
16. What about allied health professionals like psychologists, physiotherapists, podiatrists and so on?
17. Are you happy with the health care you are receiving?
18. How happy are you with your health?

Social and Community prompts

19. Do you have any family? Do you see them? Do they help you? Do you help them? Are you happy with the contact you have with your family? Would you like a better relationship with them? Would you rather not see them at all? Would you like to spend more time with them?
20. Do you have friends? Do you enjoy your time with them? Do you hope to make more friends? How might you do that?
21. Do you do activities in the community? Join in with group activities, clubs or societies? Would you like to do more in the community? Have you made plans with [PDRSS worker] about doing more in the community?

22. Have you worked or studied in the past? Now? Would you like to? Are you planning to do this?
23. Are there any other things you've talked with [PDRSS] about doing?
24. What do you think your life will be like in a year's time?

Stakeholder Telephone Interview Schedule

General questions

1. Can you tell me about your role in IRRCP and the organisation that you work for?
2. How long have you been working with IRRCP?
3. How many IRRCP consumers do you work with?
4. Can you explain how you work with consumers? For example, what support do you provide?

Consortium and partnerships

5. In terms of consortium and partnerships, do you feel that IRRCP is working effectively? Why or why not?
6. What are the major successes?
7. What are your concerns/issues?

Governance

8. Are you involved in managing IRRCP? In what way?
9. With whom? What do they do?
10. How often do they meet?
11. What is their role?

Staffing and supervision

12. How is staff engaged in IRRCP e.g. sole responsibility, one of many responsibilities, part of a team?
13. What are the arrangements for supervision, training and reflective practice?
14. What are the strengths and weaknesses of these arrangements?

PDRSS and clinical services

15. What contact do you have with other people involved in implementing IRRCP?
16. What are the strengths and weaknesses of these arrangements?

Funding

17. If you are involved in managing IRRCP, do you know how IRRCP is funded and how the budget has been used? Are the resources you have available sufficient to address the needs of consumers at this stage of implementation?

Assessment

18. What is the process of assessment? (What are the assessment tools?)
19. What process do you go through when you first meet a consumer?
20. Do you have any comments about the referral and assessment processes?

Care coordination

21. How will care of the consumers be coordinated? E.g. Care plan, housing and mental health services
22. Who will be involved in developing and implementing the care plan?

Consumers

23. Who are the consumers? E.g. CALD or Indigenous background.
24. What do you think will be the overall benefits of IRRCP for consumers? Can you think of any examples?
25. What do you think will be the risks for IRRCP for consumers? Can you think of any example? (E.g. Loneliness, isolation)

Families and carers

26. Will families and carers be involved in IRRCP? If yes, how? If no, why not?

Housing

27. How has a housing provider been involved in IRRCP?
28. How long have you been involved with them?
29. What type of accommodation do they provide?
30. What is your relationship like with the housing provider?

Overall

31. Do you feel that the IRRCP is having a significant impact for consumers?
32. Do you feel that the IRRCP is having a significant impact for integrating the way services are organised?
33. Do you have any comments about the administration of IRRCP? E.g. funding, service design, resources
34. How do you see the future of the program?
35. What have been some of the facilitators to implementing IRRCP?
36. What have been some of the barriers to implementing IRRCP?
37. Any other comments?

Appendix C Average 6 Month Costs for IRRCS to July 2008

Table C. 1: IRRCS Average 6 Month Cost to IRRCS and NGO per NGO January 2007 to July 2008 (\$)

	January-June 2007		July-December 2007		January-June 2008	
	IRRCS ^a	NGO ^b	IRRCS	NGO	IRRCS	NGO
Project management						
Management and governance ^c	15651	11183	5600	7865	4667	6088
Establishment ^d	10506	4187	2858	4648	2381	1423
Operating	3565	0	1300	0	1083	0
Care coordination						
Staff, coordinators, support workers	2500	4754	7718	4686	8874	2118
External consultants ^f	0	0		0	400	400
Operating	0	0	2139	460	1782	0
Care delivery^g						
Staff, coordinators, support workers	0	0	15902	0	30774	0
Operating and consumer brokerage	0	0	2529	0	4263	0
Housing^h						
Rent, repairs, property maintenance	0	0	550	0	856	0
Total expenditure per 6 months	32222	20124	38595	17659	55080	10028

Notes: Project management – not specific to serving individual consumers

Care coordination – consumer costs that are not direct service e.g. identifying consumers, screening, assessment, care planning, arranging services, finding housing

Care delivery – direct services to consumers

Housing – ongoing housing costs

a. Cost to IRRCS is the contract funding to the NGO. Cost to NGO is additional NGO expenditure to run IRCSS not covered by the contract funding

b. All costs for Northeastern area are available from October 2007 quarter onwards

c. Northeastern and Western did not pay for management costs from the IRRCS funding

d. For example training, protocols, consultant. Northeastern had no establishment costs

e. Northeastern had no other project management operating costs

f. Northeastern and Western did not pay for external consultants or specialists

g. Western and Southern care delivery began July 2007. Northeastern began October 2007

h. Southern and Northeastern had no housing costs to IRRCS or the NGO. Western (\$11,651) and Southern (\$2628) reported annual housing costs to consumers.

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