Evaluation of NSW Community-based Mental Health Programs: Community Living Supports and Housing and Accommodation Support Initiative

CLS-HASI evaluation report

2022

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Appendices

Meanings and abbreviations

In this report, the term ‘Aboriginal’ includes people from the Torres Strait Islands. We acknowledge the diversity of traditional countries and Aboriginal language groups across the state of New South Wales.

ACCHO	Aboriginal Community Controlled Health Organisation
AMS	Aboriginal Medical Services
CALD	Culturally and Linguistically Diverse
CLS	Community Living Supports
CMO	Community Managed Organisation
CTO	Community Treatment Order
DCJ	NSW Department of Communities and Justice, formerly FACS
FACS	Family and Community Services
GP	General Practitioner
HASI	Housing & Accommodation Support Initiative
HoNOS	Health of the Nation Outcome Scales
JH&FMHN	Justice Health and Forensic Mental Health Network
K10	Kessler Psychological Distress Scale
LCQ	Living in the Community Questionnaire
LGBTI	Lesbian, Gay, Bisexual, Trans, and/or Intersex
LHD	Local Health District
LSP	Life Skills Profile
MDS	Minimum Data Set
MDSV1	Mental Health Community Living Programs Minimum Data Set version 1, November 2017 to April 2019
MDSV2	Mental Health Community Living Programs Minimum Data Set version 2, May to September 2019
Ministry	NSW Ministry of Health
NDIS	National Disability Insurance Scheme
QALY	Quality Adjusted Life Year
RRSP	Resource and Recovery Support Program
SPRC	Social Policy Research Centre
UNSW Sydney	University of New South Wales

The following words are used in this report when we refer to people who participated in evaluation interviews and focus groups:

- ‘consumers' or ‘people’ are people who received CLS-HASI support or other types of support
- ‘CMOs’ are CMO managers and staff (frontline workers), both in the fieldwork sites and other areas
- ‘LHDs’ are LHD managers and staff members, both in the fieldwork sites and other areas
- ‘families’ or ‘families and carers’ are informal supporters of the consumers
- ‘stakeholders' are all other interviewees from government and state-level positions, and from Aboriginal Medical Services.

Short summary

The Community Living Supports (CLS) and Housing and Accommodation Support Initiative (HASI) are community-based programs that support people with severe mental illness to live and participate in the community, the way that they want to. The programs offer psychosocial support, tenancy support and, where appropriate, clinical mental health services. Many consumers are also supported to access secure housing.

CLS-HASI are statewide programs funded by the NSW Ministry of Health (Ministry) and delivered locally through partnerships between local health district (LHD) mental health services and specialist mental health Community Managed Organisations (CMOs). The programs also have a strong partnership with the NSW Department of Communities and Justice (DCJ) and community housing providers for social housing.

The Ministry commissioned the Social Policy Research Centre (SPRC) to evaluate the CLS-HASI programs. The evaluation involved two rounds of qualitative interviews and focus groups, as well as the analysis of quantitative program data and statewide outcomes data about consumers. It ran from November 2017 to January 2020.

CLS-HASI supported 5,533 consumers in the study period from 2015 to 2019. Most consumers were in the programs for only part of this period. The average time in CLS-HASI was 10.7 months. Overall, the evaluation shows that CLS-HASI is generally working well, achieving its goals and is cost effective.

At a broad summary level:

- Consumers liked the programs, and most experienced positive outcomes – overall the programs improved wellbeing, helped people better manage their mental health, enhanced aspects of consumers’ physical health and increased opportunities for social inclusion.

- Consumer contact with community mental health services decreased by 10% in the first year in CLS-HASI and was 63.7% less if they remained in the programs for more than one year.

- Hospital admissions due to mental health decreased by 74% following program entry, and the average length of stay decreased by 74.8% over two years. This improvement was sustained after consumers exited the programs.

- Consumers with a new charge in the criminal justice system and with community corrections orders dropped to almost zero in the year after program entry.

- The programs are generating more in cost offsets than the cost of the programs, with a net cost saving per person of about $86,000 over 5 years. Over 90% of the cost offsets were for reduced inpatient hospital admissions and lower lengths of stay.

- As the NDIS became established during the evaluation period, more consumers gained access to the NDIS before, during or to support exit from CLS-HASI.

The factors identified as most important for the success of CLS-HASI were:

- strong local partnerships between CMOs and LHDs
- a person-centred, responsive approach to service provision
- focus on early intervention when consumers became unwell
- an increasing focus from CMOs on consumer choice.

The main areas where CLS-HASI was not operating as successfully were:

- local and state level partnerships beyond the CMO and LHD
- diversity of referrals into the programs
- responsiveness to the needs of some priority groups
- remaining questions on implementation of the hours of support structure.

Finally, good practice was evident throughout the evaluation, enabled by a range of facilitators. Program partners should consider how these facilitators of 1) effective implementation of CLS-HASI and 2) positive outcomes for CLS-HASI consumers, could be used to continue to improve the programs further.

Executive summary

The Community Living Supports (CLS) and Housing and Accommodation Support Initiative (HASI) are NSW Government programs that support people who have a severe mental illness so that they can live and participate in the community the way they want to. The programs help people to work towards their own, unique recovery goals. The types of support that people receive depend on their individual needs and what they want to achieve.

Support available to program consumers includes support with daily living activities like shopping, meeting people in the community, learning new skills, maintaining their tenancies, and accessing other services such as clinical mental health services. Many HASI consumers are also supported to apply for and access secure housing. The programs are funded by the Ministry and delivered through partnerships between local health districts (LHDs) and Community Managed Organisations (CMOs). The programs also have strong partnerships with the Department of Communities and Justice (DCJ) and community housing providers for social housing.

The Ministry commissioned the Social Policy Research Centre (SPRC) at UNSW Sydney (University of New South Wales) to evaluate CLS-HASI. The evaluation ran from November 2017 to January 2020. It aimed to assess the outcomes of CLS-HASI, identify what worked well in the programs and determine whether the programs were cost effective.

Evaluation methods involved two rounds of qualitative interviews and focus groups, as well as the analysis of quantitative program data and statewide outcomes data about consumers.

CLS-HASI supported 5,533 consumers in 2015-2019. The average time in CLS-HASI was 10.7 months. Each month, about 150 consumers entered the programs. Exits from the programs increased from about 30 to 80 per month by 2019.

The evaluation found that CLS-HASI generally worked well and achieved its goals. Important success factors were the strong local partnerships between CMOs and LHDs and the person-centred, flexible approach to service provision. Consumers liked the programs. During the evaluation, CMOs increased their focus on consumer choice, as intended, and adapted to the newly implemented National Disability Insurance Scheme (NDIS).

The main findings are listed below. Details are in **Appendices 1** to **11**.

Implementation of CLS-HASI

The intended program partnerships between CMOs and LHDs generally worked well. They selected CLS-HASI consumers from waitlists, organised referrals, reviewed cases and coordinated ongoing program support. Relationships with hospital inpatient units were generally effective. Links with other agencies and services seemed to be informal. These agencies included housing providers, Aboriginal organisations and Corrective Services.

The main referrals were from public mental health services (75%). Some stakeholders said that in some areas only consumers of the local LHD mental health service were referred to CLS-HASI. Referral pathways from Corrective Services were not well developed (less than 1% of referrals).

CMO staff were generally well-trained, suitable and with workplace support. CMOs appeared to under-utilise the special expertise of staff who were Aboriginal, culturally diverse or had lived experience of mental illness.

CMOs generally interpreted the programs' recovery approach as aiming to facilitate independence in all consumers. By the second round of fieldwork, CMOs appeared to be increasingly responsive to consumer preferences about defining their recovery and the way individual circumstances affected pathways to independence.

One third of consumers (31.8%) had low level support of under 5 hours per week; two thirds (66.6%) had medium level support (5 hours per day to 5 hours per week) and a few consumers had high level support (1.6%) of more than 5 hours per day.

The current program service model is based on hours of support that vary according to consumer needs. CMOs, LHDs and stakeholders said this was flexible and improved consumer recovery. At the time of the interviews, some CMOs were uncertain how to implement some elements of the model.

By the second round of fieldwork CMOs had a stronger focus on individual support for consumers, as intended by the programs, rather than group support. Following consumer feedback, group activities were changed to be more meaningful to consumers.

CLS-HASI priority groups were: Aboriginal people (15.2%), people living in boarding houses (2.3%) or in social housing (43%), refugees (0.7%) and people leaving prison (0.3%). Program support in the fieldwork sites did not seem to adjust much to respond to the needs of priority groups.

There were some good practice examples in the fieldwork sites where CLS-HASI engaged with families and carers. This facilitated the consumer's mental health recovery.

During the evaluation, links between the NDIS and CLS-HASI were strengthening. Many CMOs supported consumers to apply for NDIS packages. As intended, CMOs adjusted CLS-HASI services to complement a consumer's NDIS support. Stronger networks between the programs led to better coordination and flexibility of support.

CMOs said they planned program exits together with the consumer, as part of their recovery focus. It seemed to help if the consumer was aware of the goal to exit from the beginning. The main barriers to timely exits seemed to be a shortage of suitable housing and support services.

The Ministry worked with CMOs to improve accuracy of the program data collected. LHD managers and the Ministry had different understandings about several aspects of program monitoring.

Outcomes for CLS-HASI consumers

The programs appear to improve consumers' mental health and wellbeing. 30% of consumers had a clinically meaningful improvement in both the K10[1] measures and the HoNOS[2] scores. Contact with community mental health services decreased by 10% in the first year in CLS-HASI and 63.7% less if they remained in CLS-HASI for more than one year. Success factors included strong program partnerships and consumer-centred support. Providing support in the home facilitated early intervention when consumers become unwell.

CLS-HASI also seems to enhance aspects of consumers' physical health. The programs offer support with, for example, shopping and cooking, physical activity and medical appointments.

Most CLS-HASI consumers had capacity to increase their social inclusion when they had appropriate support. A key to success was the quality of the relationship with the CLS-HASI support worker. Once the consumer trusted their worker, they often also engaged with other people and with services. Few consumers seemed to take part in formal learning and work. Such activities might occur later in consumers' recovery goals.

CLS-HASI reduced hospitalisations, both the number of instances and the length of stay. Hospital admissions due to mental health dropped by 44.8% in the first year in CLS-HASI, and a further 29.2% decrease in Year 2. This is a total decrease of

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[1] Kessler 10 (K10).

[2] Health of the Nation Outcome Scales (HoNOS)

74.0% following program entry (decrease 1.5 to 0.4 hospital admissions per year). Average days in hospital decreased by 74.8% over 2 years (decrease 49.4 to 12.4 days after 2 years). A similar drop happened with involuntary hospital days. After consumers left CLS-HASI, the number of admissions remained as low as at the time of exit. Average days in hospital dropped another 2 days. Improvements in emergency department presentations were similar. Other inpatient admissions were few and the change was small. Success factors include a focus on early intervention, strong program partnerships and maintaining contact with the consumer while in hospital.

CLS-HASI supported consumers to obtain housing and to maintain their housing. About 28% of CLS-HASI consumers moved onto a housing waitlist or obtained housing, or both, after entering CLS-HASI. Consumers had an average wait time of 9.7 months, substantially less than general wait times. This program aspect could be even more successful if coordination with housing providers improved.

Consumers with a new charge in the criminal justice system and community corrections orders dropped to almost none in the year after entering CLS-HASI. Both types of events increased slightly in Year 2 but remained low.

Program costs

The CLS-HASI program funding for 2018-19 was $70.0 million, of which $69.4 million (99%) was funding to CMOs. About 65% of CMO expenses were for employees (mainly salaries). Operational and administration expenses accounted for about 23%.

Based on the program funding, the average cost of CLS-HASI per consumer was $35,622 in 2018-19. MDS data show there were 867,284 hours of consumer support in 2018-19. Based on the program funding, the average cost per hour was $80.71.

While direct comparison with other support programs like the NDIS is difficult, average hourly costs may indicate sufficient cover for typical CLS-HASI cost profiles. However, not enough detailed data were available to assess how well costed the hours of support in CLS-HASI were across individual CMOs, locations, support levels or support types.

Economic evaluation

The economic modelling results for a 5-year timeframe show the CLS-HASI program is highly cost effective. The model shows a net cost saving per person of about $86,000 and a positive outcome of about 0.25 Quality Adjusted Life Years (QALYs).

The economic modelling shows that it is not likely that CLS-HASI is cost effective in a very conservative 1-year scenario (43% probability that it is cost effective). The likelihood of cost effectiveness increases to 67% over 2 years and to 95.3% over 5 years.

Facilitators of good practice

Good practice in CLS-HASI was evident in the evaluation. There were many examples of effective processes and positive consumer outcomes. Good practice was enabled by a range of facilitators. These facilitators could be used to continue to improve CLS-HASI.

The facilitators are listed below according to the structure of this report. The report structure mirrors the main topics in the evaluation questions. More detailed elements of each facilitator are listed at the end of each corresponding report section.[3] The Ministry could generate opportunities for the program partners and other relevant stakeholders to share and discuss the facilitators of good practice, which are:

Facilitators of effective implementation of CLS-HASI

1. Dedicate time towards fostering and widening **program partnerships** at the local and state levels
2. Review the functions of CLS-HASI **governance structures** and monitor their implementation
3. Clarify **referral** processes into CLS-HASI and address barriers
4. Fill gaps in **staff capacity** by using the specialised expertise of Aboriginal and culturally diverse staff and of staff with lived experience of mental health issues
5. Review how staff apply personal **recovery approaches** to maximise consumer choice and autonomy
6. Clarify with CMOs any remaining questions about how the **hours of support** structure was intended to work on a day-to-day basis
7. Align **support services** with individual consumer preferences

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[3] Specific details about the facilitators are presented in the 4 focus reports produced as part of the evaluation (Appendices 2 to 5). These facilitators are applicable only to the topic of each focus report and are structured according to the analysis framework used in the focus report. The findings of the focus reports are condensed in this summary report in the respective thematic sections. In this way, the focus report facilitators informed the overall program facilitators presented in this summary report.

8 Increase the focus on CLS-HASI **priority groups**, by connecting with relevant local community groups and local providers, and with relevant state agencies

9 Involve a consumer’s **family and carers**, consistent with consumer preferences, wherever possible and support their ongoing involvement

10 Support relationships between local CLS-HASI agencies and **NDIS** providers and improve knowledge about each other’s services

11 Discuss the goal to **exit** CLS-HASI with all consumers at or near entry

12 Continually review the content, usefulness and accuracy of **program data** collected by CMOs

Facilitators of positive outcomes for CLS-HASI consumers

13 Clarify respective roles of program partners in improving consumers’ **mental health and wellbeing**

14 Find ways to enable consumers to make sustained changes to benefit their **physical health**

15 Improve **social inclusion** of consumers by addressing each consumer’s individual preferences and barriers

16 Further reduce consumer **hospital stays** by maintaining contact with consumers while they are in hospital

17 Build on staff knowledge and local partnerships to support consumers accessing **safe and secure housing** when needed.

Easy read summary

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Evaluation of community based mental health programs

Contents Page

Report by Christiane Purcal and Bella Bauer

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About this report

This report is about programs for people with mental health problems.

The programs are called

HASI

- **Housing and Accommodation Support Initiative**

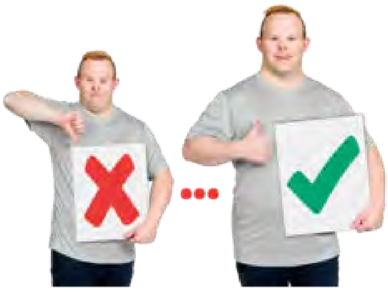
  HASI for short.

and

CLS

- **Community Living Supports**

  CLS for short.



This report talks about what
- The programs do well
- Could be done better.

This is called an **evaluation**.

About the programs

NSW Health pays for the programs.

The programs have services so people with mental illness can have better lives.

Support workers help people reach their goals.

The goals could be

- Learn new skills
- Find a job
- Make new friends
- Find other help like drug or alcohol services.

About the evaluation

Researchers from the Social Policy Research Centre did the evaluation of the programs.

SPRC for short.

Researchers are people who find things out by

- Talking to people
- Looking at numbers
- Reading about other research.

NSW Health paid for the evaluation.

SPRC started the evaluation in 2017.

The evaluation finished in 2021.

How we did the evaluation

We talked to people with mental health problems who used the programs.

We talked to their families and carers.

We talked to the support services.

We looked at information about the people who used the programs.

We looked at how much the programs cost.

What the programs did well

These are some things that the programs did well.

People in the programs felt better.

People did not go to hospital as much.

Some people found better homes.

People went out more and made new friends.

People did more things that they wanted to do.

People had less to do with police.

The service providers and NSW Health worked well together.

The programs were cost effective.

Hospitals and police spent less money.

How the programs could be better

These are things that the programs could do better.

They should always let people choose

- Their goals
- What they want to do.

They should do more with people to help their physical health.

Physical health is keeping your body well.

More people who leave prison should be able to use the programs.

They should listen more to staff who

Are Aboriginal

Are from different cultures

Have a mental illness themselves.

They should work more with other local services.

If you want more information about the evaluation click on the website link here.

1 Introduction

The Community Living Supports (CLS) and Housing and Accommodation Support Initiative (HASI) programs offer support to people who have a severe mental illness so that they can live and participate in the community the way that they want to. The programs support people to work towards their own, unique recovery goals. The types of support that people receive depend on their individual needs and what they want to achieve.

Support for program consumers is for daily living activities like shopping, for meeting people in the community, learning new skills, maintaining their tenancies, and accessing other services such as clinical mental health services. Many HASI consumers are also supported to apply for and access secure housing. The programs are partnerships between local health districts (LHDs) and Community Managed Organisations (CMOs). The programs also have a strong partnership with the Department of Communities and Justice (DCJ) and community housing providers for social housing.

A similar program, the Resource and Recovery Support Program (RRSP), supported consumers to access community and educational services, as well as social and recreational activities. RRSP was integrated into HASI over 2018/2019.

The NSW Ministry of Health (Ministry) commissioned the Social Policy Research Centre (SPRC) at UNSW Sydney (University of New South Wales) to evaluate the CLS and HASI programs. The evaluation aimed to:

- assess the outcomes of CLS-HASI (outcome evaluation)
- identify what worked well in the programs (process evaluation)
- determine whether the programs were cost effective (economic evaluation).

There was no program logic available for CLS-HASI. As RRSP was integrated into HASI during the evaluation timeframe, it was not evaluated separately. The evaluation ran from November 2017 to June 2020. It used a mixed-methods design with two rounds of data collection.

This is the final evaluation report. It answers the evaluation questions (**Appendix 7**) by presenting a summary of findings from the two rounds of qualitative data collection and from the analysis of quantitative program data and linked outcomes data. Evaluation questions were answered if data were available. This report also summarises facilitators of good practice in CLS-HASI. These could be used to continue to improve CLS-HASI. There are 11 appendices to this final report. The appendices present the evaluation approach and the evaluation findings in more detail.

2 CLS-HASI programs

Both CLS and HASI support mental health consumers with psychosocial support, tenancy support and clinical mental health services (a more detailed description of CLS-HASI is in **Appendix 9**. Many HASI consumers are also supported to access secure housing. The programs are based on partnerships between local organisations and are available across NSW. Support is to be oriented towards recovery and the individual needs and goals of each consumer. Hours of support are flexible and can be varied when the consumer’s needs change.

HASI has been operating since 2003, providing packages of fixed support hours for consumers. In 2016/17 CLS was introduced. It adopted the more flexible hours-of-support model, where support varies with the consumer’s changing needs. In 2017/18, HASI was re-tendered and also adopted the CLS hours-of-support model. During the re-tender, all HASI programs (HASI in the Home, Aboriginal HASI and HASI) were consolidated into a single program.

A similar program to CLS and HASI was the Resource and Recovery Support Program (RRSP). It offered lower-intensity support for people with mental illness. It facilitated access to mainstream community and educational services, and also to social and recreational opportunities. RRSP was integrated into HASI during the evaluation timeframe. It was therefore not evaluated separately.

CLS and HASI are delivered through a partnership between Community Managed Organisations (CMOs) and local health districts (LHDs). The Ministry funds CMOs to deliver support services to program consumers. Other organisations involved at the local level include Aboriginal community organisations and programs. Other state-wide agencies involved are the Department of Communities and Justice (DCJ, formerly FACS), Corrective Services NSW and the Justice Health and Forensic Mental Health Network (JH&FMHN).

The roles of CMOs include to:

- develop individual support plans with the consumer and their family/community
- facilitate support from other programs and agencies
- build the consumer’s capacity for daily living skills
- participate in assessing whether consumers are eligible for the programs.

CMOs are also required to support the participation of Aboriginal consumers in Aboriginal community activities, if and how the consumer wishes it.

LHD community mental health services have the tasks to:

- participate in assessing whether consumers are eligible for the programs
- allocate staff for support and treatment
- engage families if the consumer agrees.

The programs focus on supporting people with a severe mental illness to live and recover in the community in the way that they want to. A critical program objective is to ensure that people who would otherwise be in hospital often or for the foreseeable future are supported to live well in the community. Program focus groups are:

- people living in social housing
- people serving community-based detention orders
- Aboriginal people
- people living in boarding houses (although many would by now have transitioned to the NDIS)
- people leaving prisons
- refugees (the Ministry started a specific program for refugees, CLS-R, in 2019).

Any person or organisation can refer someone to CLS-HASI. People can also self-refer. Referrals can be made to CMOs or LHD community mental health teams. The person who is referred, or their legal guardian, must give informed consent. Eligible applicants who are not admitted to the programs should be placed on a waiting list. Vacancies in CLS-HASI arise when consumers require less support hours because their recovery is progressing or when they exit the programs.

When consumers enter CLS-HASI, an Individual Support Plan is developed. The plan identifies the goals of the person for their recovery, what services they will receive and from whom. The plans should reflect the person’s specific support needs and cultural background. They should be reviewed with the consumer at least every 13 weeks, to ensure that CLS-HASI responds to any changing needs. Each consumer should also have a Mental Health Care Plan through the LHD mental health team. CLS-HASI consumers may receive additional supports from the NDIS.

Some of the many reasons why people may exit CLS-HASI include:

- they no longer need the support and have achieved their goals or
- the support is insufficient to meet their needs or
- the consumer chooses to no longer receive support.

CMOs are required to collect three sets of data so the Ministry can monitor the programs: a Minimum Data Set (MDS) with monthly data about consumer characteristics, support and outcomes; service reporting of the flow of consumers into CLS-HASI and the wait list; and annual program reports. A revised MDS was implemented in May 2019 (the MDSV2). It includes suggested changes from early findings of the evaluation.

3 Methods

The evaluation adopted a mixed-methods design with two rounds of data collection. The methods included qualitative interviews and analysis of quantitative program data and outcomes data. The evaluation questions are set out at **Appendix 7**.

Evaluation methods are described below, with more detail about the methodology in **Appendix 8**.

1. Qualitative methods
    - a review of program documents provided by the Ministry
    - fieldwork interviews with CLS-HASI consumers, family and carers, CMOs and LHDs in three sites
    - interviews and focus groups with statewide organisational stakeholders
    - case studies describing the housing pathways of CLS-HASI consumers

2. Quantitative methods
    - analysis of program data about consumer demographics and outcomes from the CLS, HASI and RRSP Minimum Data Set (MDS). The evaluation spanned 2 versions of the MDS: MDSV1 from November 2017 till April 2019, and MDSV2 from May till September 2019. We also analysed program data from before the MDS, starting in January 2015.
    - analysis of linked data (statewide data sources about consumers, such as hospital admissions) for the outcome and economic evaluation and the cost modelling.

The methods included peer research strategies. That means mental health consumers and Aboriginal consumers contributed to evaluation design, data collection and analysis. Tharawal Aboriginal Corporation (an Aboriginal Community Controlled Health Organisation – ACCHO) gave advice about how to design and carry out the evaluation so that it was sensitive to Aboriginal considerations, and they gave feedback on reports.

The evaluation involved 2 rounds of qualitative data collection, in 2018 and 2019. We conducted 114 interviews and 5 focus groups in total. The full sample for MDS and linkage data was 5,533 consumers. There were data about 4,619 consumers in the MDSV1 and 2,880 consumers in the MDSV2. Some consumers were in both datasets because they were in the programs before and after the change from MDSV1 to V2 in May 2019.

The evaluation aimed to include a comparison group from the CLS-HASI waitlist, but the sample was too small for meaningful analysis. Details are in **Appendix 8**.

4 CLS-HASI consumer profile

This section contains summary information about the number of CLS-HASI consumers and about their characteristics when they entered the programs. Findings are based mainly on program data collected by the CMOs (MDS data). Information from the data linkage was added where available. The previous HASI evaluations (Bruce et al 2012, Muir et al 2007) also reported consumer demographics. Those data were added where they could be compared with the current findings.

Between January 2015 and September 2019, CLS-HASI supported 5,533 consumers in total. Many were in the programs for only part of this period. The average length of time consumers stayed in CLS-HASI was 10.7 months.[4] Each month, about 150 consumers entered the programs. Over the evaluation period, exits from the programs increased from about 30 to about 80 per month.

The characteristics of CLS-HASI consumers when they entered the programs are summarised below.

- Program consumers were almost evenly men and women (53% men and 47% women). This was similar to the previous HASI evaluation in 2012 (Bruce et al 2012).[5]
- CLS-HASI definitions of sexual orientation changed during the evaluation. By April 2019, 3.1% of consumers had identified as lesbian, gay, bisexual, trans and/or intersex (LGBTI). Since May 2019, using the new definitions, 10.6% of consumers identified as LGBTI.
- The average age of consumers in the current evaluation was 42 years, up from 41 years in the 2012 HASI evaluation and 34 years in the 2007 evaluation. Almost half the consumers were in the middle groups 35 to 55 years (47.6%). The smallest numbers of consumers were in the youngest and oldest age groups (2.4% and 4.6%).[6]
- The number of CLS-HASI consumers identifying as Aboriginal or Torres Strait Islander increased over time, from 4% in the 2007 evaluation to 8.8% in 2012 and to 13.8% in this evaluation. It was above the current NSW Aboriginal population of 3.5%. CLS-HASI saw Aboriginal people as a priority group. This was consistent with data indicating that Aboriginal people are over-represented in

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[4] 68% of consumers stayed in the programs for up to 1 year, another 21.1% for up to 2 years, and the remaining 10.9% stayed for 3 years or more.

[5] Gender based on MDS 'Sex' data item, not gender identity.

[6] At the time of this evaluation, the programs were open to people over 65, while the 2012 program was not.

mental health services, affirming the need for services to meet the specific needs of Aboriginal consumers.[7]

- Almost 16% of consumers were born in a country other than Australia. More than 5% reported a preferred language other than English. This was lower than in 2012, when 8% mainly spoke a language other than English at home. It was also lower than the proportion in the general NSW population.[8] CLS-HASI might consider targeting people with a culturally and linguistically diverse (CALD) background more. Population data show that people with a CALD background have less access to mental health care than others.[9]
- About 20% of consumers (591 people) had legal orders in place at some time from May to September 2019. Most common was a community treatment order (CTO) [10], which almost 14% of consumers had.
- About 43% of consumers lived in social housing when they entered the programs. About 40% lived in private or other stable accommodation. Almost 12% of consumers who entered CLS-HASI between May and September 2019 lived in unstable housing. This was down from almost 19% of consumers between January 2015 and April 2019 and 43% of consumers in the 2012 HASI evaluation.
- Schizophrenia was the most common primary diagnosis of CLS-HASI consumers at 44.2%. This was lower than in 2007 (75%) and 2012 (65%). About 40% of consumers also had a secondary mental health diagnosis, compared with 26% in 2012. The most frequent secondary diagnoses were anxiety disorders and depression, at about 7% each of all consumers.
- Consumers' coexisting conditions and risk factors included smoking (39.6%) and drug and alcohol dependency (17.9%). Drug and alcohol dependency had declined from 28% in 2012.[11] About 5% of consumers experienced domestic and family violence or had anti-social behaviour warnings.

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[7] In NSW Aboriginal people made up almost 11% of emergency department presentations for mental health reasons in 2017–18. The proportion was 21% in regional and rural areas (Ministry of Health data: Mental health-related emergency department presentations in public hospitals 2017–18, cited in Audit Office of NSW 2019).

[8] According to the 2016 census, 28% of the NSW population were born overseas and 25% spoke a language other than English at home (Multicultural NSW .id)

[9] Cultural and Linguistic Characteristics of People Using Mental Health Services and Prescription Medications, 2011 | Australian Bureau of Statistics (abs.gov.au)

[10] A Community Treatment Order (CTO) is a NSW legal order made by the Mental Health Review Tribunal or a Magistrate. A CTO sets terms under which a person must accept medication and therapy, counselling, management, rehabilitation and other support services while living in the community.

[11] The MDS did not collect definitive information on drug and alcohol dependency. It was a marker about whether support was adjusted to accommodate the consumer's use of drugs or alcohol.

5 Implementation of CLS-HASI

This section presents the findings of the process evaluation. It identifies what worked well in how the CLS-HASI programs were structured and how they were put into place. The findings are based on the two rounds of fieldwork (interviews and focus groups) with consumers, families and carers, CMOs, LHDs and stakeholders; MDS data collected by the CMOs; linkage of consumer data across the programs, hospitals, community mental health services, housing and corrective services; and case studies collected by DCJ about consumers' housing pathways.

5.1 Program partnerships

CLS-HASI was designed as a partnership program that involves various state and local stakeholders. The evaluation interviews and focus groups found that LHDs and CMOs had close, formal relationships, as intended. LHDs and CMOs generally felt they worked effectively together at all levels, from frontline support workers to clinicians and managers.

> .. [our level of collaboration] varies with the [CMO] involved. Some [CMOs] like to be very autonomous, they prefer to run their own race and to work to their own philosophies and do what they will. Others like to be more involved… (LHD manager)

Comments from the CMOs indicate where partnerships and collaboration could be further improved. Many CMOs felt that LHDs regarded them more as assistants than equal partners. Many CMOs were also uncertain about roles and responsibilities, for example who monitors medications or which tasks are part of case management.

CMOs appeared to have good relationships with hospital inpatient units. CMOs visited patients and built relationships before the person was discharged and started receiving CLS-HASI support. They provided similar support where people entered the programs before they left prison. One CMO mentioned poor communication with their local LHD when consumers re-entered hospital.

Some good partnerships between CMOs or LHDs and local community housing providers were reported. This helped CMOs to support consumers accessing and maintaining community housing.

Links with other agencies and services seemed to be casual and informal. These agencies included housing providers and Aboriginal organisations. Other casual relationships were with Corrective Services and local minority group services such as Migrant Resource Centres. There was no evidence of written agreements or of ongoing collaborations in the fieldwork sites.

Facilitator of good practice and details:

1 Dedicate time towards fostering and widening **program partnerships** at the local and state levels

  A encourage regular local forums where CMOs and LHDs liaise with each other and identify any issues in program implementation

  B include clear guidelines about program roles and responsibilities of CMOs and LHDs in the Ministry’s manual

  C re-instate collaborative housing arrangements

  D foster partnerships between CMOs, LHDs and relevant local organisations, for example Aboriginal and migrant resource services

  E include other relevant government agencies in local partnerships.

5.2 Governance structures

The local Selection and Coordination Committees seemed to work effectively and as intended. They reviewed waitlists, selected CLS-HASI consumers, reviewed cases and coordinated ongoing program support. Flexibility helped, with committees adapting procedures to their locations.

Aboriginal Community Reference Groups were intended across the state but had not been established in most locations. CMOs reported that often the local Aboriginal organisation that was the most appropriate to participate was time-poor. At the state level, there was opportunity to draw more on the expertise of organisations in the Peak Stakeholders Forum.

Facilitator of good practice and details:

2 Review the functions of CLS-HASI **governance structures** and monitor their implementation

  A dedicate time towards establishing Aboriginal Community Reference Groups

  B review the role and operation of the Peak Stakeholders Forum.

5.3 Referrals

Under CLS-HASI guidelines, any person or organisation can refer someone to the programs, including self-referral.

MDS data show that the main referral sources in both MDS versions were public mental health services (64% in MDSV1 and 75% in MDSV2). CMOs made about 12% of referrals.

According to the qualitative data, referral processes worked well overall. This was partly due to regional variation in referral procedures, which took account of local factors. There was some confusion about eligibility criteria. Some CMOs wanted LHDs to involve them more in referral decisions. Consumers in the interviews reported positive experiences with referrals and no wait times to enter CLS-HASI.

Some stakeholders said that in some areas only consumers of the local LHD mental health service were referred to CLS-HASI. They were concerned that this practice excluded many Aboriginal people from the programs. Referral pathways from Corrective Services did not seem to work well. The MDS indicates that less than 1% of the accepted referrals came from Corrective Services. CMOs, LHDs and stakeholders mentioned barriers to successful referrals from Corrective Services, including short notice of referrals, lack of vacancies in CLS-HASI and poor communication between CLS-HASI and Corrective Services.

Facilitator of good practice and details:

3 Clarify **referral** processes into CLS-HASI and address barriers

  A improve communication about statewide policy on referral processes and eligibility criteria
  B review the roles of CMOs and LHDs in referral decisions
  C CMOs, LHDs and Corrective Services could work together to improve referral pathways and to support new referrals.

5.4 Staff capacity and approaches to recovery

The CLS-HASI service model offers flexible hours of support. CMOs can vary the hours of support each consumer receives in response to the consumer’s needs. Across the state, the programs were running at full capacity or close to it. Some staff shortages were mentioned, especially in non-metropolitan areas.

There were some examples in the fieldwork sites where CMOs used the special expertise of staff who were Aboriginal, culturally diverse or had lived experience of mental illness. But it seemed this could be expanded.

There was good retention among support workers generally in the fieldwork sites. Possible reasons are that CMOs recruited well-trained, suitable staff and gave them workplace support.

CMOs generally interpreted the programs' recovery approach as aiming to facilitate independence in all consumers. In the first round of fieldwork, the focus on independence appeared to be sometimes at the expense of consumer choice and autonomy. CMOs appeared to be increasingly responsive to consumer preferences about defining their recovery and the way individual circumstances affected pathways to independence.

> [Recovery is] around empowering people to not make them reliant on the service, and [CMOs] do seem quite good at doing that, making sure that people are prepared to look after themselves. (LHD)

Many CMO staff said they found it difficult to engage some consumers in the programs. It was not clear from the fieldwork how large this group was and how much individualised effort and what kinds of approaches CMO staff used.

Facilitators of good practice and details:

4 Fill gaps in **staff capacity** by using the specialised expertise of Aboriginal and culturally diverse staff and of staff with lived experience of mental health issues

  A develop ways to better use the special expertise of staff who are Aboriginal, culturally diverse or have lived experience of mental illness, for example:

    a. develop consistent role definitions for specialised workers
    b. include mentoring of other staff in their role
    c. use training options for staff and managers to better understand and use the expertise of specialised workers
    d. allocate Aboriginal consumers to Aboriginal workers where that is the consumer's preference
    e. involve Aboriginal workers in planning and goal setting for consumers, rather than mostly in frontline roles.

5 Review how staff apply personal **recovery approaches** to maximise consumer choice and autonomy

  A review staff approaches to consumers who the staff find difficult to engage in the programs.

5.5 Hours of consumer support per month

The current program service model is based on hours of support delivered to consumers. The number of hours for each consumer can vary over time according to the consumer's needs. Through most of the evaluation, the average hours per month for all consumers ranged from about 32 to 35 hours. From May 2019, the new

MDSV2 included additional support types. The average support increased to about 49 hours per month.

MDS data about level of support need show that:

- almost one third of all consumers (31.8%) received low level support of under 5 hours per week
- about two thirds of all consumers (66.6%) received medium level support of between 5 hours per day and 5 hours per week
- few consumers received high level support (1.6%) of more than 5 hours per day.

Consumers in the interviews were content with the number of support hours they received. CMOs, LHDs and stakeholders generally preferred the current hours-of-support structure. They said it was more flexible for consumers than the former packages, and that it improved consumer recovery.

> The benefit of the CLS program and the new HASI program as well is that we can look at adjusting our service levels in response to a consumer's need, as opposed to providing pre-set levels of service. (CMO)

Through both rounds of fieldwork, some CMOs were uncertain about how they were meant to implement the structure, for example whether CMOs needed daily, weekly or monthly plans. Despite these uncertainties, second-round interviews with CMOs showed that they had found ways to offer flexible support to consumers. For example, they had started innovative programs such as drop in centres that supported consumers on evenings and weekends.

Facilitator of good practice and details:

6 Clarify with CMOs any remaining questions about how the **hours of support** structure was intended to work on a day-to-day basis

5.6 Support services

CLS-HASI is designed to provide each consumer with the types of support most suitable for their individual needs. There were two types of support. Individualised support was one-on-one activities between the CMO and the consumer. In group support, several consumers did activities together. Consumers in the interviews were generally satisfied with the support services that CLS-HASI offered.

MDS data show that across all consumers in the evaluation, the biggest support type was drafting and updating Individual Support Plans. It took up about 10 hours per month on average in the MDSV2. Consumers received about 6 hours per month for psychosocial support. About 5 hours per month were for support to access social activities, and another 5 hours for support with daily living skills (or homecare needs) such as cleaning, shopping and cooking. Another 5 hours were for CMOs travelling to and from the consumer. Other support types took up fewer hours. The support types above were usually individualised support.

The fieldwork showed that CMOs used individual support to work with the consumers towards more independence. This was successful where individual goal setting and timelines reflected consumer need over time. Some CMOs reported budget pressures because of the perception that the program guidelines emphasised one-on-one over group support, with individual support having higher staff costs than group support[12]. They said budget pressures were growing stronger over time as staff wages increased and the Ministry asked for more reporting of program data (**Section 7.1**).

Hours for group support were reported since the MDSV2 started. Group support was, on average, 8 hours per month per consumer. Group activities were organised around social and recreational interests. Examples included cooking classes, craft groups and cinema visits. By the second round of fieldwork, it appeared that CMOs were offering more group activities that were meaningful to consumers and offered more activities outside of the CMO buildings and in the community, for example walking groups.

> Sometimes they'll have different programs running, which is really good because me and a few other ones, we actually don't get out a lot, so just having those little groups … it makes it so much easier. (Consumer)

It also seemed that CMOs placed greater emphasis on supporting consumers to gradually become used to group activities. Such changes occurred in response to feedback from consumers.

Facilitator of good practice and details:

7 Align **support services** with individual consumer preferences

  A consistently prioritise individual support, as intended by the programs

  B review CMO experience of budget pressures from individual support focus and manage any pressures that exist

  C regularly review suitability of group activities for consumers’ preferences

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[12] Several CMO and LHD managers mentioned that this resulted in fewer face-to-face hours of support than Ministry benchmarks required. In response, the Ministry confirmed that there were no benchmarks for face-to-face hours of support.

D regularly review the effectiveness of mechanisms for consumer feedback.

5.7 Priority groups

CLS-HASI is expected to focus on people with the highest and most complex need. Among these, CLS-HASI has particular priority groups as detailed below. Referrals to the programs are meant to focus on these groups. So is the support provision once they are in the programs.

It appears that in the fieldwork sites there was little adjustment of support to respond to the needs of priority or minority groups. Most CMOs said they prioritised individual choice in the support plans, and they aimed to be inclusive. Overall, there appeared to be little cultural awareness among staff and few connections with local diverse communities. Conversely, stakeholders said it was important to adapt support to meet the specific needs of priority and minority groups.

<u>Aboriginal people:</u> According to MDS data, Aboriginal people are well represented in CLS-HASI. How well the programs support Aboriginal consumers and communities is the subject of a focus report for this evaluation (**Appendix 4**). The interview data show examples where CLS-HASI supported Aboriginal consumers well.

> Yeah, she's down to earth. She's an Aboriginal woman. She had similar upbringings to me, you know, with drugs and alcohol in her family. We've got a lot of similarities with Aboriginal families. Like I've explained things to her and she said, "I know what you're talking about babe" … She's experienced it. She's great. (Consumer)

Cultural awareness was increasing among CMOs and LHDs. But overall, responding to cultural difference was not a key feature of service provision. Most CMOs did not mention cultural disadvantage and any systemic challenges that Aboriginal people might face. Instead they considered equity and equality as the same concept, stating that the program intention was to treat all people equally. Most interview participants felt that CLS-HASI needed to engage better with Aboriginal culture, communities and organisations.

<u>People living in boarding houses:</u> According to MDS data, 2.3% of CLS-HASI consumers lived in a boarding or rooming house when they entered the programs. The fieldwork interviews indicate that consumers and CMOs considered boarding houses a short-term housing option. The focus of CLS-HASI support was finding more appropriate, stable housing. While consumers were still living in boarding houses, CLS-HASI seemed to support them as well as possible.

People living in social housing: According to MDS data, about 43% of consumers lived in social housing when they entered the programs.[13] In the interviews, most consumers living in social housing were happy with their accommodation. CMO and LHD managers said they worked in partnership with government and community housing providers to retain safe and stable housing for CLS-HASI consumers. Any collaboration seemed to be case-based rather than formalised.

Refugees: The MDS reported 41 CLS-HASI consumers with a refugee status. This represented 0.7% of consumers. None of the consumers in the interviews identified as a refugee. CMOs and LHDs across the state reported that there were none or few referrals of refugees in their areas. They also reported little engagement with refugee communities in their areas. The Ministry states that further work is needed to ensure refugees and asylum seekers are supported in CLS-HASI. The Ministry said this was particularly important in areas where the NSW Mental Health Community Living Supports for Refugees (MH-CLSR) program was not available.

People leaving prison: MDS data show that 16 consumers were in prison at program entry, 11 were referred from a prison or Justice Health and 83 had left prison in the year before CLS-HASI. The interviews indicate that once these consumers entered the programs, they were supported well. CMOs said it helped when they could start to work with the consumer while still in prison.

Although not a priority group, older people (people aged 60 years and over) were slightly under-represented in CLS-HASI. In 2019, they made up 10.8% of all program consumers but 15.9% of the general population[14]. Promoting the programs specifically to older people seemed to increase referrals in some locations. Older people in the interviews felt they received age-appropriate and useful support from CLS-HASI that they did not get from other services.

Facilitator of good practice and details:

8 Increase the focus on CLS-HASI **priority groups**, by connecting with relevant local community groups and local providers, and with relevant state agencies

   A dedicate time towards fostering local connections with diverse communities

   B establish regular, systematic collaboration with government and community housing providers in each area

   C engage with refugee communities to increase referrals and improve support for consumers from these communities

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[13] Social housing includes public housing, community housing, Aboriginal public housing and Aboriginal community housing.

[14] 3101.0 - Australian Demographic Statistics, Jun 2019 (abs.gov.au)

   D engage with Corrective Services to increase referrals to CLS-HASI of people leaving prison
   E promote CLS-HASI for older people
   F make cultural competency training mandatory for staff.

5.8 Family and carer involvement

One of the CLS-HASI principles is that CMOs engage family members and carers as partners in the programs if the consumer agrees. MDSV1 data show that about 38% of consumers had a family member or carer actively involved during their time in CLS-HASI. The level of family and carer involvement was higher in the most recent MDSV2 data at 52%, where reporting this information was mandatory.

There were good practice examples in the fieldwork sites where CLS-HASI engaged with families and carers. This facilitated the consumer's mental health recovery. It seemed to be useful when CMOs had a wide, inclusive view of family and carers that went beyond close blood relations and involved a kinship or community network (**Section 5.7**).

The CLS-HASI programs do not specifically support families and carers. Some CMOs referred families to support programs or gave them information. LHDs found it helpful to employ family and carer coordinators. Families asked for more support from CLS-HASI. Interviewees from all groups agreed that CLS-HASI could do more to engage families and carers.

> So if you have any plan we can spend family time together, like me, my daughter, my husband for one day or day a week, somewhere we can enjoy ... We'd like that … (Family member)

Facilitator of good practice and details:

9 Involve a consumer's **family and carers**, consistent with consumer preferences, wherever possible and support their ongoing involvement

   A collect more data about family and carer involvement in the programs
   B share good practice about family and carer involvement among CMOs.

5.9 Links with the NDIS and the RRSP

People with a psychosocial disability that is due to a mental health condition may be eligible for support through the National Disability Insurance Scheme (NDIS). Many of these people are also eligible for CLS-HASI. A focus report for this evaluation considered how CLS-HASI and the NDIS worked together, based on program data and the experiences of interview and focus group participants (**Appendix 3**). In summary, the fieldwork indicates that during the evaluation, links between the NDIS and CLS-HASI were strengthening. This increase was confirmed in the MDS data.

Consumer access to the NDIS seemed to improve. By the second round of fieldwork, many CMOs had learned more about the NDIS and supported consumers through the NDIS application process. This is reflected in the MDS data. The proportion of CLS-HASI consumers who were accepted as eligible for the NDIS increased from about 11% in the MDSV1 to 21% in MDSV2. Accessing the NDIS remained difficult for some eligible mental health consumers, including people in rural areas, from culturally diverse groups and from prisons and mental health hospitals.

Referral agencies decided whether to refer a person to CLS-HASI, support them to try to access the NDIS or both. As there were no formal guidelines about that process, decisions seemed to vary among locations and agencies.

As intended, CMOs adjusted CLS-HASI services to complement the consumer’s NDIS support. CMOs said it was easier when they gave both CLS-HASI and NDIS support to consumers. This raises questions about conflict of interest.

Coordination between CLS-HASI and NDIS-funded services seemed to improve during the evaluation. More NDIS support coordinators were involved. Other improvements were closer relationships between CLS-HASI staff and NDIS workers, and local meetings with the service providers.

> Yes, I've been granted access [for NDIS] and soon the plan will be put into place. [My CLS-HASI support worker] has been looking for people who would be willing to work in [small rural town]. So she's finally found some and we'll be meeting them soon. So that should be helpful as well with cleaning and things like that. (Consumer 14)

Flexibility of NDIS support also improved. This was partly due to stronger networks developing between NDIS-funded services and mental health services.

MDS data about exits show that the NDIS was an important source of support for consumers after leaving CLS-HASI. 43% of consumers who were eligible for the NDIS left to an NDIS funded service.

During the time of the evaluation, the lower-support Resource and Recovery Support Program (RRSP) was integrated into HASI. Interviews and focus groups indicate that the integration went well.

Facilitator of good practice and details:

10 Support relationships between local CLS-HASI agencies and **NDIS** providers, where possible, and improve knowledge about each other’s services

- A NSW Health could suggest that LHDs guide local referrers about how to decide whether to refer consumers to CLS-HASI, the NDIS or both, so that consumers have access to the most appropriate local support for recovery
- B review and fill knowledge gaps among CMO and LHD staff about how NDIS-funded supports can complement CLS-HASI to meet people’s needs and goals
- C support NDIS providers to learn more about meeting the needs of mental health consumers
- D build the professional and organisational relationships between CMOs and NDIS support coordinators, and between support workers and providers, to coordinate support with NDIS-funded services
- E include NDIS service providers in networking, capacity building and coordination activities at the local level if possible
- F allocate time to CMOs to support collaboration in the sector.

5.10 Consumer exits from the programs

Consumers exit CLS-HASI because they no longer need or want the support, or they need different support. MDS data indicate that about half of all consumers exited to lower intensity support or no support. MDSV2 data show that 12% of consumers exited to higher intensity support, and 5% were admitted to mental health hospitals.

Some consumers in the interviews were aware of the program’s exit goal, others were not. CMOs said they planned program exits together with the consumer, as part of their recovery focus. LHD managers said it helped exit planning if the consumer was aware of the goal to exit from their commencement in CLS-HASI.

During the evaluation, the NDIS was established as a possible new support pathway for exiting CLS-HASI consumers who were eligible (**Section 5.9**).

> There was a period of time when we had three people exited very quickly because they were all just meeting their goals and they had support from NDIS still, so we weren't just leaving them in the cold. (CMO staff)

The main barrier to timely exits seemed to be a shortage of suitable support services. If consumers were in unstable housing, the shortage of housing was also a barrier to exit. CMOs said they needed consistent, high numbers of referrals to replace exited consumers immediately so they could continue to meet their consumer benchmarks.

Facilitator of good practice:

11 Discuss the goal to **exit** CLS-HASI with all consumers at or near entry

5.11 Program data and reporting

The reporting of CLS-HASI program data consists of three components: the minimum data set (MDS), service reporting and annual program reports. A revised version of the CLS-HASI MDS was launched in 2019. It included improvements identified in the Ministry and in early phases of this evaluation.

The Ministry was continuing to work with CMOs to improve the accuracy of the data collected. LHD managers and the Ministry had different understandings about several aspects of program monitoring.

Facilitator of good practice and details:

12 Continually review the content, usefulness and accuracy of **program data** collected by CMOs

    A continue to review and update the MDS to improve the usefulness of data collected
    B NSW Health could continue work with the CMOs to improve data accuracy
    C improve common understanding of what is measured and for what purpose.

6 Outcomes for CLS-HASI consumers

This section reports evaluation findings about intended program outcomes for CLS-HASI consumers. Findings are based on the qualitative interviews and focus groups as well as MDS and linked outcome data. The findings from the linked data are reported as overall figures for all consumers. More detail about consumer subgroups is in **Appendix 1** and **10**.

Better integrated care is an intended outcome of CLS-HASI. Evaluation findings about integrated care relate to the program implementation. They are reported in the sections about program partnerships (**Section 5.1**) and referrals (**Section 5.3**). The evaluation had no MDS or linkage data about integrated care.

6.1 Mental health and wellbeing

Most consumers in the interviews stated that CLS-HASI had enabled them to better manage their mental health challenges and improve their wellbeing. CMOs, LHDs and stakeholders were also positive about the programs' psychosocial support. Some saw it as the greatest strength of CLS-HASI and what distinguished it from other mental health programs.

> [My CLS-HASI support workers are] very good at encouraging me to do things, but making me feel what I am doing is a good thing and making me feel almost normal, I suppose. When I'm not feeling great, they're still very supportive and very encouraging. (Consumer)

Interview participants mentioned several factors that enabled program success:

- program characteristics such as being evidence-based and consumer-centred
- filling a gap in the system
- giving intensive support in the home, which allowed early intervention when consumers became unwell
- having consistent support staff from day to day and retaining long-term staff (a factor that was not always present). It allowed consumers to build and maintain trust
- strong program partnerships between the CMOs, LHDs and the Ministry.

Many CMO and LHD managers were uncertain about their respective roles. For example, they brought up questions about who was responsible for case planning, for carrying out case plans and for monitoring medication.

Linked data from mental health outcome scales confirmed the positive qualitative findings. 30% of consumers had a clinically meaningful improvement in both the K10[15] measures and the HoNOS[16] scores. Consumers improved significantly in the year following program entry and the improvements continued into year 2 post program entry in both measures.

LSP-16[17] scores decreased slightly following entry to the programs. This change was not statistically significant. There were low numbers of scores at program entry. The analysis still showed a clinically meaningful improvement in 26% of consumers.

The number of times a consumer contacted community mental health services decreased slightly by 10% in the first year after entering CLS-HASI. Consumers who remained in CLS-HASI longer than 1 year had 63.7% less contact with community mental health services than before the programs. After consumers left CLS-HASI, their contacts with community mental health services reduced further. This might indicate that their recovery continued beyond taking part in the programs.

Facilitator of good practice and details:

13 Clarify respective roles of program partners in improving consumers’ **mental health and wellbeing** and share success factors

  A share success factors for improving consistency of support staff and retaining staff

  B communicate responsibilities of program partners, for example in regular forums and through Ministry guidelines.

6.2 Physical health

CMOs offered various supports to enhance consumers’ physical health. This included support with shopping and cooking, physical activity and medical appointments. Interview participants reported success.

> HASI have just changed my life. They take me out nearly every day exercising, which was one of my main goals was to get back in to being healthy again. They gave me a membership with a gym and a pool to swim. They come to my place, they help me cook meals, they show me how to cook meals. They take me on group walks on the weekends and stuff. (Consumer)

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[15] The Kessler 10 (K10) is routinely used in Australia as an established screening survey for serious mental illness in the general population. A lower K10 score indicates an improvement.

[16] The Health of the Nation Outcome Scales (HoNOS) is a clinician-rated instrument of 12 scales across four domains: behaviour, impairment, symptoms and social functioning. As for the K10, a lower HoNOS score indicates an improvement.

[17] The Life Skills Profile-16 (LSP-16) was developed in Australia. Clinicians use the LSP to assess a consumer’s general functioning in life. 16 items are rated, covering social behaviour and self care.

Some challenges to physical health were also mentioned, such as ageing, lack of money and consumers not feeling able to make changes. There were no quantitative outcome data available for physical health.

Facilitator of good practice:

14 Find ways to enable consumers to make sustained changes to benefit their **physical health**

6.3 Social inclusion

A focus report for the evaluation examined how CLS-HASI supports the social inclusion of consumers so they can live and participate in the community in the way they want to (**Appendix 2**). The evaluation data were analysed with a social inclusion framework, which says social inclusion means that people can engage, learn, work and have a voice in their communities.

In summary, most CLS-HASI consumers had capacity to increase their social inclusion when they had appropriate support. CMOs worked with consumers in various ways to enable more social participation, for example they supported consumers to:

- access financial support, safe and secure housing, and transport (economic capital)
- improve mental and physical wellness, knowledge of social services, and relationships with family and friends (human capital)
- engage with other consumers and the wider community, with support workers, with the CMOs and with the wider health and social service system (social capital)
- foster their sense of identity as a member of their cultural group or foster their cultural connection (cultural capital)
- learn social and daily living skills as the basis for possible formal learning in the future, for example at TAFE or university (learning)
- connect with employment opportunities (work)
- have a voice in deciding about their support and their life goals (having a voice).

The key to better social inclusion was the quality of the relationship with the CMO support worker. Once the consumer had built trust with their support worker, they often also engaged with other people and with services.

> You know, like I'll get there some days, and I just don't want to go to the doctors. And [support worker] used to … turn up, park out the front door, the driveway, park right at the front door, yell out to me, and I had no choice. She gave me no choice. And then she used to come into the doctors with me, which took a lot of pressure off me. (Consumer)

Consumers also then participated in more decisions about their lives. Few consumers took part in formal learning and work. Such activities might occur later in recovery.

Facilitator of good practice and details:

15 Improve **social inclusion** of consumers by addressing each consumer's individual preferences and barriers

  A organise free and low-cost social activities
  B encourage engagement from consumers' families to increase social activities
  C make schedules of support workers as consistent as possible to increase consumer trust, which seemed to be the basis of improved social inclusion
  D train and support staff to be responsive to cultural diversity to foster consumers' connections to their cultural groups
  E review support for consumers to engage in formal learning
  F identify and address individual consumers' barriers to paid and unpaid work
  G review processes for encouraging and managing consumer feedback, so consumers always feel they have a voice.

6.4 Reduced hospital stays

Consumer hospital admissions due to mental health challenges dropped in the year after entering the programs by 44.8%. Year 2 showed a further 29.2% decrease. This adds to a total decrease of 74.0% following program entry, from an average of 1.5 to 0.4 hospital admissions per year. Improvements in emergency department presentations were similar. Other inpatient admissions were few and the change was small (**Appendix 10**).

When consumers were admitted to hospital due to mental illness, the average number of days in hospital decreased by 74.8% over 2 years, from an average 49.4 before program entry to 12.4 days after 2 years. A similar drop happened with involuntary hospital days.

After consumers left CLS-HASI, the number of admissions remained as low as at the time of exit. Average days in hospital dropped another 2 days.

Like the quantitative findings, interview data indicate that CLS-HASI was effective in reducing hospitalisations, both regarding the number of instances and the length. Factors that seemed to contribute were:

- CMOs focused on prevention and early intervention
- effective partnerships between local CMOs and LHD community mental health teams
- CMOs maintained contact with the consumer while in hospital.

> For example, we had a man from [town] that went into the inpatient unit in [another town], so [CMO] staff would go out and visit him every couple of days in the unit to keep that level of connection up with services … and then we were able to coordinate that for when he returned home as well, that that [CMO] team came and picked him up from [hospital] … I'm a big fan of in-reach to hospitals. I think that works really well and helps people to know that there's someone on the outside. (CMO)

Facilitator of good practice:

16 Further reduce consumer **hospital stays** by maintaining contact with consumers while they are in hospital

6.5 Safe and secure housing

CLS-HASI aims to reduce homelessness, find suitable housing and support stable tenancies for program consumers. On entry to the programs, about 43% of consumers lived in social housing, and about 40% lived in private or other stable accommodation. The interviews and focus groups show that CLS-HASI was often successful in supporting consumers to obtain housing.

> Well, prior to [HASI], … I was homeless. (Consumer)

CMOs supported consumers with the housing application process. It also helped when there were good partnerships between CMOs or LHDs and local community housing providers. In some areas LHDs reported that regional and local coordinating committees had lapsed and left a gap. At the time of the evaluation fieldwork, the Ministry was developing a new Housing and Mental Health Agreement (HMHA) together with DCJ.

Some consumers encountered stigma from private landlords due to their mental illness. CMOs managed this by explaining the consumer's situation and the support they received through CLS-HASI.

Data linkage from DCJ Housing show that CLS-HASI was successful in supporting consumers to access social housing[18] for the first time or to access more suitable social housing than they were living in. About 28% of CLS-HASI consumers moved onto a housing waitlist or obtained housing, or both, after entering CLS-HASI. New public housing tenancies increased by 39.6% after entering the programs. Most consumers who accessed housing in year 1 had been on a priority waitlist (67.3%). It is not clear whether this happened through formal or informal channels. These consumers had an average wait time of 9.7 months, substantially less than wait times on the general housing waitlist.

The programs seemed successful also in supporting consumers to maintain their tenancies. CMOs worked with the consumer and the housing provider to solve any issues, for example keeping the house clean as stipulated in the rental agreement or addressing behaviour from neighbours that made the consumer feel unsafe, including violence or drug and alcohol use. Sometimes it was necessary to find new accommodation for the consumer. Some program consumers also accessed DCJ housing support such as rental bond loans, rental subsidies, assistance for rental arrears and other DCJ support programs[19]. Data from after consumers exited CLS-HASI did not show further changes in application or tenancy rates.

All CMOs, LHDs and stakeholders agreed that a shortage of stable and affordable housing limited transitions in and out of the programs.

Facilitator of good practice and details:

17 Build on staff knowledge and local partnerships to support consumers accessing **safe and secure housing** when needed

  A share good practice in CMO support for consumer housing applications

  B support partnerships between CLS-HASI and local housing providers

  C re-establish local housing coordinating committees.

6.6 Reduced criminal offences

CLS-HASI aims to reduce criminal offences as an indicator of mental health recovery. Data linkage showed that charges in the criminal justice system and community corrections orders dropped to almost none in the year after entering CLS-HASI. Both types of events increased slightly in the second year after entering CLS-HASI but remained low.

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[18] Social housing includes public housing, community housing, Aboriginal public housing and Aboriginal community housing.

[19] These housing supports were for private rental. 98 consumers in total accessed the supports.

There were fewer than 5 penalties for criminal offences in the year after program entry, down from 347 in the year before entry. At the same time, the offences became less severe once consumers joined CLS-HASI. For example, there were no prison sentences during the first year in the programs, and fines dropped.

Year 2 after entering the programs saw 34 penalties, where the most common penalty was a fine in 10 cases. There were fewer than 5 prison sentences.

There were fewer than 5 community corrections orders in the year after program entry, and 10 in year 2 in the programs. This compares to 200 in the year before entering CLS-HASI. An assessment tool to classify a person’s risk of re-offending showed that over half of total orders (54.2%) were rated high or medium high risk of reoffending, but the few orders in the 2 years following CLS-HASI entry were rated mostly at lower medium risk.

After consumers exited CLS-HASI, criminal charges and community corrections orders increased slightly, but to a level well below what it was before the programs.

7 Economic evaluation

The economic component of the evaluation examined the costs of the CLS-HASI programs and the outcomes and benefits to consumers in an economics sense.[20] It is based on available program costs from the Ministry, the CMOs and the MDS, and on outcomes from the data linkage.[21] The program cost section reports funding and expenses per year, average cost per consumer and per hour of support. The economic modelling is a framework to develop scenarios of program cost effectiveness over different timeframes. More detail is in **Appendices 1, 10** and **11**.

7.1 CLS-HASI program costs

The total CLS-HASI program funding for 2018-19 was $70.0 million, predominantly (99%) for support services provided by CMOs. Program management (Ministry costs) and partner agency costs accounted for an estimated $410,000 (0.6%).

About 65% of CMO expenses were for employees (mainly salaries). Operational expenses accounted for about 14%, and administration expenses were almost 9%. Motor vehicles cost about 5%, and other expenses made up about 4%. In the evaluation period employee costs rose consistently from 59.4% in 2016-17 to 63.5% in 2017-18 to 69.2% in 2018-19.

To calculate the average cost of CLS-HASI per consumer, the evaluators combined program funding figures with MDS data about support hours. In 2018-2019, the average program cost per consumer was $35,622. Costs ranged from about $10,400 for low support consumers, about $43,000 for medium level support and about $203,000 per consumer on high level support at over 8 hours per day. Program data linkage showed that, over time, many consumers stepped down from high and medium support to low level support.

MDS data show there were 867,284 hours of consumer support in 2018-19. Based on the program funding, the average cost per hour was $80.71. Staffing was the predominant cost category at $55.83 (69.2%), followed by operational costs of $11.74 (14.5%).

While it is not possible to directly compare CLS-HASI costs with those of other programs, the CLS-HASI average support costs appear similar to NDIS average

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[20] A cost benefit analysis (CBA) was not conducted for this evaluation. A CBA depends on valuing all program costs and benefits in monetary terms, and therefore it is not generally used in healthcare and human service evaluations. Cost effectiveness analysis (CEA) as used in this evaluation often includes a loose reference to cost/benefit without mentioning the difference to a CBA.

[21] In this evaluation, CLS-HASI program cost reporting is not split up by sub programs, metropolitan or remote locations, LHDs and CMOs. This is to protect confidentiality.

costs. The total hourly CLS-HASI pricing level may indicate sufficient cover for typical cost profiles. However, not enough detailed data were available to assess how well costed the hours of support in CLS-HASI were across individual CMOs, locations, support levels or support types.

7.2 Program cost effectiveness analysis

The economic evaluation developed a Markov model framework, which integrated program costs with the outcomes from the data linkage. The Markov model is a framework to establish scenarios based on costs while in the programs and projected outcomes during and following program exit. This was the basis to include cost offsets across hospital admissions and lengths of stay, community mental health service use, emergency department presentations, criminal charges and community corrections.

Two- and 5-year economic model scenarios illustrate the likely improving cost effectiveness when positive outcomes are sustained over longer time periods. It is not based on how long consumers were in the programs. Despite a conservative modelling approach and sensitivity testing, and increased uncertainty in forward years, the model indicates that the CLS-HASI programs continue to be highly cost effective. This further validates similar positive results from the previous HASI evaluation in 2012.

The economic modelling results indicate that, over 5 years, the costs per consumer in CLS-HASI were substantially lower than before they entered. The average cost per consumer before program entry was about $185,000 over 5 years, compared to $99,000 when they were in the programs (including the cost of program support and cost offsets). This means a net cost saving per person of about $86,000 over 5 years.

The average cost offsets over 5 years mostly result from reduced inpatient admissions and lower lengths of stay (as high as $113,000 per consumer or 93%), reduced community mental health services of around $7,000 (around 6%) and lower emergency department presentations of around $1,000 (less than 1% of estimated offsets).

The modelling also shows that the CLS-HASI programs produced a positive outcome of about 0.25 Quality Adjusted Life Years (QALYs) per consumer over 5 years. QALYs are used in economic evaluations to help understand how effective health programs are at improving people’s health and wellbeing. Based on reported K10 scores, CLS-HASI consumer QALYs were estimated on a scale between 0 to 1, with people who were well sitting higher on the scale than people who were unwell.

Getting CLS-HASI support meant consumers had an average positive increase of 0.25 QALYs over 5 years. This exceeds commonly reported QALY results. The recent Productivity Commission inquiry into mental health indicates outcomes below $33,000 per QALY are very cost effective (Productivity Commission 2020). For CLS-HASI the estimated cost per QALY was negative over 5 years, or ‘cost saving’, indicating the programs were highly cost effective. The Productivity Commission presented QALYs as an appropriate measure to assess improved mental health outcomes as they are well established in health economics and the Australian health sector.

Model scenarios for shorter timeframes show that CLS-HASI was somewhat unlikely to be cost effective over a very conservative 1-year period (43% probability that the programs were cost effective). The Productivity Commission modelling was also very conservative, based on a single year of outcomes, which they acknowledge is likely to understate estimated cost effectiveness (Productivity Commission 2020). In this perspective, it is positive that the CLS-HASI programs were approaching likely cost effectiveness in a highly conservative single-year timeframe. The likelihood that the programs were cost effective increased to 67% over 2 years and 95.3% in the 5-year case, as the initial cost investment appeared to have sustained consumer outcomes.

The results are consistent with the previous HASI evaluation, which reported the program was likely to be self-funding for each person over 2 years when health care cost offsets were included.

The economic modelling results were also consistent with the recent Productivity Commission Inquiry into mental health (Productivity Commission 2020), which indicated that community-based programs are likely to be highly cost-effective.

8 Facilitators of good practice in CLS-HASI

Good practice in CLS-HASI was evident in the evaluation. There were many examples of effective processes and positive consumer outcomes. Good practice was enabled by a range of facilitators. These facilitators could be used to continue to improve CLS-HASI. The Ministry could make opportunities for the program partners and other relevant services to share and discuss the facilitators of good practice:

Facilitators of effective implementation of CLS-HASI

1. Dedicate time towards fostering and widening **program partnerships** at the local and state levels
2. Review the functions of CLS-HASI **governance structures** and monitor their implementation
3. Clarify **referral** processes into CLS-HASI and address barriers
4. Fill gaps in **staff capacity** by using the specialised expertise of Aboriginal and culturally diverse staff and staff with lived experience of mental health issues
5. Review how staff apply personal **recovery approaches** to maximise consumer choice and autonomy
6. Clarify implementation questions among CMOs about how to allocate **hours of consumer support**
7. Align **support services** with individual consumer preferences
8. Increase the focus on CLS-HASI **priority groups**, by connecting with relevant local community groups and local providers, and with relevant state agencies
9. Involve a consumer's **family and carers**, consistent with consumer preferences, wherever possible and support their ongoing involvement
10. Support relationships between local CLS-HASI agencies and **NDIS** providers and improve knowledge about each other's services
11. Discuss the goal to **exit** CLS-HASI with all consumers at or near entry
12. Continually review the content, usefulness and accuracy of **program data** collected by CMOs

Facilitators of positive outcomes for CLS-HASI consumers

13. Clarify respective roles of program partners in improving consumers' **mental health and wellbeing**
14. Find ways to enable consumers to make sustained changes to benefit their **physical health**
15. Improve **social inclusion** of consumers by addressing each consumer's individual preferences and barriers

16. Further reduce consumer **hospital stays** by maintaining contact with consumers while they are in hospital
17. Build on staff knowledge and local partnerships to support consumers accessing **safe and secure housing** when needed.

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Appendix 1: Full analysis

Evaluation of NSW Community-based Mental Health Programs: Community Living Supports and Housing and Accommodation Support Initiative – CLS-HASI Evaluation Report

Prepared for NSW Ministry of Health, 2022

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Contents

Tables

Figures

Meanings and abbreviations

In this report, the term ‘Aboriginal’ includes people from the Torres Strait Islands. We acknowledge the diversity of traditional countries and Aboriginal language groups across the state of New South Wales.

ACCHO	Aboriginal Community Controlled Health Organisation
AMS	Aboriginal Medical Service
CALD	Culturally and Linguistically Diverse
CLS	Community Living Supports
CMO	Community Managed Organisation
DCJ	NSW Department of Communities and Justice, formerly FACS
FACS	Family and Community Services
GP	General Practitioner
HASI	Housing & Accommodation Support Initiative
HMHA	Housing and Mental Health Agreement
HoNOS	Health of the Nation Outcome Scales
ISP	Individual Support Plan
JH&FMHN	Justice Health and Forensic Mental Health Network
K10	Kessler Psychological Distress Scale
LCQ	Living in the Community Questionnaire
LGBTI	Lesbian, Gay, Bisexual, Trans, and/or Intersex
LHD	Local Health District
LSP	Life Skills Profile
MDS	CLS, HASI and RRSP Minimum Data Set
MDSV1	Mental Health Community Living Programs Minimum Data Set version 1, from November 2017 till April 2019
MDSV2	Mental Health Community Living Programs Minimum Data Set version 2, from May till September 2019
MHOAT	NSW Mental Health Outcomes and Assessment Tools
NDIS	National Disability Insurance Scheme
NGO	Non-Government Organisation
OAT	Outcomes and Assessment Tool
OIMS	Offender Integrated Management System
PTSD	Post-Traumatic Stress Disorder
QALY	Quality Adjusted Life Year

ROD	Reoffending Database
RRSP	Resource and Recovery Support Program
SMHSOP	Specialist Mental Health Service for Older People
SPRC	Social Policy Research Centre
Ministry	NSW Ministry of Health
UNSW Sydney	University of New South Wales

Definitions

Effect size	Effect size is a statistical measure that emphasises the size of the difference. It indicates the practical significance of a research outcome. A large effect size means that a research finding has practical significance, while a small effect size indicates limited practical significance.
Psychosocial support	this is not any particular type of support but a catch-all or ‘other’ category
Social housing	The term includes public housing, community housing, Aboriginal public housing and Aboriginal community housing.
Statistically significant	A statistically significant result (usually a difference) is a result that is very likely not random. More technically, a difference is statistically significant when its p-value falls below a certain threshold, called the level of significance. Most authors refer to statistically significant as $P<0.05$ and statistically highly significant as $P< 0.001$ (less than one in a thousand chance of being wrong). In this report, statistical significance is represented in diagrams as a 95% confidence interval based on a $P<0.05$ threshold.

The following words are used in this report when we refer to people who participated in evaluation interviews and focus groups:

- ‘consumers' or ‘people’ are people who received CLS-HASI support or other types of support
- ‘CMOs’ are CMO managers and staff (frontline workers), both in the fieldwork sites and other areas
- ‘LHDs’ are LHD managers and staff members, both in the fieldwork sites and other areas
- ‘families’ or ‘families and carers’ are informal supporters of the consumers
- ‘stakeholders' are all other interviewees from government and state-level positions, and from Aboriginal Medical Services.

1 Introduction and methods

This is **Appendix 1** of the final evaluation report of the evaluation of the CLS-HASI programs. CLS means Community Living Supports, and HASI means Housing and Accommodation Support Initiative. **Appendix 1** is an extended version of the final evaluation report.

The Community Living Supports (CLS) and Housing and Accommodation Support Initiative (HASI) are NSW Government programs that provide support to people who have a severe mental illness so that they can live and participate in the community the way they want to. The programs support people to work towards their own, unique recovery goals. The types of support that people receive depend on their individual needs and what they want to achieve.

Support for program consumers is for daily living activities like shopping, for meeting people in the community, learning new skills, maintaining their tenancies, and accessing other services such as clinical mental health services. Many HASI consumers are also supported to apply for and access secure housing. The programs are partnerships between local health districts (LHDs) and Community Managed Organisations (CMOs). The programs also have a strong partnership with the Department of Communities and Justice (DCJ) and community housing providers for social housing.

An earlier program, the Resource and Recovery Support Program (RRSP), supported consumers to access community and educational services, as well as social and recreational activities. RRSP was integrated into HASI over 2018/2019.

The evaluation had the following objectives:

- identify what works well in the CLS-HASI programs and how they are put into place, and identify opportunities to improve how the programs are delivered and their effectiveness (process evaluation)
- assess the impact of CLS-HASI on consumers and how well the programs are achieving their objectives (outcome evaluation)
- conduct an economic analysis of the programs to see their cost-effectiveness, including a cost utility analysis to assess impact on the consumers’ quality of life, and cost modelling to see how well costed the hours of support are (economic evaluation).

The evaluation framework had outcome, process and economic components to assess CLS-HASI. There was no program logic for the CLS and HASI programs. The evaluation questions are set out in **Appendix 7**.

Evaluation methods were:

- a review of program documents supplied by the Ministry
- analysis of program data about consumer outcomes and demographics (CLS, HASI and RRSP MDS)[1]
- interviews with CLS-HASI consumers and family members in three fieldwork sites
- interviews and focus groups with CMO, LHDs and other organisational stakeholders
- case studies describing the housing pathways of CLS-HASI consumers
- analysis of linked data (state-wide data sources about consumers, such as hospital admissions) for the outcome and economic evaluation and for cost modelling.

The evaluation involved 2 rounds of qualitative data collection, in 2018 and 2019. We conducted 114 interviews and 5 focus groups altogether. The full sample for MDS and linkage data was 5,533 individual consumers. There were data about 4,619 consumers in the MDSV1, and the MDSV2 had data about 2,880 consumers. Some consumers were in both datasets because they were in the programs before and after the change from MDSV1 to V2 in May 2019.

Appendix 6 shows how each method answers the evaluation questions. More detail about the evaluation methods and sample is in **Appendix 8**. The review of program documents is in **Appendix 9**.

The evaluation aimed to include a comparison group, but the group was too small for meaningful analysis (**Appendix 8**). The evaluation methods included peer research

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[1] All Program data presented in the final evaluation report and the appendices are based on two versions of the MDS. MDS version 1 (MDSV1) included CLS from January 2017 and HASI and RRSP from October 2017. For this reason, average numbers in this report are based on the period from November 2017, when the full MDSV1 data were available.
Program data transitioned in May 2019 to CLS-HASI MDS version 2 (MDSV2). This version includes more detail in many program areas, including the final 5 months of the evaluation. Where possible, numbers were merged across both MDS versions. Otherwise, content from both MDS versions is presented separately due to different classifications, reporting durations and sample sizes.

strategies, that is mental health consumers and Aboriginal consumers contributed to evaluation design, data collection and analysis. An Aboriginal Community Controlled Health Organisation (ACCHO) offered research control from local Aboriginal communities.

The methods were approved by the ethics committees of UNSW Sydney, the NSW Aboriginal Health & Medical Research Council (AH&MRC), the South West Sydney LHD, Corrective Services NSW, the Justice Health and Forensic Mental Health Network (JH&FMHN), Department of Communities and Justice (DCJ) and the NSW Population and Health Services Research Ethics Committee (P&HSREC).

The findings in this report are generally reported as totals across all three programs CLS, HASI and RRSP (the CLS-HASI programs). This is because there were small numbers in RRSP, RRSP was absorbed into HASI during the evaluation timeframe, and consumers shifted between programs.

This **Appendix 1** includes the detailed findings. Summaries and implications are in the final evaluation report.

1.1 CLS-HASI consumer profile

This section presents information about the number of CLS-HASI consumers and about their characteristics at entry to the programs. The numbers are based mainly on the CLS-HASI Minimum Data Set (MDS). The MDS is supplemented with information from the data linkages where available.

The previous HASI evaluations (Bruce et al, 2012, Muir et al, 2007) also reported consumer demographics. Those data were added where they were comparable with the current findings.

1.2 Number of program consumers

During the evaluation period from January 2015 to September 2019, a total of 5,533 consumers received support from CLS-HASI, **Figure 1**. The number of consumers who entered the programs was consistent at about 150 consumers per month (**Figure 1**, grey dotted line). The number of consumers in the programs at any one time was above 2,000 from November 2017 (**Figure 1**, black dashed line). The number remained fairly constant and was 2,325 in September 2019.

The 5,533 consumers in the evaluation include 106 consumers who had exited and then returned to the programs. Some people had multiple start dates in the MDS, for example when they transitioned between programs, LHDs or CMOs. In these cases, the first start date was counted as entry into the programs.

The number of consumers exiting the programs increased during the evaluation period from about 30 to 80 per month (**Figure 1**, grey dashed line). The exit process may include a period of monitoring or reducing contact with CMOs before formally leaving the programs.

Some consumers had not received support for at least 6-12 months but had not formally exited. This was partly due to some CMOs not formally exiting consumers after program supports had ended.[2] Among the 3,369 consumers who had not exited by the end of the study period in September 2019, about 40% had no support services for over 6 months. About 30% of this group had no support services for over 12 months. Because these consumers had not formally exited, they were included in the study group for this evaluation.

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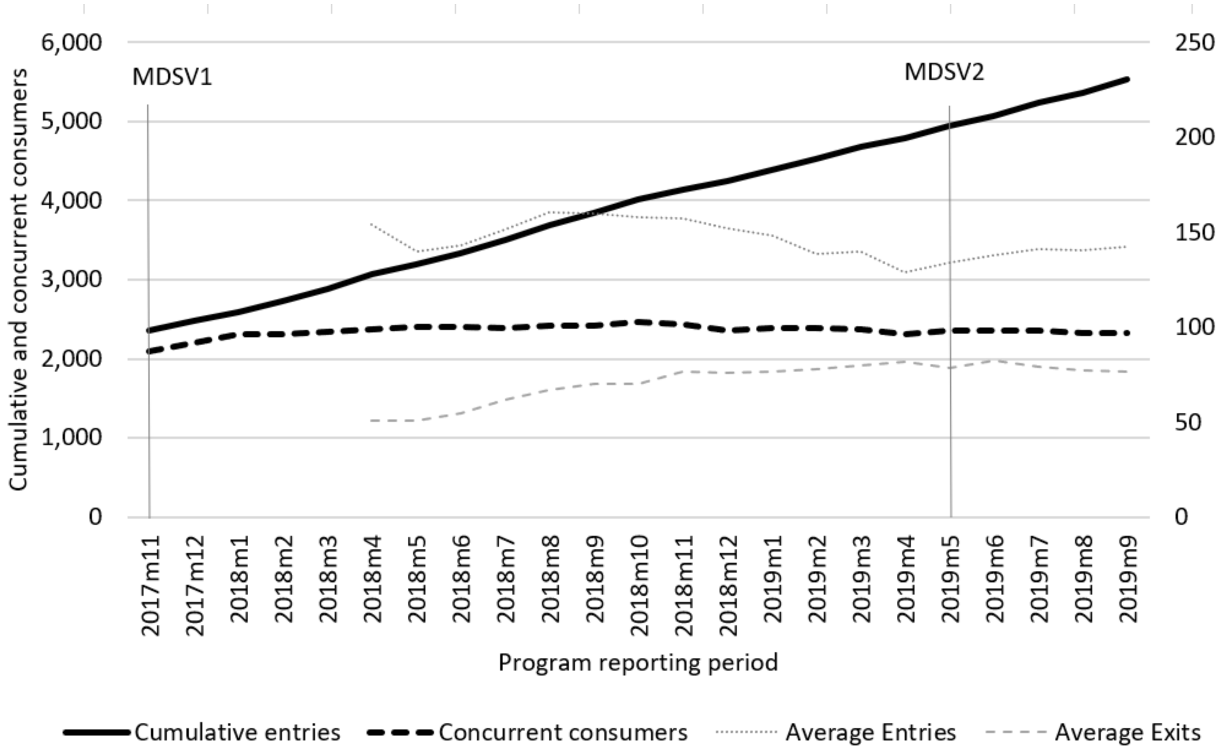
[2] The Ministry advised that program exit data was subsequently reviewed and the Ministry now routinely follows up on all program exits.

Figure 1: CLS-HASI consumers November 2017 to September 2019



Source: CLS-HASI MDSV1 and MDSV2 to September 2019, n=5,533.
Note: Consumers across CLS and HASI programs, number of entries and exits based on collated multiple dates across programs and episodes, presented as 6-month averages to smooth the trend. Before November 2017 is not shown as there was a staggered transition to MDS V1.

1.3 Duration in program

The average time consumers stayed in CLS-HASI was 10.7 months. Since the programs offered flexible support according to people’s needs, time in the programs varied substantially among consumers. More than two thirds of consumers (68%) stayed in CLS-HASI for up to 1 year, another 21.1% for up to 2 years, and the remaining 10.9% stayed for 3 years or more.[3]

Among 106 consumers who exited and later returned to the programs, the average time in CLS-HASI was shorter at 6.1 months.[4] The average period consumers were out of the programs before returning was 10.5 months.

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[3] Number of consumer exits based on complete support periods and single exit point, n=1,872, standard deviation 10.2 months.

[4] n=62, standard deviation 4.4 months.

1.4 Demographic characteristics

CLS-HASI effectiveness includes that the programs reach people in the community with a variety of backgrounds and attributes. This section presents findings about the demographic characteristics of consumers recorded in the MDS.

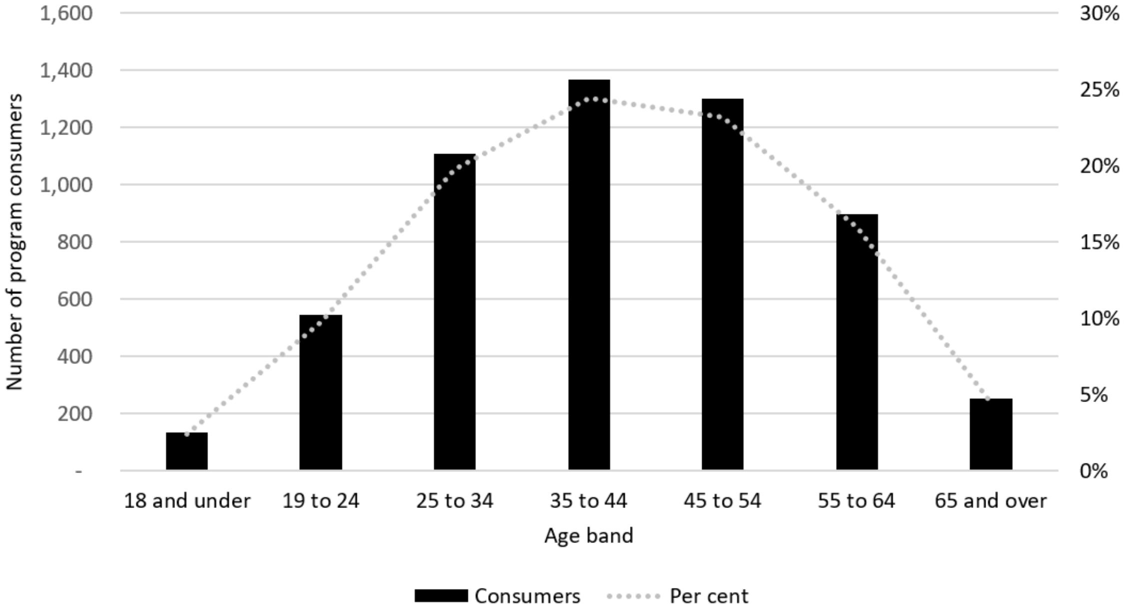
1.4.1 Gender and age

There were similar proportions of men and women among the CLS-HASI consumers (53% and 47%).[5] This gender balance was similar to the previous HASI evaluation in 2012 and was an improvement on the 2007 HASI evaluation, which reported 33% women in the program (Muir, Fisher, Dadich, Abello, & Bleasdale, 2006).

The average age in the current evaluation was 42 years, up from 41 years in the 2012 HASI evaluation and 34 years in the 2007 evaluation.[6] Since the 2012 HASI evaluation, consumer distribution by age has become slightly more even across age groups[7].

Figure 2 shows consumer age groups in the current evaluation. The largest numbers of consumers were in the middle age groups 35 to 44 years (1357 consumers, or 24.5%) and 45 to 55 years (1277, or 23.1%). The smallest numbers of consumers were in the youngest and oldest age groups (2.4% and 4.6%).

Figure 2: CLS-HASI consumers by age group



Source: CLS-HASI MDS to September 2019 n=5,533. Note: Age calculated at program entry

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[5] Gender based on MDS ‘Sex’ data item, not gender identity.

[6] At the time of this evaluation, the programs were open to people over 65, while the 2012 program was not.

[7] The 2012 HASI evaluation reported different age groupings to the current evaluation.

1.4.2 Aboriginal consumers

The proportion of CLS-HASI program consumers identifying as Aboriginal has increased over time. It was 4% in the 2007 evaluation, 8.8% in the 2012 evaluation, and it is now about 15% (**Table 1**). This is above the proportion in the Australian general population of 3.3% and the NSW estimated resident population of 3.5% (Australian Bureau of Statistics, 2016b).

The higher proportion of Aboriginal consumers in CLS-HASI reflects that Aboriginal people have poorer mental health than the general population and that they are almost three times as likely to have high or very high levels of psychological distress (Australian Institute of Health and Welfare, 2018). It was also consistent with data indicating that Aboriginal people are over-represented in mental health services, affirming the need for services to meet the specific needs of Aboriginal consumers.[8]

The 100 packages from the past Aboriginal HASI program were integrated into general HASI in 2017. Following the integration, the number of Aboriginal consumers receiving program support increased to about 200 by the end of 2017.[9] The number of Aboriginal consumers continued to grow to about 250 in the first six months of 2018 and about 270 for the last half of 2018. During the time of this evaluation from 2015 to 2019, a total of 788 consumers at some point identified as Aboriginal in the MDS.

Table 1: CLS-HASI Aboriginal and/or Torres Strait Islander consumers

Aboriginal status	Consumers	
	Number	% of 5,533
Neither Aboriginal nor Torres Strait Islander	4,456	85.9%
Aboriginal	716	13.8%
Aboriginal and Torres Strait Islander	42	0.8%
Torres Strait Islander	20	0.4%
Indigenous not further specified	10	0.2%

Source: CLS-HASI MDS to September 2019 n=5,533

Note: Data unknown for 343 consumers out of 5,533. Aboriginal consumer numbers do not sum to 100% because 54 reported more than one status during the study period and because of minor variation in MDS coding over time.

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[8] In NSW Aboriginal people made up almost 11% of emergency department presentations for mental health reasons in 2017–18. The proportion was 21% in regional and rural areas (Ministry of Health data: Mental health-related emergency department presentations in public hospitals 2017–18, cited in Audit Office of NSW 2019).

[9] The numbers of consumers prior to November 2017 are not directly comparable due to the staggered introduction of the MDS during 2017.

1.4.3 Country of birth

Almost 16% of consumers were born in a country other than Australia (**Table 2**). The largest proportions were 2.2% in New Zealand and 0.9% in England. The next largest groups were people born in Asia (Vietnam, China, India and the Philippines were about half a percent each). Many other countries made up the remaining 10% of consumers, all with less than half a percent each.

Table 2: CLS-HASI consumer country of birth

Country of birth	Consumers	%
Australia	4,660	84.2%
New Zealand	120	2.2%
England	50	0.9%
Vietnam	35	0.6%
China	33	0.6%
India	32	0.6%
Philippines	28	0.5%
Other countries	575	10.3%
Total	5,533	100.0%

Source: CLS-HASI MDS to September 2019 n=5,533

Fewer CLS-HASI consumers were born overseas compared to the NSW population as a whole. According to the 2016 census, 28% of the NSW population were born overseas and 25% spoke a language other than English at home (Multicultural NSW .id). Population data also show that people with a CALD background have less access to mental health care than others.[10]

1.4.4 Preferred language

About 5% of CLS-HASI consumers reported a preferred language other than English (**Table 3**). This compares to about 27% of the Australian population speaking a language other than English at home (Australian Bureau of Statistics, 2016a). The data on country of birth and language diversity indicate that people with a culturally and linguistically diverse (CALD) background are under-represented in CLS-HASI.

Generally, people with a CALD background seem to have less access to mental health care. For example, about 8% of people born in Australia and speaking English

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[10] Cultural and Linguistic Characteristics of People Using Mental Health Services and Prescription Medications, 2011 | Australian Bureau of Statistics (abs.gov.au)

accessed a Medicare-subsidised mental health service in 2011. This compares to about 6% of people born in Australia who spoke a language other than English at home and 5.6% of people born overseas who spoke a language other than English at home (Australian Bureau of Statistics, 2011).

Table 3: CLS-HASI consumer preferred language

Preferred language	Consumers	%
English	5,221	94.4%
Other	141	2.5%
Southern European	43	0.8%
Gaelic	35	0.6%
Arabic	32	0.6%
Vietnamese	20	0.4%
Mandarin	16	0.3%
Cantonese	15	0.3%
Hindi	10	0.2%
Total	5,533	100.0%

Source: CLS-HASI MDS to September 2019 n=5,533

Note: ‘Southern European' reported in MDS as a regional code. Specific language for this group is not known.

1.4.5 Sexual orientation

CLS-HASI consumers reflected community diversity in sexual orientation (**Table 4**). 3.1% of consumers identified as lesbian, gay, bisexual, trans and/or intersex in April 2019.[11] This indicates the program supported a similar proportion of LGBTI people as in the Australian general population (3%) (Australian Bureau of Statistics, 2014). CLS-HASI reporting of sexuality changed with the introduction of MDSV2 in May 2019. Since then, more consumers have identified as LGBTI (10.6%).

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[11] Report item was non mandatory and self-reported (n=4,619). Figure includes 56 consumers who reported a changed LGBTI identification during their support period.

Table 4: CLS-HASI consumer sexuality

Sexuality	Consumers	% MDSV2	Consumers	% MDSV1
Heterosexual	1,943	91.5%		
LGBTI	226	10.6%	141	3.1%
Not LGBTI			4,534	98.2%

Source: CLS-HASI MDS versions 1 and 2
Notes: CLS-HASI MDSV2 introduced in May 2019 has revised questions, LGBTI is presented here as all non-heterosexual. Percentages do not sum to 100% due to multiple responses across study period.

In the Australian population generally, adults identifying as LGBTI report higher levels of psychological distress than heterosexual adults (Australian Institute of Health and Welfare, 2017). 32% of homosexual or bisexual people aged 16 and over in Australia met the criteria for an anxiety disorder, more than twice the rate of heterosexual people at 14%; and 19% met the criteria for an affective disorder compared to 6% of heterosexual people (Australian Bureau of Statistics, 2007).[12] Both anxiety and bipolar affective disorders are prevalent among CLS-HASI consumers (**Section 2.6**).

1.5 Legal orders

About 20% of consumers (591 people) had legal orders in place at some time from May to September 2019. 59 consumers had more than 1 order during the time they were in the programs. Most common was a community treatment order (CTO) [13], for almost 14% of consumers (**Table 5**). 4% of consumers had court-appointed financial management orders[14] and combined orders. Lower proportions had guardianship, parole and forensic orders.

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[12] These statistics refer to the full spectrum of mental health severity, while CLS-HASI are for people on the severe end.

[13] A Community Treatment Order (CTO) is a NSW legal order made by the Mental Health Review Tribunal or a Magistrate. A CTO sets terms under which a person must accept medication and therapy, counselling, management, rehabilitation and other support services while living in the community.

[14] Financial management orders by a court or tribunal appoint a private trustee company or NSW Trustee & Guardian as a financial manager to make financial decisions on a consumer's behalf.

Table 5: CLS-HASI consumer legal status, May to September 2019

Legal order type	Consumers	%
Community Treatment Order	392	13.60%
Combination of orders	165	5.80%
Financial management order	120	4.20%
Parole Order	39	1.40%
Forensic order	34	1.20%
Guardianship order	27	0.90%
Total with at least one order	591	
No order	2,289	
Total consumers	2,880	

Source: CLS-HASI MDSV2 from May 2019 n=2,880
Note: values and percentages do not sum to 100% due to multiple orders for some consumers during their time in CLS-HASI.

1.6 Housing

Social housing includes public housing, community housing, Aboriginal public housing and Aboriginal community housing. The definitions in the MDS of ‘consumer housing on entry’ changed between the MDSV1 and MDSV2 [15]. For this reason, numbers across the MDS versions are not directly comparable. On entry to the programs, about 43% of consumers lived in social housing, and about 40% lived in private or other stable accommodation (**Table 6**).

Table 6**Table 8**). They were reported in the MDS, and the linkage contained no further data on risk factors for tenancies.

Almost 12% of consumers who entered CLS-HASI from May 2019 lived in unstable housing. This was down from almost 19% in the MDSV1 and 43% of consumers in the 2012 HASI evaluation.

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[15] MDSV2 rewording of data items include “Living with family or friends” to “Living with family or friends as a long term arrangement where the person considers the address as their home”, “Boarding house” to “Boarding / rooming house” and “Emergency housing” to “Emergency temporary accommodation”. New data items with MDSV2 include Specialist homelessness services including short term, crisis or transitional housing, Insecure housing, Hospital (mental health inpatient unit), Hospital (non-mental health unit), Public Place and Private dwelling (owned home, rental home, private shared accommodation with secure tenure).

Table 6: CLS-HASI consumers' type of housing at entry to the programs

	Consumers MDSV1	% MDSV1	Consumers MDSV2	% MDSV2
Social housing	1,491	42.60%	623	43.00%
Private and stable accommodation	1,353	38.60%	653	45.10%
Living with family or friends	553	15.80%	274	18.90%
Private rental	523	14.90%		
Private dwelling			379	26.20%
Owned home	277	7.90%		
Unstable accommodation	657	18.80%	173	11.90%
Hospital	395	11.30%		
Boarding or rooming house	94	2.70%	31	2.10%
Homeless (rough sleeping)	103	2.90%		
Emergency temporary accommodation	54	1.50%	21	1.40%
Hospital mental health inpatient unit			56	3.90%
Insecure housing			25	1.70%
Specialist homelessness services			18	1.20%
Correctional facility	16	0.30%	5	0.30%
Public place			11	0.80%
Other			6	0.50%
Total	3,501	100.00%	1,449	100.00%

Source: CLS-HASI MDSV1 (n=3,501) and MDSV2 (n=1,449) to September 2019

Notes: 'Other' was grouped to ensure confidentiality, includes Public Place, Hospital non-mental health unit and HASI Plus

1.7 Diagnoses

Having a severe and persistent mental health diagnosis is one of the eligibility criteria for CLS-HASI. All consumers had a primary diagnosis (**Table 7**). Schizophrenia was the most common primary diagnosis at 44.2%. Schizophrenia was also the most common primary diagnosis in previous evaluations (65% in 2012 and 75% in 2007). Depression, bipolar affective disorder, schizoaffective disorder anxiety and personality disorder were less common, with about 5 to 13% of consumers in each. Post-Traumatic Stress Disorder (PTSD) was introduced only with the MDSV2 in May 2019 and was a smaller proportion of 1%.

About 40% of consumers had a secondary mental health diagnosis (**Table 7**), an increase from 26% in the 2012 HASI evaluation. Anxiety disorders and depression remained common at about 7% each, which was consistent with previous evaluations.

Table 7: CLS-HASI primary and secondary diagnoses

	Consumers	%
Primary diagnoses		
Schizophrenia	2,447	44.20%
Depression	728	13.20%
Other	617	11.20%
Bipolar affective disorder	586	10.60%
Schizoaffective disorder	490	8.90%
Anxiety disorder	351	6.30%
Personality disorder	259	4.70%
Post-Traumatic Stress Disorder (PTSD)	55	1.00%
Primary diagnoses total	5,533	100.00%
Secondary diagnoses		
Other	616	11.00%
Anxiety disorder	417	7.40%
Depression	379	6.80%
Personality disorder	120	2.10%
Bipolar affective disorder	65	1.20%
Post-Traumatic Stress Disorder (PTSD)	39	0.70%
Schizoaffective disorder	37	0.70%
Schizophrenia	33	0.60%
No secondary mental health diagnosis	3,900	69.60%
Secondary diagnoses total	5,533	100.00%

Source: CLS-HASI MDS to September 2019 n=5,533
Notes: Diagnosis data unknown for 73 consumers. Cell responses below 5 for consumers diagnosed with eating disorders have been grouped as ‘other’ to ensure confidentiality.

Consumers with primary and secondary diagnoses grouped as ‘other’ gave a description of their condition. The main responses were psychosis (17.1%, n=88) and psychiatric (11.2%, n=58).[16]

Consumers’ coexisting conditions and risk factors

The CLS-HASI MDS includes coexisting conditions and consumer risk factors (**Table 8**). The major ones were drug and alcohol dependency (17.9%) and smoking (39.6%).[17] CLS-HASI consumers reflected Australian population data, which showed that people with mental health conditions and high levels of psychological distress were more likely than other people to smoke, consume alcohol at risky levels and use illicit drugs (Australian Institute of Health and Welfare, 2019). Concerns of domestic and family violence were identified for 5.5% of consumers. 4.6% had received anti-social behaviour warnings.[18]

Table 8: CLS-HASI consumers’ coexisting conditions and risk factors

	Consumers	%
Drug or alcohol dependency	1,004	17.90%
Domestic and family violence	311	5.50%
Smoking	2,219	39.60%
Anti-social behaviour warnings	258	4.60%

Source: CLS-HASI MDS to September 2019 n=5,533

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[16] There was no additional diagnostic information in the linkage data for this evaluation.

[17] MDS version 2 introduced enhanced details of drug and alcohol from an indicator of drug and alcohol dependency to “Harmful or dependent alcohol or other drug use has been identified as a possible factor which may impact on this person’s psychosocial support needs”. Item made mandatory in MDSV2. Figures reported include responses across both MDS versions.

[18] MDSV2 reworded to ‘Indicators or concerns about possible domestic or family violence’ from “Experiencing Domestic and Family Violence (DFV)”. New data item emphasises that domestic or family violence has been identified as a possible factor which may impact on this person’s psychosocial support needs.

2 Implementation of CLS-HASI programs

This section presents the findings of the process evaluation. It identifies what works well in how the CLS-HASI programs are structured and how they are put into place. It also identifies opportunities to improve how the supports are delivered. The findings are based on:

- the two rounds of fieldwork (interviews and focus groups) with consumers, families and carers, CMOs, LHDs and stakeholders
- MDS data collected by the CMOs[19]
- Linkage of data across the programs, hospitals, community mental health services, housing and corrective services
- DCJ case studies about housing pathways of consumers.

The topics in this section align with themes in the evaluation questions **(Appendix 7**). For most topics, there was little or no change between the first and second rounds of fieldwork. It is mentioned in the text whenever there was noticeable change in the findings. A description of the intention of the programs from the policy documents is in **Appendix 9**.

2.1 Program partnerships

CLS-HASI was designed as a partnership program with state government and local stakeholders (**Appendix 9**). Core partnerships are between the Ministry as funder and CMOs as contracted providers. At the local level, CMOs work with LHD community mental health services and other organisations like hospitals and housing providers. Other state agencies involved are DCJ (formerly FACS) for housing, Corrective Services and Justice Health. Partnerships are also intended to include, where possible, a wide range of Aboriginal community organisations and programs.

2.1.1 LHDs

In the interviews and focus groups, most LHD and CMO managers said that effective CLS-HASI partnerships existed between their organisations at all levels. They also felt that everyone was making genuine efforts to work together to address any issues

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[19] MDS version 1 from January 2017 to April 2019 and MDS version 2 from May 2019 to January 2020.

about consumers and about the programs. There was no noticeable change between the first and second rounds of fieldwork.

In the three fieldwork sites, LHDs and CMOs met regularly in Local Selection and Coordination Committees, as intended (**Appendix 9**). These committees discussed referrals into the programs, consumer progress in CLS-HASI and possible exits from the programs. CMO and LHD managers stressed that local relationships were important across all organisational levels – from frontline support workers to clinicians and managers. CMO and LHD managers generally felt that they had good relationships at all levels. They said these relationships supported effectiveness of:

- processes such as referrals and exits
- program systems, for example data management
- case planning and support.

There was evidence of collaboration between LHDs and CMOs to support individual consumers. The level of collaboration varied between sites and even within sites. Some LHDs reported closer relationships with one CMO than others:

> .. [our level of collaboration] varies with the [CMO] involved. Some [CMOs] like to be very autonomous, they prefer to run their own race and to work to their own philosophies and do what they will. Others like to be more involved… (LHD manager)

One LHD manager saw a conflict of interest within the CMO-LHD partnership: on the one hand the LHD was a partner in the programs, and on the other hand they monitored the CMOs on behalf of the Ministry.

There were some differences in how LHD and CMO managers viewed their partnerships. LHD managers expressed a more positive view of the partnerships than CMO managers did. Most LHD managers viewed the CMOs as extensions or parts of their own departments. They said, for example, ‘where does [LHD] end and where does CMO begin?’, ‘we treat [CMOs] like they are part of the team’. Many LHD managers thought that locating CMO offices near LHDs was useful, particularly for consumers who needed frequent communication between agencies to meet their support needs. CMO managers and staff generally did not like this idea. They preferred clearer boundaries between the program partners.

Many CMOs saw their relationship with LHDs as unequal. CMOs expressed some concern that LHDs viewed the CMOs as assistants in the treatment of consumers and not as independent experts in recovery. For example, CMOs were concerned that there was:

> …a misconception that CLS-HASI staff are there to follow the instruction of the LHD case manager, when in fact [the CMO] provides so much more. (CMO manager)

Some CMOs also said that LHDs shared less information about consumers than the CMOs did. Some CMOs reported occasional tensions. These resulted mainly from uncertainty about the separate roles of LHDs and CMOs in the programs. These tensions were evident about referrals, case management and assessment. For example:

> So, I think what has been a gradual thing to address is a lack of understanding about what each of us do… Now, [we are] not supposed to be doing case management work. But what is case management work? You know it's not necessarily something you can classify. So, I think that can create a bit of confusion when working with other service providers. (CMO manager)

These findings indicate a need to clarify the respective roles and responsibilities of CMOs and LHDs. Examples include who monitors medications or arranges case conferences. There was also uncertainty about whether transport to and from LHD appointments was part of the programs. According to Ministry advice, transporting consumers is not part of the programs. The confusion indicates that communication about program responsibilities could be improved. At the time of this report, the Ministry was working on a manual to guide program partners.

2.1.2 Hospitals

Interview participants in the fieldwork sites also spoke about partnerships between CMOs and hospital inpatient units. Many consumers reported they were in hospital when the CMO first approached them (**Section 3.3**). They received daily visits in hospital to build a relationship, and they got support when they were discharged, to find a home and ensure basic needs were met, for example shopping.

One CMO reported poor communication with their CLS-HASI program partners in the LHD offices about the hospitalisation of consumers. They reported that sometimes they found out by chance that one of their consumers was in hospital, rather than through formal communication. Program documents available for this evaluation did not include processes to inform CMOs about consumer hospitalisation.

2.1.3 Housing providers

Partnerships between CMOs and LHDs on the one hand and social housing providers on the other hand were mostly informal. In the Ministry's view, this was largely due to changes in special coordinating groups. In 2011, the first Housing and Mental Health Agreement (HMHA) in NSW set up committees to foster local collaboration between NSW Health, mental health programs and public housing providers across NSW. These committees were called Housing and Mental Health District Implementation and Coordinating Committees (DIAC) and Local Implementation and Coordinating Committees (LIACC).

The Ministry reported that, over time, many of these committees had stopped operating under the same model. Some of the reasons were that the arrangements established in 2011 were no longer suitable, and that alternative groups made up of similar members had started within LHDs. Another complication was that public housing was transitioning to community housing providers in many regions.

Stakeholders in the interviews and focus groups saw opportunities for CLS-HASI and housing providers to work together to support consumers' housing needs better. Similarly, the DCJ case studies about housing pathways of consumers showed where collaboration could be improved. For example, some consumers' housing applications were suspended or closed because consumers did not respond to contact. Such decisions did not seem to account for the fact that people on a priority social housing list are usually in temporary housing or have no fixed address. Even when correspondence reaches them, they may need support to respond.

At the time of the evaluation fieldwork, the Ministry was developing an updated Housing and Mental Health Agreement (HMHA) together with DCJ. A key finding of the Review of the 2011 HMHA was the need to recognise the modern service delivery environment, including the increased role of Community Housing Providers and for more integrated service planning across agencies. Some stakeholders in the evaluation interviews and focus groups hoped that the new HMHA would be successful at strengthening partnerships.

2.1.4 Corrective services

People in the interviews and focus groups mentioned only informal and sporadic partnerships with corrective services agencies. The agencies that mentioned these relationships were mainly the program partners in NSW Department of Corrective Services, and Justice Health and Forensic Mental Health Network (JH&FMHN).

According to the MDS, 16 consumers were in a prison at program entry. The recent MDSV2 shows that another 12 were directly referred from a prison or Justice Health (**Section 3.3**). 83 consumers had left prison within the year before entering the CLS-HASI programs.[20]

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[20] MDSV1, (2.2%, n=3,854) data Item discontinued. Reported as Yes/No "Exited a correctional facility in last 12 months"

2.1.5 Aboriginal organisations

Connections with Aboriginal organisations seemed informal across most of the state. In internal information that CMOs supplied to the Ministry, CMOs stated that they offered Aboriginal consumers clinical support through local Aboriginal Medical Services (AMS), where this option was available. In the fieldwork, some Aboriginal consumers preferred that connection. Others indicated they chose not to attend Aboriginal-specific services. These people and many local CMO staff cited the following reasons: family conflict, concerns about confidentiality, discrimination, lost cultural identity and being off country.

Fieldwork interviews also showed that some Aboriginal consumers did not trust mainstream community mental health facilities. For the most part, CMO staff supported the choices of Aboriginal consumers:

> So just because a person identifies as Aboriginal or Torres Strait Islander doesn’t mean that they want to be in an Aboriginal medical service. It doesn’t mean that they want to receive any specific supports. [Culturally responsive practice is] really going beyond that, and listening, and going, “What is it that you want?” (CMO staff)

Most CMOs across the state had initiatives in place to engage with Aboriginal communities, such as Reconciliation Action Plans (RAP). These initiatives were not CLS-HASI specific but applied to all programs run by the CMOs.

For more details see **Appendix 4** Focus Report Aboriginal Experience

2.1.6 Ministry response

In summary, there were close, formal partnerships between LHDs and CMOs. Links with other agencies and services seemed to be informal. These agencies included housing providers, Aboriginal organisations and Corrective Services. Other informal relationships were mentioned with local services such as Migrant Resource centres and TAFEs.

The informal partnerships with other agencies and services remained that way during the evaluation timespan. The Ministry said it had responded to this issue from early on in the evaluation, by emphasising at program meetings and discussions with the stakeholders the importance of formal structures and guidelines. One focus had been finalising Service Level Agreements between LHDs and all CMOs, which outline how their collaborative relationships operate. Further, the Ministry expected that a communication plan would improve understanding of the programs among other agencies. The communication plan was being finalised at the time of this report.

2.2 Governance structures

The Ministry manages the overall programs and oversees issues that affect CLS-HASI (**Appendix 9**). Elements of the CLS-HASI program governance include a Stakeholder Forum for CMOs and LHDs and a Peak Stakeholder Forum for community and sector organisations. At the local level, there are the Selection and Coordination Committees and Aboriginal Community Reference Groups.

CMOs and LHDs regarded the Selection and Coordination Committees as the main governance group at the local level. These committees met regularly to review waitlists, select CLS-HASI consumers, review cases and coordinate the ongoing support, as intended by the program governance structures (**Appendix 9**). In addition, the program partners developed processes that suited their location. LHD managers said that joint governance helped to quickly resolve any issues about consumers or cooperation between the partners. They said the goal of these processes was to ensure good consumer outcomes. According to MDS data, CMOs spent about one hour per consumer per month on program governance.[21]

Aboriginal Community Reference Groups, which are also part of the intended CLS-HASI governance structure (**Appendix 9**), had not been established anywhere in the state at the time of earlier evaluation phases. This was evident from internal information from CMOs to the Ministry. CMOs reported to the Ministry that often the local Aboriginal organisation that was the most appropriate to participate was time-poor. Some of these groups had formed by the end of the evaluation. As described in **Section 3.1**, most links with Aboriginal services and organisations remained informal and ad hoc.

State-wide organisations were involved in the CLS-HASI Peak Stakeholders Forum (**Appendix 9**). They said they appreciated receiving information about the programs during the meetings. They felt that CLS-HASI missed some opportunities to draw on their expertise and advice during or between the meetings. Reviewing the role and operation of the Forum might benefit CLS-HASI governance.

The Ministry meets with the CMOs and LHDs through the Stakeholders Forum (**Appendix 9**) to exchange information about policy guidance, how the programs are operating and opportunities for improvement.

The governance structures and processes to address any opportunities did not seem to have changed markedly between the two rounds of fieldwork.

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[21] MDS version 1, number of hours to participate in program governance including Local Selection and Coordination Committees and Stakeholder Forums.

2.3 Referrals

Under CLS-HASI program guidelines, any person or organisation can refer someone to the programs, including self-referral (**Appendix 9**). The person who is referred, or their legal guardian, must give informed consent. Participation in CLS-HASI is voluntary. Referrals can be made to CMOs or LHD community mental health teams. Not all referrals are presented at the Local Selection and Coordination meetings. The process of reviewing referrals is determined locally to account for local needs and includes people that are not engaged with the LHD. Eligible applicants who are not admitted to the programs should be placed on a waitlist. This section summarises findings about referral processes and referral sources.

Consumers in the interviews generally appeared to find out about the programs when they were referred. This process is consistent with the program intention that people have to give informed consent. Consumers did not report any wait times before they were accepted into CLS-HASI. A few people who had recently entered CLS-HASI had accessed HASI support previously and did not wait for re-entry.

The primary referral sources in both MDS versions were public mental health services (64% and 75%, **Table 9**). CMOs made about 12% of referrals. The MDS identifies which organisation referred a consumer to CLS-HASI. With the new MDSV2 from May 2019, more referral sources were added.

Table 9: CLS-HASI source of consumer referrals

	Consumers MDSV1	%	Consumers MDSV2	%
Public Community Mental Health	2,948	63.80%	1,049	39.50%
Public Inpatient Mental Health			939	35.40%
Unknown	574	12.40%	271	10.20%
CMO (Different program provider)	546	11.80%	243	9.10%
FACS - Housing NSW /public housing	25	0.50%	175	6.60%
Other Public Health Service	227	4.90%	145	5.50%
Self	190	4.10%	106	4.00%
CMO (Same program provider)	277	6.00%	98	3.70%
PHN funded service	-	-	63	2.40%
Community Housing Provider	37	0.80%	28	1.10%
Other Private Health Service	34	0.70%	26	1.00%
Other Government Department	82	1.80%	26	1.00%
Carer, family or friend	31	0.70%	17	0.60%
General Practitioner	24	0.50%	14	0.50%
Specialist Aboriginal Service	22	0.50%	12	0.50%
Specialist Homelessness Service	-	-	12	0.50%
Specialist D&A Service	13	0.30%	8	0.30%
Correctional Facility	-	-	7	0.30%
Justice Health - Custodial	-	-	5	0.20%
Boarding House	<5	<0.1%	<5	<0.2%
NDIS funded provider or NDIA	-	-	<5	<0.1%

Source: CLS-HASI MDSV2 (n=2,880) and MDSV1 (n=4,619) to September 2019

Notes: PHN=Primary Health Network

CMO and LHD managers reported that referral pathways into the programs generally worked well. Some CMO managers wanted more information about how wait lists at the LHD level were managed. One LHD manager suggested prioritising consumers with higher support needs. CMO managers reported that referral procedures were locally established and varied depending on local factors. One CMO that serviced two LHDs with different referral processes reported that both worked well for the needs of their regions.

Some stakeholders found that because the referral process was managed through the LHDs, it was more difficult to access CLS-HASI for people who were not consumers of the LHD mental health services. AMS staff said that in some areas only consumers of the local LHD mental health service were eligible for CLS-HASI. They were concerned that this practice excluded many Aboriginal people from the programs. It would also be inconsistent with the CLS-HASI program guidelines, which allow any person or organisation to refer someone. It seems necessary to improve consistent communication across the state about referral processes. The program manual currently being developed by the Ministry might be useful here.

Some CMOs felt that LHDs did not involve them appropriately in referral decisions. They said LHDs appeared to pre-determine referral lists prior to the Local Selection and Coordination Committees. Some CMO managers said that they received few referrals for consumers with high support needs, that is five hours or more per day. They speculated that these consumers might be directed towards the NDIS.

Most CMO and LHD managers and stakeholders said that referral pathways from Corrective Services (Corrections) to CLS-HASI did not generally work well. MDS data show that few referrals came from Corrections (**Table 9**). CMO and LHD managers described barriers including:

- obtaining referrals required ongoing promotion of CLS-HASI and relationship building with Corrections
- delays in processing any referrals at Corrections
- high numbers of last-minute and incomplete referrals from Corrections
- Corrections withdrew many referrals when the consumer’s release date neared
- the dominant role of LHDs in managing referrals did not leave many vacancies for other agencies
- lack of formal communication mechanisms between CLS-HASI and Corrections.

2.4 Staff capacity and approaches to recovery

The CLS-HASI program service model provides flexible hours of support (**Appendix 9**). Consumers are to receive as many support hours as they need at any given time. As their needs go up and down over time, so do their support hours. In allocating support hours, CMOs use a recovery-oriented approach, where they support people to recover and reduce the impact of their mental illness. Consumers take responsibility for their wellbeing and define their own goals for their lives. As people reach their recovery goals, they may need fewer support hours.

All CMOs reported a perception that their organisation was running at full, or close to full, caseload capacity. This meant they were using all the support hours they were funded for. The number of consumers varied between CMOs and over time. It depended on the needs of consumers, as intended by the programs:

> CLS reports primarily against hours as opposed to head count. We have allocated 252 hours of support a week …Yeah, it's fully allocated … We've got about 35 clients (CMO staff)

In response, the Ministry stated that the data and financial reporting submitted by the CMOs did not support these experiences. The Ministry said the data demonstrated that CMOs did not always achieve the total number of support hours they were contracted to provide, and that the programs consistently had surplus.

A possible explanation is that the CMOs' capacity was impeded by staff shortages. CMOs appeared to find it difficult to recruit sufficient staff, especially in rural and regional areas. Some particular shortages were mentioned, such as:

- Aboriginal support workers
- culturally diverse support workers
- support workers with lived experience of mental illness
- replacements for staff on leave.

There were some examples of good practice engaging workers or partnering with people with lived experience or special expertise of mental health, Aboriginality and cultural diversity:

> We have Aboriginal workers that can provide supervision, support and mentoring, particularly cultural supervision in understanding those kinds of kinship structures and networks… We use cultural consultants and communities to support us connecting Aboriginal people to the appropriate campaigns. (CMO)

Practice about Aboriginal workers is explored in more detail in **Appendix 4** Focus Report Aboriginal experience.

There seemed to be good retention of support workers in the fieldwork sites. Most of the staff interviewed were the same in both rounds of fieldwork. CMOs mentioned workforce and workplace arrangements they had in place for staff retention because they saw them as essential to the success of the programs:

- recruiting staff whose training aligned with the recovery framework
- good staff supervision
- ongoing training in the workplace.

Many CMOs spoke about their organisation’s recovery approach, which is one of the program principles underpinning CLS-HASI (**Appendix 9**). As intended, all CMOs had put a process in place to support consumers to set goals and help them work towards their goals in a planned and gradual manner. There was significant variation in how recovery orientation was understood and practised, which is discussed in detail in the recovery focus report (**Appendix 5**). Some CMOs found it difficult to attract and retain staff who understood the recovery approach.

Overall, the fieldwork showed that most CMOs placed an emphasis on independence as the number one goal of recovery orientation. For example:

> [Recovery is] around empowering people to not make them reliant on the service, and [CMOs] do seem quite good at doing that, making sure that people are prepared to look after themselves. (LHD Service Provider 27 R2)

This focus on independence worked well for many consumers. Some consumers who had been in the program longer-term found it challenging. Some CMOs managed this by supporting the consumer with small steps towards individual recovery goals. They then adjusted these steps and goals over time.

There was some change between the first and second rounds of fieldwork. In the first round, the focus on independence appeared to be sometimes at the expense of consumer choice and autonomy. By the second round, CMOs appeared to be more responsive to individual consumer preferences about defining their recovery:

> So, we work with each individual that’s supported by HASI, on what they view their recovery as. So, it’s a goal-based approach, I guess. Some of them, their recovery goals are simple, straightforward; and for others, they’re bigger, and they’re complicated, and they’re more complex. (CMO)

Many CMO staff said they found it difficult to engage some consumers in the programs. Generally, support workers would try a few times to make contact with new consumers and involve them in one-on-one or group activities. When consumers did not respond and not participate for a few months, the CMO would discharge the consumer from CLS-HASI. It was not clear from the fieldwork interviews how much effort and what kinds of approaches CMO staff used with consumers to engage them in the programs.

2.5 Hours of consumer support per month

This section reports on the effectiveness of the program structure based on hours of support. HASI was originally delivered through a range of packages for different levels of support need among consumers. The packages had set hours, from 8 hours a day for people with very high support needs, to 5 hours a week for people with low support needs. In 2017/18, HASI changed to a more flexible, individualised approach of hours of support according to need, bringing it in line with the CLS support model introduced in 2016/17 (**Appendix 10**).

We analysed the MDS data about consumer support across 3 levels of support need:

- Low level support: 20 hours per month or less (up to 5 hours per week)
- Medium level support: Between 20 and 152.5 hours per month
- High level support: 152.5 hours per month or more (5 hours or more per day).[22]

The hours of support to CLS-HASI consumers varied throughout their time in the programs. This variation was in response to their changing mental health needs and individual recovery pathways. For an overall perspective and comparison, the evaluation grouped consumers by the hours of support they received for the greatest proportion of their time in the programs. For example, a consumer entering at medium support for 2 months and then reducing to low level for their remaining 5 months was grouped as low level as this was the level reported for the largest proportion of their time in the programs. In this perspective:

- almost one third of all consumers received low level support (31.8%)
- about two thirds of all consumers received medium level support (66.6%)
- few received high level support (1.6%), sometimes close to 24 hours 7 days per week.

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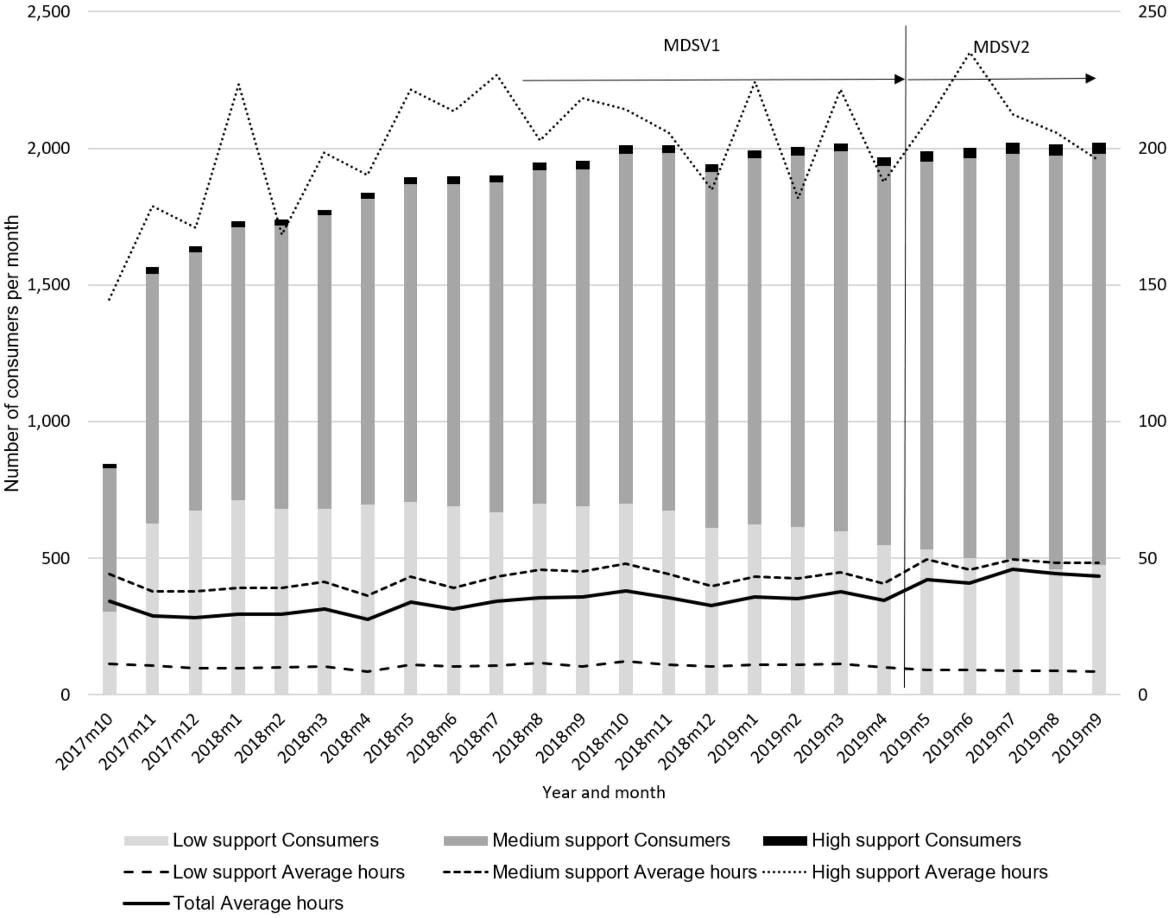
[22] High level support assumes 5 hours per day * 30.5 days per month = 152.5

This is shown as stacked bars in **Figure 3.**

Figure 3: CLS-HASI consumers and average support hours by support level



Source: CLS-HASI MDSV1 and MDSV2 to September 2019
Note: Figures are average support hours across all support types, excluding governance, in line with section 3.6.1. MDSV2 group hours excluded as each support type hour separately reported.

The average hours per month for all consumers ranged from about 32 to 35 hours.[23] This was relatively stable throughout the evaluation to April 2019. The new CLS-HASI MDSV2 introduced in May 2019 included reporting of additional support types that were not reported before.[24] Further, all support type hours were made mandatory in the MDSV2. These factors may explain why the average support increased to about 43 hours per month (solid black line in **Figure 3**).

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[23] Based on MDSV1 to April 2019.

[24] MDSV2 new support types include hours of support for educational, vocational activity or work and number of hours of support for tenancy or accommodation. MDSV2 also introduced the number of hours of support provided to a consumer by more than one staff member. These hours are included in figure 3 as they report support from the additional staff members. The support type hours for the primary staff member are separately reported for each support type.

Average hours of low level support per consumer were about 10 hours per month (dashed black line) and about 40 hours per month for medium level support (thick dotted black line). The small number of consumers on high level support received significantly more, over 250 hours per month at the end of the evaluation period (thin dotted black line).

In the interviews, most consumers were content with the number of support hours they received.

CMOs, LHDs and stakeholders generally preferred the flexible hours-of-support funding structure to the former fixed packages. They felt the hours-of-support structure made the programs more flexible for consumers and improved consumer recovery:

> The benefit of the CLS program and the new HASI program as well is that we can look at adjusting our service levels in response to a consumer's need, as opposed to providing pre-set levels of service. (CMO staff)
>
> … you need that ability to respond when things change. So that flexibility was welcomed. (Stakeholder)

Both CMO and LHD managers mentioned some challenges of the hours-of-support structure, particularly their perception that it emphasised one-on-one support, which was more expensive than group support. CMO managers and staff said this created some budget pressures, which they said resulted in:

- limited resources for administration, travel and planning
- reduced weekend and after-hours support
- fewer face-to-face hours than Ministry benchmarks required.

They said that budget pressures were growing stronger over time as staff wages increased and the Ministry asked for more reporting of program data (**Section 5.1.4**).

Some CMO managers felt that they had to deliver obligatory, minimum weekly and daily hours of support under the new structure. They argued that these benchmarks created problems, where CMOs might have to deliver hours of support on a day when the consumer did not need or want them. CMOs said this was not a client focussed approach and did not support the recovery goal of CLS-HASI. In response, the Ministry confirmed that there were no benchmarks for face-to-face hours of support.

Although the Ministry advised that, by the second round of fieldwork, it had clarified whether to offer support over 5 or 7 days a week, and that CLS-HASI program benchmarks had adjusted to reflect this, there was still some uncertainty among both

CMOs and LHDs about how CMOs were meant to implement the hours-of-support structure. Questions included how to price non-face to face hours and whether CMOs needed daily, weekly or monthly plans.

However, they had all worked out ways to offer flexible support to consumers. For example, CMOs still structured support for a week or a month in advance and then adjusted this plan according to consumer need. They still had some concern about their capacity to offer more support hours in a sudden crisis.

These findings indicate that CMOs were adjusting to the hours-of-support funding structure. At the same time, CMOs needed more clarification about how the structure was intended to work on a day-to-day basis.

LHD managers suggested ways to adapt further to the hours-of-support structure. They said CMOs could establish innovative programs such as consumer training cafés and drop in centres to support consumers after hours and on weekends.

2.6 Support services

This section reports available MDS data about support services in CLS-HASI. It also summarises fieldwork findings about the experiences of consumers and CMOs with program support.

CLS-HASI intends to support each consumer according to their individual needs. The kind of support the person wants and receives is meant to be recorded in three different plans (**Appendix 9**):

- the Individual Support Plan (ISP). It identifies the recovery goals of the person and the services they will receive. The CMO works with the consumer to develop the ISP. Families and carers are involved in the development of the ISP if the consumer agrees. The LHD is involved in the development of the ISP if the consumer is linked with the LHD.
- the Mental Health Care Plan. This is about any medication and psychiatric support for the consumer. It comes from the LHD if the consumer receives clinical support from the LHD. If the consumer were not linked with the LHD, it would come from a different source.
- the Risk Assessment and risk management plan for each consumer. The Risk Assessment is prepared by the LHD, although CMOs may also do their own.

Each consumer is expected to have all 3 plans. The MDSV1 shows that about 65% of consumers had one or more of these plans.[25] The remaining 35% of consumers had no plan recorded. In the recent MDSV2, where the data item was mandatory, around 70% of consumers had a reported review of support and risk management plans.[26] The Ministry said the shortfall had been a discussion point with CMOs during six monthly catchups. At these occasions, most CMOs reported that consumers did have the plans in place but that it was difficult to update the records.

Consumers receive support in two ways: individual support, that is one-on-one activities with the provider, or group support, where several consumers do activities together. Early evaluation findings were that group activities were offered widely to CLS-HASI consumers, alongside individual support. However, their group support did not always seem to be an element of an individualised, recovery-focused approach.

The Ministry confirmed that the emphasis of the programs should be on individual support. To better understand and monitor the use of group activity, the Ministry updated the programs' MDS. CMOs now report the total hours of group support. The Ministry also said it had used the six monthly catchups with CMOs to understand how the programs were operating and to point out how important individualised support was. According to the Ministry, several CMOs had indicated that the programs would not be financially viable without a large proportion of group activity. This problem is analysed in **Section 5**.

Below are findings about which support types consumers received and how many hours of each type. The consumers' experiences of individual and group support are analysed.

2.6.1 Support types and hours

This section examines which types of support services consumers received during the evaluation period[27]. The support service mix and number of hours of each service varied between consumers and across time, as consumer needs changed. The average hours per type of support for all consumers (**Figure 4**) shows that

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[25] The MDS does not record if a Mental Health Care Plan is in place. This is through the LHD and not a recordable data point for the CMOs.

[26] MDSV2 data item was 'client's support plan and risk management plan has been reviewed and updated within the reporting period'. This question relates to but is not directly comparable with MDSV1, which reported whether a support plan was in place.

[27] MDSV2 included additional types of support. These data were made mandatory for reporting, which may increase accuracy.

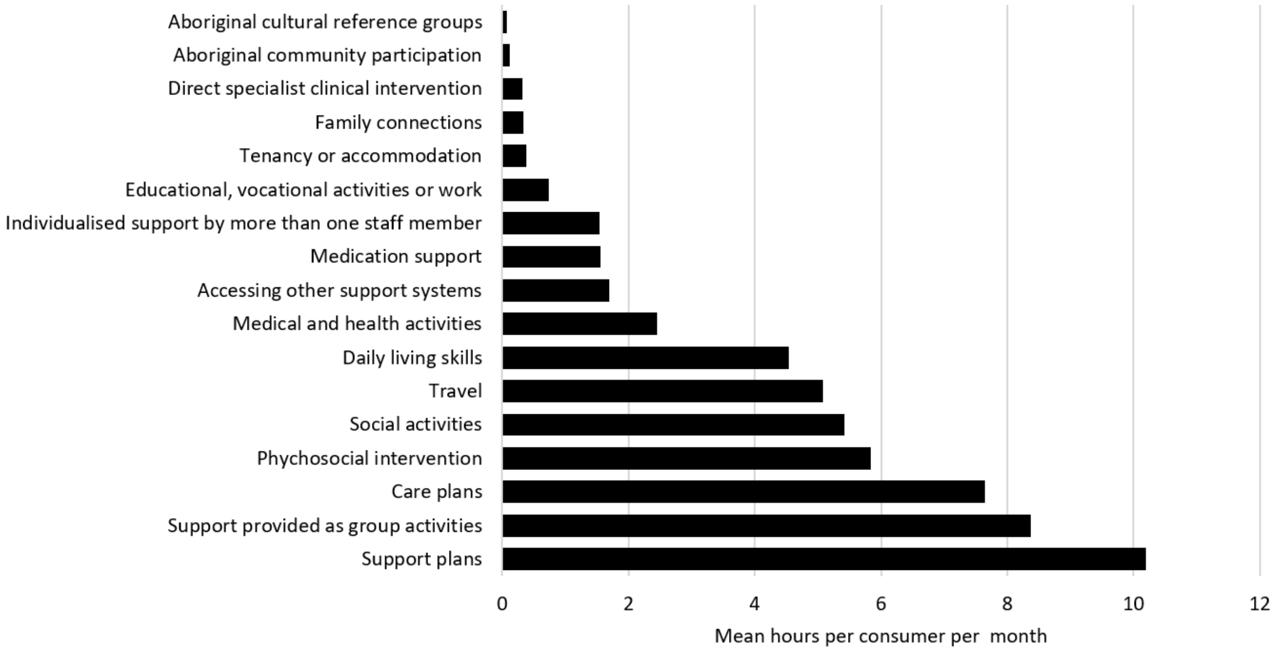
drafting and updating Individual Support Plans was the predominant support type, taking up about 10 hours per month in the more recent MDSV2.[28]

Consumers received about 6 hours per month for psychosocial support (a catch-all or ‘other’ category) and about 5 hours for support to access social activities. Travel time was for CMOs travelling to and from consumers, which was 5 hours per month on average. Support with daily living skills was also an important activity. CMOs spent about 5 hours per month supporting consumers with cleaning, shopping, cooking, personal hygiene, and using transport.

Medical and health related supports took up less time. Consumers received over 2 hours on average for support addressing lifestyle improvements and physical health needs, such as attending medical and allied health appointments, exercise and quit smoking activities. In addition, consumers received 1 to 2 hours per month for monitoring use of medications and for support to take medication as required.

The programs also offered an hour or two per month supporting consumers to access other services such as the NDIS and aged care, where eligible. Less than 1 hour was spent on support with each of the following: educational or work activities, keeping stable accommodation, connecting with family, arranging specialist clinical treatments and fostering Aboriginal connections.

Figure 4: Average hours by support type per consumer per month



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[28] MDSV1 to April 2019 reported as care plans, shown on separate bar in figure 5.

Source: CLS-HASI MDSV1 (n=4,619) and MDSV2 (n=2,880) to January 2020 (total n=5,533). This includes 4 months program activity for new MDSV2 consumers after the end of the study period in September 2019

Since MDSV2 started, CMOs reported hours spent on group activities, which was another 8 hours per month. Consumers also received about 2 hours per month of individual support with more than 1 staff member.

Average hours of support type varied between consumers with low, medium and high support needs (**Table 10**). Support planning was the prominent activity for consumers with low and medium support needs. High level support included a larger share of medication support, psychosocial intervention, and individual support by more than 1 staff member.

Table 10: Average hours by support level per consumer per month

Support Type	Low	Medium	High	Total 5,533
Total consumers	2,707	2,715	111	
% of consumers	48.9%	49.1%	2.0%	100.0%
Support type	Average support hours per consumer per month			
Support plans	4.4	11.8	14.8	10.2
Support offered as group activities	1	9.7	42.6	8.4
Care plans	3	10.1	15.6	7.7
Psychosocial intervention	1.6	6.7	54.5	5.8
Social activities	1.3	6.6	35.5	5.4
Travel	1.8	5.9	36	5.1
Daily living skills	1.5	5.6	20.5	4.5
Medical and health activities	0.9	3.1	6.6	2.5
Accessing other support systems	0.6	2.2	3.3	1.7
Medication support	0.2	1.8	18.6	1.6
Individualised support – multi staff	0.2	1.5	18	1.5
Educational, vocational activities or work	0.3	0.9	1.8	0.7
Tenancy or accommodation	0.1	0.4	0.5	0.4
Family connections	0.1	0.4	2.5	0.3
Direct specialist clinical intervention	0.1	0.3	3.6	0.3
Aboriginal community participation	0	0.2	0.2	0.1
Aboriginal cultural reference groups	0	0.1	0.9	0.1

Source: CLS-HASI MDSV1 (n=4,619) and MDSV2 (n=2,880) to January 2020 (total n=5,533 includes double-counting of consumers who were in both MDS versions)

Notes: Support level based on average support per consumer over support period

Some consumers were also supported to transition into the programs. About 11% of consumers had a pre-discharge plan as hospital inpatients or a prisoner preparing for release.[29] CMOs suggested that more support from Corrections after releasing prisoners might help CMOs better manage the transition into CLS-HASI.

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[29] Based on MDSV1 reporting (10.7%, n=4,619)

The focus reports include more detail about support types for social inclusion, the interface with NDIS funded support, Aboriginal specific support and the recovery approach (**Appendices 2-5).**

In the interviews, most consumers were satisfied with the support services they received. People's experiences in the fieldwork sites with individual and group activities are described below.

2.6.2 Experiences with individual support

CMO staff described how they tailored support to individual consumers' goals and life situation. For example, they supported consumers:

- to apply for other services or to resolve issues with other services
- with transport to go to the shops or to doctors' appointments
- to go to public places when they experienced anxiety in crowds
- with specific issues, such as furnishing the consumer's home.

Some CMOs reported budget pressures because the program guidelines emphasised individual over group support, with individual support having higher staff costs than group support. At the same, it appeared that by the second round of fieldwork CMOs had increased their focus on individual support, away from group support.

Most comments from consumers and CMOs about individual support were about transport. According to information from the Ministry, providing transport to consumers was not required in CLS-HASI. It was optional according to individual consumer need. It appears that, by the second round of fieldwork, some individual transport needs were met through NDIS packages.

Most consumers who were interviewed in the 3 fieldwork sites received support with transport to attend medical appointments. Some also received transport assistance to attend group activities in the CLS-HASI programs. This support happened more often in services that were not located near public transport. Some consumers with mobility or social phobia issues also received transport assistance for daily living activities such as shopping. Consumers were generally content with the amount of transport support they received.

Some CMOs viewed transport as a useful means for early engagement with consumers, facilitating conversations and building trust:

> We do have a car to and from if customers need support … And I find it gives me an opportunity to debrief with them as well. …it's good to be able to pick them up and debrief with them as well. (CMO staff)

The interviews with consumers and CMOs suggest that transport support had been reduced before the start of the evaluation. Some CMOs said they were now actively working to reduce transport in order to foster consumer independence (**Section 3.4**). At least one service offered a transport training program. It consisted of support to gain a driver's licence or of practical advice to use public transport:

> We [worker and consumer] took the bus last Wednesday to go to [place] and then we did the shopping and then we went back to my place [on the bus] … I was a bit nervous but we did it, yeah. (Consumer)

Travel training seemed to be successful for some consumers. Between the first and second rounds of fieldwork, some had started to catch public transport alone.

Most CMOs reported that they offered transport based on the goals and support needs that the consumers set in their individual support plans:

> We've got one lady that was referred to us, she needs a lift to [place]. Well, we're not a taxi service … I will be going through what her goals are, where she wants to see herself, what outcomes, measures that she wants. And if [support with transport] is going to help her mental health, then yes, we can do that. (CMO staff)

Consumers reported changes in individual support after they had transitioned to a different provider when HASI was re-tendered in 2017/18 (**Appendix 9**). According to a few consumers, the previous HASI provider had supported them with cleaning their house, while the new provider showed them how to clean it themselves and/or supported them to seek homecare assistance. The new approach was consistent with the provider focus on consumer independence (**Section 3.4**). The second-round fieldwork indicates that some consumers with NDIS packages were funded for homecare support needs (**Appendix 3**).

Some stakeholders spoke about the support needs of specific groups of people. For example, people exiting prison might need support to re-integrate into the community. Housing providers said some consumers needed support to prevent anti-social behaviour. As stakeholders worked at government and other state-level positions, they were generally not aware to what extent CLS-HASI offered individualised support on the ground:

> I'm not getting a lot of data through about geographic variations in how CLS-HASI is working. Like we've got a one size fits all model on a community that's not a one size fits all. (Stakeholder)

This perception seems to indicate that information about the individualised approach could be shared more regularly.

2.6.3 Experiences with group support

Group activities were organised around social and recreational interests. Examples included art and craft groups, cooking classes, walking groups and social activities, such as barbeques, cafés or the cinema. Many consumers found group activities helpful and enjoyable:

> Sometimes they'll have different programs running, which is really good because me and a few other ones, we actually don't get out a lot, so just having those little groups … it makes it so much easier. (Consumer)

In the first round of fieldwork, several consumers said they were not attending group activities because they did not find them interesting, or they did not feel comfortable in groups, or they could not afford the activity, for example lunch at a café.

By the second round, it appeared that CMOs were offering group activities that were more meaningful to consumers and less often based at the CMO facilities, for example walking groups. It also seemed that CMOs placed greater emphasis on supporting consumers to gradually become used to group activities. For example, they would do individual walks with consumers and, when they were ready, walk with two consumers together.

Such changes to group activities occurred in response to informal consumer feedback. There appeared to be few formal structures or processes in place for consumer input, other than a suggestion box at one site and each person’s individual service plan. The Ministry stated that CMOs also collect the Your Experience Survey and Carer Experience Survey with outcomes reported to InforMH. These data were not available to the evaluation.

2.7 Priority groups

Groups of people who are priority for CLS-HASI support are people living in social housing, in boarding houses, leaving prison or serving community-based detention orders; as well as Aboriginal people and refugees (**Appendix 9**).

This section summarises available evaluation data about how well the CLS-HASI programs reach and work with priority groups. Some interview and MDS data were collected about other consumer groups who may have particular support needs, e.g. cultural diversity and people with drug dependency. In 2019, the Ministry made Aboriginal and CALD cultural competency training available to all CLS-HASI providers.

MDS data show that representation from priority groups in CLS-HASI was mixed (**Section 2**). The share of Aboriginal CLS-HASI consumers increased since previous HASI evaluations, now well above the general NSW population. CALD consumers by comparison were under-represented in the programs.

It is unclear whether referral processes focused on these groups as intended. The interviews indicate that some people in the priority groups found it difficult to access LHD community mental health services, which were the dominant referrers for CLS-HASI (**Section 3.3**).

Consumers who identified with any of these groups did not report differences in service delivery. In general, the interviews suggest that in the fieldwork sites there was little adjustment of support to respond to the needs of priority or minority groups. A CMO stakeholder mentioned one exception. The service had set up a female-only group activity to meet the cultural needs of a CALD consumer who found a mixed-gender group uncomfortable.

Most CMOs interviewed did not find it necessary to offer specialised services. They said they already prioritised individual choice in the support plans and they aimed to be inclusive. These attitudes did not change between the two rounds of fieldwork. There appeared to be little cultural awareness among staff. Few support workers had cultural competency training by the second round of fieldwork.

CMOs in the fieldwork sites did not appear to have strong connections with culturally diverse communities in their area. For example, CMO staff in an area with high cultural diversity used a telephone interpreting service to communicate with a consumer. There was no staff member or contact available who spoke that language and at the same time had sufficient language skills and content knowledge. Also, there seemed to be little recognition of how important family and community might be, particularly for Aboriginal and culturally diverse consumers. This aligns with a narrow understanding about the focus of service delivery on the individual consumer and their recovery goals (**Section 3.4**), without considering what that means for the person in their social context of family and community.

Conversely, stakeholders said it was important to adapt support to meet the specific needs of priority and minority groups, including people who identify as Aboriginal, people from CALD backgrounds, people exiting prison and people in different geographical areas.

2.7.1 Aboriginal people

From 2009, a separate Aboriginal HASI stream gave support to Aboriginal people with mental health challenges. This stream was integrated into the general HASI program in 2017 (**Appendix 9**). To ensure that CLS-HASI supports Aboriginal people well, the Ministry requires that CMOs:

- support a minimum number of Aboriginal consumers
- consult with an existing local Aboriginal service or group, so that CLS-HASI is culturally appropriate and respected in local communities
- support Aboriginal people to participate in their community and access Aboriginal services.

In 2019 the Ministry made Aboriginal cultural competency training available to all CLS-HASI providers. The training started after data collection for this report finished, too late to assess its impact.

MDS data show that about 15% of the study group identified as Aboriginal or Torres Strait Islander. This was an increase since the 2012 HASI evaluation and more than 4 times the proportion in the NSW population as a whole (**Section 2.2**), indicating that the programs were reaching this priority group.

How well CLS-HASI supports Aboriginal consumers and communities is the subject of a separate focus report for this evaluation (**Appendix 4**). The evaluation data show good program outcomes for Aboriginal consumers, similar to non-Aboriginal consumers. There were many good practice examples in the fieldwork, where CLS-HASI supported Aboriginal consumers well. Different forms of cultural awareness practices were increasing across the sites. This depended on the population of CLS-HASI consumers and local dynamics. Overall, most interview and focus group participants felt that CLS-HASI could engage better with Aboriginal culture, communities and organisations. Key findings from the focus report are below, and the implications of the findings are in the focus report:

Partnerships and shared responsibility with Aboriginal communities

This principle entails partnership and shared ownership in health planning and delivery between Aboriginal people, communities, Aboriginal Community Controlled Organisations (ACCOs), governments and other service providers.

The evaluation found some effective partnerships between CLS-HASI providers and Aboriginal organisations. Service providers found that the best way to develop these partnerships was to build from existing Aboriginal committees and processes. Most connections were informal, and their structures depended on local connections. Stakeholders suggested that other programs and agencies intersecting with CLS-HASI, such as the NDIS and Corrective Services, also needed to develop stronger relationships with Aboriginal organisations and to formalise them for sustainability.

That might improve referral pathways into CLS-HASI, giving more Aboriginal people access to the programs. In the most recent data, 3% of Aboriginal consumers were referred to CLS-HASI by a specialist Aboriginal service.

Engagement with Aboriginal communities

Engagement involves the ongoing participation of Aboriginal people and communities, including ACCOs, in all levels of decision making to ensure that all policy and activity has their support and input.

The evaluation found good practices of engagement with Aboriginal consumers and communities at the service delivery level, through the employment of Aboriginal people, and at the community level, with most CMOs engaging with AMS when supporting consumers who access both services.

Most CLS-HASI providers employed Aboriginal people as frontline staff. Consumers reported that having Aboriginal staff supported them to develop trust and engage with the service. In some sites, Aboriginal staff had roles specific to their Aboriginality, for example they were matched with Aboriginal consumers. Few Aboriginal staff participated in case planning or were managers. Most CMOs tried to recruit additional Aboriginal staff. Recruitment appeared most effective where the staff had connection to the Country or the ‘mob’ where they were working.

CLS-HASI staff generally offered the consumers the option to receive services from a local AMS, leaving the decision whether to use AMS services up to the consumer. Most consumers used an AMS if they had a previous connection or positive experience with it.

Capacity building of Aboriginal communities

The capacity building principle refers to developing and providing knowledge, skills, resources and systems to support Aboriginal people and communities to engage in designing and implementing health services.

The evaluation found evidence of Aboriginal capacity building with Aboriginal consumers, including connecting to culture and community, and to live independently. CLS-HASI supported Aboriginal consumers to reconnect with culture and community if they wished to. Aboriginal consumers suggested some future additional activities that could increase consumers’ cultural connections. Some CMO staff drew on the knowledge of Aboriginal consumers with good cultural connections to improve their own and their colleagues’ cultural practices.

Equity

The principle of equity encompasses physical and cultural accessibility, inclusiveness and equitable health outcomes.

The share of Aboriginal people among CLS-HASI consumers increased since previous evaluations. It is now about 15% (**Table 1**), which is more than the Aboriginal share of the NSW population of 3.5% (Australian Bureau of Statistics, 2016b). Aboriginal consumers in CLS-HASI had levels of support similar to non-Aboriginal consumers in many support types. Aboriginal consumers had more support for accessing other services and for housing. They had less psychosocial support, less support for social activities and less staff travel to and from the consumer. Data were not available to determine reasons for these differences.

Linked data show that CLS-HASI had good outcomes for Aboriginal consumers, similar to non-Aboriginal consumers. There were drops in hospital days for mental health issues, in use of emergency departments and in the number of contacts with community mental health services. Applications for housing increased as well as new tenancies. This change was bigger than for non-Aboriginal consumers. All findings were statistically significant.

The fieldwork found good practice examples of how CLS-HASI supported Aboriginal consumers to challenge inequity that consumers experienced at personal and community levels, for example racism or lack of cultural awareness, and at systemic levels, including accessing services such as housing.

Elements of service provision that needed improvement to reduce inequities included difficulties reaching people in remote areas, resulting in access inequities, and cultural awareness regarding the specific challenges faced by Aboriginal consumers. Most CMOs said they attempted to treat all people in the programs the same, or ‘equally’, rather than adapting support to address cultural disadvantage, or equity.

Accountability, evidence based and data governance

Accountability applies to government, mainstream and Aboriginal services and is necessary to understand the effects of program implementation. Evidence-based policy and program approaches necessitate a robust process of program evaluation and the integration of evaluation outcomes into policy making and program design. Aboriginal communities have the right to govern, control and manage the collection and use of their own data for their purposes and in ways that they see fit.

Privacy and use of program data to inform improvements were not discussed directly in the interviews. When consumers join the CLS-HASI programs, they consent to CMOs collecting and using consumer data that is needed to deliver the programs and monitor success. This consent includes outcome measures regularly collected by CMOs.

Some LHD and CMO managers and a few Aboriginal consumers considered that CLS-HASI needed to further adopt elements evidenced as effective from the former Aboriginal HASI program, such as brokerage funding, packages of support hours, outreach to remote areas and more Aboriginal staff. These additional resources could address the greater inequity faced by Aboriginal consumers, including access to CLS-HASI and appropriate support, linking to the Aboriginal community.

Holistic concept of health

A holistic approach to health recognises the physical as well as the spiritual, cultural, emotional and social aspects of wellbeing and their role in contributing to health outcomes for Aboriginal people and communities.

The evaluation found good practice evidence of how CLS-HASI embraced the concept of holistic health through various approaches. Consumers said the psychosocial support offered by the programs improved their emotional wellbeing. Building stronger connections to family and community also improved social-emotional wellbeing. This holistic approach was successful where staff took a wide cultural view and where Aboriginal staff were available. Other aspects of a holistic approach included supporting physical health and ensuring that Aboriginal consumers retained safe and suitable housing.

Cultural competence

Cultural competence recognises the diverse cultures and histories of Aboriginal peoples, the important role of key representative bodies and local ACCOs.

The evaluation found that employing Aboriginal staff improved the cultural competence of CLS-HASI services. CMOs increasingly considered cultural diversity in program delivery, for example through participating in Aboriginal events. Some CMOs and LHDs included cultural responsiveness training for staff. CLS-HASI would benefit from more training and reflective practice about cultural responsiveness overall and to share good practice to develop consistency across providers.

Cultural competence also refers to how the CLS-HASI programs liaise with ACCOs, discussed in the section ‘Engagement with Aboriginal communities’.

Capitalising on Indigenous strengths

Appropriate mechanisms need to be in place to identify community strengths, expertise and skills, allowing communities to capitalise on their strengths.

There were several examples where CMOs involved Aboriginal staff as experts to offer support and cultural advice for non-Aboriginal staff. Most CMOs fostered learning and art activities as part of their cultural programs.

Some service providers, key stakeholders and consumers suggested that facilitating a part of HASI managed and staffed by Aboriginal people could capitalise on Indigenous strengths.

2.7.2 People living in boarding houses

The Ministry reported that people living in boarding houses had been a focus in CLS while the support for this group transitioned from the NSW Government (former Ageing, Disability and Home Care or ADHC) to the NDIS. At the time, the Ministry saw CLS-HASI as a temporary support option until people could arrange an NDIS package. The NDIS was fully implemented in NSW by July 2018.

According to MDS data, 2.3% of CLS-HASI consumers lived in a boarding or rooming house when they entered the programs (**Section 2.5**).

The fieldwork interviews indicate that consumers and CMOs considered boarding houses a short-term housing option. The focus of CLS-HASI support was finding more appropriate, stable housing:

> I think yes because of the lack of housing that we have here there are [consumers living in boarding houses] – but with the view to getting them into more permanent housing, which I have witnessed a number of times … one of the main goals is to get people into stable accommodation. (LHD)
>
> Well, the only boarding houses I've been into are [not] what I'd consider ideal accommodation for anybody. (CMO staff)

A few consumers said CLS-HASI had supported them to move out of boarding houses into more stable housing. Sometimes this took considerable time, especially if they were waiting for social housing.

While consumers were still living in boarding houses, CLS-HASI seemed to support them as well as possible. One consumer, for example, reported that the CMO supported them to negotiate for another room in the boarding house that better met the consumer's needs until they could move on.

Some CMOs mentioned safety issues with home visits in boarding houses and how they ensured the safety of their support workers:

> We are honest in saying, we can't come into that property if it's not safe, like we would any house. Then we talk about that from the referral process of how

> we are going to safely cater, rather than just saying no [to the referral]. (CMO staff)

2.7.3 People living in social housing

CLS-HASI aims to reduce the risk of people losing their social housing due to problems arising from their mental illness and generally understanding their responsibilities as a tenant. Problems could be, for example, accumulating too many things or not paying rent on time.

About 43% of consumers lived in social housing when they entered the programs (**Section 2.5**).

In the interviews, most consumers living in social housing were happy with their home. Some reported problems with neighbours or said they felt unsafe because there was violence or drug and alcohol use in the area. A few consumers said CLS-HASI had supported them to apply for other social housing.

CMO and LHD managers said they worked in partnership with government and community housing providers to resolve housing issues. Stakeholders described such collaboration from their side. The aim was to retain safe and stable housing for CLS-HASI consumers. This support appeared to be an integral part of their recovery-oriented approach. Their collaboration seemed to be ad-hoc and case-based rather than formal or systematic (**Section 3.1**). Stakeholders suggested more information exchange between CMOs and housing providers so they understood each other better and therefore could support tenants even better.

Some CMOs felt that government agencies needed to be more supportive and responsive towards people with complex needs:

> I think Housing could be more proactive [finding housing] for people that are living with mental illness and are homeless … I think more opportunity for them to find somewhere to live. There's not much opportunity out there, and then we put them in environments where they shouldn't be. At boarding houses and hostels and things like that, and it's just not a good place. (CMO manager)

2.7.4 Refugees

Until 2019, refugees were a priority group in CLS-HASI, especially in locations that the Ministry identified as refugee settlement areas. The Ministry recognises that refugees often have complex mental health needs related to experiences of trauma. They can face unique challenges settling into a new environment.

In 2019, the Ministry launched the Mental Health Community Living Supports Refugees (MH-CLSR) program. MH-CLSR is designed to offer appropriate psychosocial support to refugees and asylum seekers in seven LHDs. The Ministry states that further work is needed to ensure refugees and asylum seekers are supported in CLS-HASI, particularly in areas without MH-CLSR.

Refugees and asylum seekers were under-represented in CLS-HASI. 41 CLS-HASI consumers reported they were refugees, which is 0.7% of consumers[30]. The highest number of refugees were from Iran (11 consumers) followed by Sudan (6 consumers).[31]

None of the consumers in the interviews identified as a refugee. A few CMOs talked about the particular challenges for refugees:

> We have a consumer who is from [country] … and he has some really significant trauma … Him and his wife came here with quite a number of children, all of whom have been removed from them. For the first two years they were here, they didn’t get access to those children at all … and it’s been very hard to find cultural connection for him, because there’s very few people that speak their language. (CMO staff)

CMO managers across the State said they had had no referrals from refugees that they knew of, and some said they had no refugee communities in their regions. Similarly, most LHD managers reported that there were no referrals of refugees in their areas. Several LHD managers reported little engagement with refugees, although there were refugee communities in their areas.

These findings indicate opportunities for CLS-HASI to engage more with refugee communities when the programs support a consumer who is a refugee.

2.7.5 People leaving prison

The Ministry is aware that people who have recently left prison can find it difficult to access the mental health support they need. These people may or may not serve community-based court orders, which means they are offenders living in the community. Referrals of people leaving prison to the CLS-HASI programs come most likely from Justice Health and NSW Corrective Services within the Department of Justice. The Ministry requires CLS-HASI to prioritise these referrals. CMOs are expected to establish effective ongoing liaison with Corrective Services. This liaison

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[30] The introduction of MDSV2 reworded ‘refugee status’ to ‘refugee background’. This resulted in four consumers reporting a refugee status and their country of birth as Australia.

[31] All other refugee country groups were below 5 consumers each and are not separately reported to protect confidentiality.

includes working with the referring officer to ensure a smooth transition from prison to living in the community.

Entry to CLS-HASI

MDS data show that 16 consumers were in prison at program entry and a further 12 were referred from a prison or Justice Health (**Table 6** and **Table 9**). 83 consumers left prison during the year before they entered CLS-HASI, and 39 were under a parole order while in the programs. Further details of corrections and consumers under community-based orders are in **Section 4.6**.

As mentioned in **Sections 3.1 and 3.3**, referrals from Corrective Services to CLS-HASI often did not work well or consistently. One stakeholder thought that perhaps the complex needs of this group could be a barrier for some CMOs, as they might not be able to support them adequately in CLS-HASI after prison:

> I think [they] get put in the ‘too hard basket’ because often those clients that come from Corrective Services are going to have dual diagnoses or very complex needs, and that can be a challenge for individual services or programs if their focus is a bit more narrow. (Stakeholder)

One CMO reported that they were more likely to receive referrals through the consumer’s new (post prison) connection with the LHD rather than through Corrections:

> Just a small number [of referrals from Corrections]. We normally get them after [consumers] have been out and then are connected with community mental health; that’s how we get the referrals. (CMO staff)

Support in CLS-HASI

One consumer in the fieldwork interviews said they had recently left prison. They were on parole and had been with CLS-HASI for a few months. The consumer said the program had supported them well:

> Oh, [CMO] is great, I like being a part of this program. I was stressed out all the time because I was missing appointments with doctors and all of that … but now that [CMO] have been with me they take me to my appointments … and I’m not so stressed out on, you know, transport or anything no more … I didn’t know anything about how to organise my appointments and [support worker] has taught me a lot. (Consumer)

Some CMOs described how they managed the challenges that consumers faced when they left prison. For example, CMOs recognised that moving from isolation in a prison cell out to living in the community might be scary. Staff responded by focusing on small steps. One CMO described the benefits of starting to work with the consumer while still in prison:

> He was able to ring … me up [while he was still in prison], and we would talk about what's going to happen when he comes home. So, we started that process right from there, and now … he's finished that parole, and he's still on the HASI program. (CMO staff).

In the focus groups, CMO and LHD managers said their impression was that reduced re-offending was a CLS-HASI outcome measure. They argued that because CLS-HASI were mental health recovery programs, CMOs should be assessed only on mental health outcomes and not on changes in criminal behaviours. In response, the Ministry stated that reduced re-offending was not an outcome measure. The Ministry said the MDS did collect exit location for statistical purposes, but not for outcome monitoring. The MDS data for this evaluation shows that, for 2 consumers, a correctional facility was their primary support following exit.

2.7.6 Older people

Although older people are not a priority group in the CLS-HASI programs, their experience is of interest because before 2017, HASI was not actively open to people over the age of 65. Every LHD has a Specialist Mental Health Service for Older People (SMHSOP) team. These teams may be an important source of referrals of older people to CLS-HASI. SMHSOP services offer mental health care and treatment, while CLS-HASI offers psychosocial support at the same time. Older people may also access other programs, such as the Commonwealth Home Support Program or Commonwealth Home Care Packages Program, while they are with CLS-HASI. These programs may, for example, offer support with household tasks or personal care. The NDIS is open to people who apply before they turn 65 years old.

More older consumers were in CLS-HASI than at the previous HASI evaluation in 2012 (**Section 2.3.1**). In the current evaluation, 597 consumers (10.8%) were 60 years or older.[32] Among these older consumers, 252 (4.6% of the total study group) were aged 65 years or older. Among all Australians, 8.7% of people aged 65 years and over accessed mental health services, which was less than younger people aged 15-24 years (20.7%)[33].

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[32] The previous HASI Evaluation in 2012 presented the oldest age group as 60 years and above.

[33] https://www.abs.gov.au/statistics/health/health-services/patient-experiences-australia-summary-findings/latest-release

Based on MDS data, about 3% of consumers accessed specialist aged care support during their time in CLS-HASI, and 2% reported specialist aged care services as their primary support after they left the programs. Regarding

Among the consumers in the interviews, 5 consumers were aged 60 years or above. 1 of those was aged over 65 years. These older consumers spoke about some of their support needs due to ageing, such as support to go to the doctor for a hearing aid.

Some older consumers said how important it was to have something meaningful to do. They described how the CLS-HASI activities had improved their mental health and wellbeing:

> Yes, because well, doing craft has stopped me from just worrying about things. Before I used to worry. I wanted to get out of the flat and leave … and just chase myself around and around being homeless. That's how I was and HASI said, "Do craft and you'll settle down," and I have. I've managed to relax better and that. I'm not running away from my flat. (Consumer)

CMO and LHD managers in the focus groups were aware that older people were under-represented in CLS-HASI. Most said this was partly because HASI had previously been restricted to consumers aged under 65 years. One Aboriginal stakeholder in the interviews said older Aboriginal community members may be under-represented because they lacked trust in the system. They said some of them do not talk about their mental health issues for fear of being ‘locked away’.

CMOs and LHDs saw opportunities for promoting CLS-HASI for older people. One LHD had run a program that specifically targeted older people. It made older people aware that CLS-HASI existed and that it was open to them. As a result, the LHD had seen an increase in referrals.

A few CMOs raised issues with supporting older people in the programs. They said some older CLS-HASI consumers were frail and needed specific support services to live independently, which were not offered by the programs. In the second round of fieldwork CMOs also said it was difficult to find additional support for older people who could not access the NDIS because they were over 65, or they were under 65 but found not eligible for the NDIS. These issues may indicate a need for the programs to review pathways into alternative support programs. More specific data were not available.

2.8 Family and carer involvement

One of the CLS-HASI principles is that CMOs engage family members and carers as partners in the programs if the consumer agrees (**Appendix 9**). The aim is twofold.

First, improved family connections, including re-connecting, is an important outcome of CLS-HASI support. It is part of the program aim of better social inclusion for consumers (**Section 4.3.1**). Second, the Ministry sees family connections as a key resource that can support a person's mental health recovery. Families and carers can be involved in support planning, in building community connections and in meeting the consumer's cultural needs. Although CMOs are not funded to provide supports to families and carers, they can link them with other services.

2.8.1 Fostering family connections

MDSV1 data show that about 38% of consumers had a family member or carer actively involved during their time in CLS-HASI.[34] More consumers had family and carer involvement in the most recent MDSV2 data at 52%. The change might be because the question was mandatory in MDSV2. The program also offered direct support for consumers to maintain or rebuild family connections, (**Section 3.6.1, Table 10**).

The Ministry acknowledged that more information about family and carer involvement would be useful. The Ministry said the current structure of the MDS did not allow collecting this information. There might be opportunities in the future to add collection items, but the Ministry also wanted to consider the reporting burden on CMOs.

In the fieldwork sites, connections between consumers and their families or other informal carers varied with the person and their living circumstances. For example, if the consumer lived with a family member, they were more likely to be engaged with their family than if they lived alone or with someone who was not related to them. Most consumers who took part in interviews did not have strong connections with their families. Sometimes there was family history or behaviour that made reconnection harmful to the consumer:

> I love my family, but the thing is they all drink alcohol and do drugs. (Consumer)

CMOs said they supported consumer recovery through reconnecting with family, where appropriate. They said that meetings between consumers and their families in safe spaces sometimes helped re-establish and foster family relationships. Safe spaces are, for example, a public place or a private room at the CMO location. CMOs and consumers also mentioned the importance of program support for reconnecting with the consumer's children.

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[34] MDSV2 reworded question to 'Family and carer involvement during the reporting period' from 'Family and carer involvement'. Data item also made mandatory.

Most CMOs seemed to interpret family as close blood relations only. Some CMOs considered a wider kinship or community network, which is predominant in many non-Anglo-Saxon cultures. Some LHDs and CMOs spoke about the importance of reaching out to the wider families of Aboriginal consumers:

> We look at the family … So we can bring them in too, if they need it, we can bring all them in and that's how we work here … You need to cast the web a bit further, just not on the individual. (LHD staff)

The findings above show how CMOs engaged families and carers of some consumers. Beyond this, the fieldwork sites seemed to have few or no events, activities or formal processes to foster family relationships.

2.8.2 Family involvement and support

In the statewide focus groups, CMO managers said that good communication with families helped recovery and aided early intervention. This was particularly evident when families gave background and insight about the consumer's life. Where the consumer had consented, some CMO managers engaged families and carers in the case planning process, as intended by the programs. CMOs also liaised with these families over time, particularly when consumers appeared to become unwell.

Few fieldwork sites had support services or activities directly for families and carers. Most CMOs said they would like more resources to support families and carers. Some CMOs referred families to appropriate support or gave them information:

> We will try and resource the families and carers as well. A lot of the time they've just been carers without any background information … We're also making referrals [for families] if required or handing out numbers for carers' agencies and resourcing them with reading material or any support groups in the area as well. (CMO manager)

Some LHD managers reported that integrating CLS-HASI and family services in their area had positive outcomes for consumers and families. One LHD manager said it was helpful that they had a family and carer coordinator at the LHD.

A CMO and a stakeholder said that CLS-HASI services replaced some of the support that families and carers gave to the consumers. Therefore, the programs enabled families to have fulfilling relationships with consumers, separate to their caring role.

> The carers that I have spoken to who have got loved ones in the scheme really appreciate it. They feel that it takes a lot of the support burden off them … but also allows perhaps a bit of space for their loved one to develop without feeling too much oppressive support from a family member. (Stakeholder)

The interviews with families and carers confirmed that they appreciated CLS-HASI support, but also showed that they needed more:

> So if you have any plan we can spend family time together, like me, my daughter, my husband for one day or day a week, somewhere we can enjoy ... We'd like that … Sometimes my daughter ask me; mama why we didn't go to outside like a family. Because we couldn't afford it … But if [CMO] can arrange that one, we would be happy ... (Family)

With regards to the quote above, it is acknowledged that CMOs did not have the financial resources to fund family activities.

Between the first and second rounds of interviews, there was no discernible change in the fieldwork sites regarding how family and carers were involved in the programs and how CLS-HASI addressed any needs of family and carers for support.

2.9 Links between CLS-HASI and the NDIS and RRSP

This section explores how CLS-HASI operated in the context of the NDIS. More details are in **Appendix 3**. It briefly considers the integration of RRSP into HASI.

2.9.1 Interface with the NDIS

In 2017 the NDIS became available throughout New South Wales. People with a psychosocial disability due to a mental health condition may be eligible for NDIS support. Many of these people are also eligible for CLS-HASI support. If people are eligible for both CLS-HASI and NDIS, the NDIS supports should be complementary and not duplicate those provided through CLS-HASI (**Appendix 9**). This has resulted in a complicated interface between the NDIS and CLS-HASI.

The evaluation data indicate that, during the evaluation, links between the NDIS and CLS-HASI became stronger. A focus report for this evaluation (**Appendix 3**) considered how CLS-HASI and the National Disability Insurance Scheme (NDIS) worked together, based on program data and the experiences of interview and focus group participants. The evaluation data were analysed using a framework developed by the Council of Australian Governments (COAG) in 2015. The framework consists of principles to distribute responsibilities between the NDIS and other service providers, including State and Territory governments. These principles structure the evaluation findings and implications for the CLS-HASI programs. Key findings from the focus report are below, and the implications of the findings are in the focus report.

Access to the NDIS

Program data from the MDS show that access to the NDIS improved during the evaluation. By the second round of fieldwork in 2019, consumers, CMOs and LHDs understood the NDIS better. At that time, many CMOs supported consumers through the NDIS application process, and many consumers were optimistic about receiving an NDIS plan.

The share of consumers who exited CLS-HASI to NDIS funded services also increased during the evaluation. CMOs felt that the NDIS was important to exit consumers successfully from CLS-HASI, as the NDIS could continue to support consumers in the community. In turn, when a consumer exited CLS-HASI with NDIS support but their mental health deteriorated, CLS-HASI could recommence temporary intensive support in the community and prevent hospitalisation.

At the time of the fieldwork, many LHD and CMO managers voiced ongoing concerns about the NDIS. Issues included long wait times for NDIS approval, shortage of appropriate NDIS-funded psychosocial support services, and weak clinical links and case management from NDIS providers.

CMOs, LHDs and stakeholders agreed that accessing the NDIS was still difficult for some eligible mental health consumers. Those with access difficulties included people in rural areas, older people, people from culturally diverse groups, and people from prisons and mental health hospitals.

LHD mental health workers or other referral agencies decided whether to refer a person to CLS-HASI, support them to try to access the NDIS or both. The eligibility for each program does not explicitly guide referrers about how to manage the potential overlap. Decisions seemed to be inconsistent between locations and agencies.

Types of support between CLS-HASI and NDIS

Consumers received different types of support from CLS-HASI and the NDIS. Many consumers received NDIS funding for home services such as personal care, cleaning, lawn mowing and transport, and also for support needs for a physical disability. Consumers often accessed CLS-HASI for psychosocial support and for links to clinical mental health support.

CMOs adjusted CLS-HASI services to complement the support that the consumer could receive from the NDIS. CMOs said complementary support was easier when the CMO provided both CLS-HASI and NDIS support to consumers. This dual role raises questions about conflict of interest.

Coordination between CLS-HASI and the NDIS

Coordination between CLS-HASI and NDIS providers appeared to improve during the evaluation. The coordination resulted in better access by CLS-HASI consumers to NDIS-funded services. CMOs and LHDs identified four periods that required coordination between CLS-HASI and NDIS-funded services.

The first coordination point was when a consumer entered CLS-HASI. CMOs noted there was little opportunity for coordination if the consumer already had an NDIS plan. A few consumers were referred to CLS-HASI by NDIS funded services.

The second coordination point was when consumers applied for the NDIS while in CLS-HASI. Coordination during this process improved during the evaluation, so that consumers were supported more often to have better access to the NDIS. Many CMOs had allocated this task to particular staff members with experience supporting access to NDIS.

Third, when consumers had both CLS-HASI and NDIS support, either consumers or CLS-HASI staff coordinated the different types of support from the two programs. CLS-HASI staff said by the second round of fieldwork in 2019, more NDIS Support Coordinators were available for CLS-HASI to refer to. Other improvements were closer relationships between CMO staff and NDIS workers, and local meetings between the service providers. Some LHD staff had a delegated role to liaise between the NDIS and other services.

Finally, services seemed well coordinated when consumers exited CLS-HASI to NDIS. Some consumers exited into more independent living with an NDIS plan. Some consumers with higher support needs were funded for Supported Independent Living (SIL) through the NDIS, which can provide access to 24-hour support.

Flexibility of support

Most CMOs, LHDs and stakeholders argued that CLS-HASI support was more responsive to the specific needs of CLS-HASI consumers than NDIS support. They felt this was true both for day to day support and for adjusting support over time. They felt that their flexibility was partly due to the mutual relationships between CMOs and LHDs, where they could discuss and access different kinds of support at short notice.

NDIS funding structure

Most CMOs and LHDs thought that the market funding model of the NDIS was disrupting the ability of the sector to support mental health consumers. They reported that many community-based mental health services had transitioned to the NDIS and were available only to consumers with NDIS packages.

CMOs and LHDs also thought the level of NDIS funding was inadequate to offer high-quality psychosocial support because it was insufficient to fund staff training in supporting this cohort. Further, they felt that collaboration in the sector suffered because of the market-driven culture of the NDIS. By the second round of fieldwork, these concerns had lessened somewhat as they adjusted to the NDIS.

It is not possible to directly compare the costs of different support programs like CLS-HASI and the NDIS. With this limitation in mind, the economic component of this evaluation shows that the average CLS-HASI cost per consumer was $34,889 in 2018-19. That was a similar amount to the average NDIS support package of $33,000 per consumer in 2019, excluding SIL funding (National Disability Insurance Agency, 2021).

2.9.2 Integration of the RRSP into HASI

During the time of the evaluation, the lower-support Resource and Recovery Support Program (RRSP) was integrated into HASI (**Section 1**). The reason for the integration was that the NSW Government's mental health reforms prioritise support programs for people with severe mental illness, such as CLS and HASI. Integration was completed at the end of February 2019.

By the middle of 2019, LHD managers in the focus groups said that integrating RRSP consumers into the HASI structure was progressing well. CMO managers identified few issues with integrating RRSP. One CMO manager noted that some RRSP consumers needed more intensive support than they had received prior to integration. Another said there had been insufficient case management of RRSP consumers prior to their transition into CLS-HASI. One CMO manager said they used RRSP funding to increase the casual staff pool for low to medium support hours.

Most CMOs and consumers in the fieldwork sites said the aims and operations of the RRSP, CLS and HASI programs were similar and they did not experience much difference between them.

2.10 Consumer exits from the programs

Some of the reasons consumers exit CLS-HASI include and are not limited to:

- they no longer need the support and have achieved their goals
- the support is insufficient to meet their needs
- long term readmission to hospital

- the consumer chooses to no longer receive support (**Appendix 9**).

Program guidelines ask CMOs to ensure that people have adequate support from other sources when they leave the programs.

This section reports on the number of consumers who exited CLS-HASI, the reasons for exit and what support consumers had after CLS-HASI. It then summarises the experiences that consumers and CMOs had with exiting.

2.10.1 Exit numbers and exit reasons

During the evaluation, 1,872 consumers exited the programs. 38 of these consumers exited a second time after re-entering the programs. Most exits (73%) were planned. A planned exit was the outcome of the consumer’s recovery process and a transition plan. Unplanned exits were sudden and did not include a transition plan.

The reasons for exiting CLS-HASI were most often reduced support need (48%), moving to another long term program including the NDIS (16%) or relocating (11%) (**Table 11**, upper section). Responses for ‘other’ reasons (23% of exits) were often that the consumer disengaged from the programs or were in hospital.

From May 2019, the MDSV2 introduced new exit reasons. The most frequently observed were (**Table 11**, lower section):

- exiting on own request with no alternative arrangement (23%)
- exiting to alternative lower intensity arrangement (14%)
- support needs reduced with no alternative arrangement (12%).

Table 11: Reasons for exiting CLS-HASI

Reason for exiting – MDSV1	Consumer (n)	Consumer (%)
Consumer no longer needs support	714	47.80%
Other	341	22.80%
Consumer moved to other long-term support program	240	16.10%
Consumer relocated	158	10.60%
Consumer moved to other provider	73	4.90%
Consumer deceased	29	1.90%
Total MDSV1	1,495	
Reason for exiting – MDSV2	Consumer (n)	Consumer (%)
Exited on own request - no alternative support	88	23.30%
Other	57	15.10%
Exited to alternative community support – lower intensity	53	14.10%
Support needs reduced – no alternative support	46	12.20%
Exited to alternative community support – higher intensity	45	11.90%
Relocated – alternative support arrangements	19	5.00%
Relocated – no alternative support arrangements	18	4.80%
Admitted to hospital (mental health related)	17	4.50%
Missing/lost to care	16	4.20%
Died (reportable death)	11	2.60%
Other – less than 5 responses each	14	3.70%
Total MDSV2	377	
Total exits	**1,872**	

Source: CLS-HASI MDSV1 and MDSV2 to September 2019, n=5,533

Note: Minor differences in MDS totals due to consolidation of exits across support periods

The additional exit reasons in the new MDSV2 showed that most consumers still exited with reduced support need. 12% exited to higher intensity support, and 5% were admitted to mental health hospitals. The new exit reasons also included breaching community correction orders including parole, return to prison and new criminal charges resulting in custody. Neither of these reasons were reported for any exits since the new MDSV2 started in May 2019.

2.10.2 Consumer support after exit from CLS-HASI

Of the consumers who had exited the programs by April 2019, one third needed no further support (**Table 12**, upper section). The NDIS was the exit destination for 18.4% based on MDSV1. Smaller proportions had support through their GP, a

Private Health Network (PHN) funded service or a private psychiatrist. Exit destinations reported as ‘other’ were descriptive text. The most common ‘other’ exit destinations were a community mental health team (8% of ‘other’), followed by hospital support (3%) and aged care (2%).

Table 12: Primary support after exit from CLS-HASI

Exit destination – MDSV1	Consumer (n)	Consumer (%)
Other	500	34.40%
No service	497	33.20%
NDIS	275	18.40%
General Practitioner	141	9.40%
PHN-funded service	77	5.20%
Private psychiatrist	35	2.30%
ACCHO	6	0.40%
Total MDSV1	1,495	
Primary support following exit – MDSV2	Consumer (n)	Consumer (%)
Other	81	21.50%
NDIS funded provider	79	21.00%
No service	54	14.30%
General Practitioner	50	13.30%
Unknown	41	10.90%
Family support	19	5.00%
PHN-funded service	17	4.50%
Mental Health Inpatient	17	4.50%
Specialist aged care service	6	1.60%
Other – less than 5 responses each	20	5.30%
Total MDSV2	377	
Total exits	**1,872**	

Source: CLS-HASI MDSV1 and MDSV2 to September 2019, n=5,533

Notes: Minor differences in MDS totals due to consolidation of exits across support periods

PHN= Private Health Network, ACCHO= Aboriginal Community Controlled Health Organisation

From May 2019, the new MDSV2 added exit destinations and reworded the item to ‘primary support following exit’ (**Table 12**, lower section). The responses covered a shorter timeframe but showed increasing post program support through the NDIS at 21% (from 18%).[35] The new MDSV2 data showed a decrease in consumers exiting

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[35] MDSV2 reworded “NDIS” to “NDIS funded provider”

with no service to 14% (from 33%). GP support increased to 13%. New categories showed primary support through family (5%) and admission to a mental health hospital (5%). The main ‘other’ exit support categories were community mental health (9% of ‘other’) and home (8%).

2.10.3 Exit experiences

A few consumers in the interviews spoke about leaving the CLS-HASI programs. Some said CLS-HASI support increased their independence so that they would need less support in the future. Some consumers envisaged that NDIS support would either replace or reduce the CLS-HASI support they were receiving. Most consumers interviewed did not seem aware of whether or how their support plans were working towards exiting CLS-HASI. Some CMO staff asked interviewers not to raise exiting with particular consumers as the staff had not had a chance to talk with the consumer about exit.

CMOs in the fieldwork sites generally said they developed program exit strategies together with the consumer, as part of their recovery focus. LHD managers said it helped exit planning if the consumer was aware of the goal to exit from their commencement in CLS-HASI. By the second round of fieldwork, CMO staff mentioned the NDIS as a new, additional pathway to exiting CLS-HASI (**Section 3.9.1**). This was especially so for some consumers with lower psychosocial support needs.

Some CMOs did not feel they had a say in deciding to transition consumers out of the programs. For example, the process in one LHD was that when a consumer was discharged from the community mental health service, they were automatically also discharged from CLS-HASI. CMOs saw this as a risk for the consumer’s wellbeing, as the consumer might continue to need psychosocial support from the CMO.

There seemed to be some barriers to exits when the consumer is ready to leave. CMO and LHD managers in the focus groups saw a shortage of suitable support services, such as NDIS, as the main barrier to timely exits. If consumers were in unstable or unsuitable housing, the shortage of housing was also a barrier to exit.

Similarly, a CMO manager said that exiting was hampered in regional areas by limited alternative support services. Both LHDs and CMOs expressed a lack of trust that other programs, including the NDIS, could adequately support consumers with severe mental illness. One CMO noted that in areas where LHDs had highly formalised exiting processes, there were fewer exits overall. Both CMOs and LHDs said that due to these barriers to exit, consumers either stayed in the programs longer, or they left and risked isolation and relapse.

A CMO consideration with exits concerned program funding and management. Some CMO managers felt they needed to maintain steady consumer numbers to have sufficient funds. Therefore they might be reluctant to exit consumers unless they were immediately replaced (**Section 3.5**). The Ministry stated that these were misconceptions: CMOs were block funded each year with a set amount as defined at the beginning of the funding agreement. Performance benchmarks were in place, but funding was not reduced if the benchmarks were not met.

2.11 Program data and reporting

The reporting of CLS-HASI program data consists of three components: Minimum data set (MDS), service reporting and annual program reports (**Appendix 9**). CMOs also provide financial acquittals and reportable incident reports to the Ministry.

The Ministry introduced a revised version of the MDS in May 2019. The revisions responded to issues identified in the Ministry and early phases of this evaluation. For example, the revised MDS includes:

- mandatory reporting of most fields in the dataset
- reworded and new responses across many data items, including: exit reasons, primary support following program exit, sources of referral, support types, diagnoses and NDIS related content
- reworded and new responses for housing status and accommodation type
- whether consumers received individual or group support
- the Living in the Community Questionnaire (LCQ) as a comprehensive outcome measure. It replaced several measures that were not collected consistently.

At the time of this report, the Ministry said it continued to work with CMOs to improve the accuracy of the data collected. The Ministry anticipated that accuracy would further improve when its new data dictionary was released.

In the state-wide focus groups for this evaluation, most LHD and CMO managers said they would like more data to inform program planning and development. CMO managers felt that the revised MDS would contain some of that data. LHD and CMO managers said they would prefer it if data collection emphasised outcomes for consumers rather than outputs, such as contact hours delivered. They felt outcome data would be more useful for working towards recovery.

LHD managers raised several issues about program monitoring. On each of these issues, the Ministry had a different understanding to the LHDs. The issues and viewpoints were:

- Some LHD managers expressed concern that the Ministry used consumer exit numbers as a measurable outcome of CLS-HASI. They argued that exit numbers may be lower than expected because some consumers had ongoing support needs. Therefore they would exit the programs only if similar support were offered in another, long-term program. Otherwise they would stay with CLS-HASI. From the Ministry's point of view, exit numbers were not a measurable outcome.

- Some LHD managers were concerned that the change from monthly to quarterly reporting in the new MDS[36] meant that the data were of limited value because they were not current. The Ministry stated that LHDs received monthly reports as well as quarterly reports. The MDSV2 still had monthly reporting. The Ministry was working on an online App that would allow LHDs to access the most up to date data. This has been in development since 2019.

- Some LHD managers said they would like to receive ongoing MDS data about program vacancies and other service delivery issues, such as low staffing or staff vacancies. The Ministry advised that staffing was not covered in the MDS.

- Some LHD managers also said they would like to receive data specifically about their local area. According to the Ministry, all reports sent to LHDs were tailored to their local area. The Ministry shared whole-program data with the LHDs but it did not share specific information about another LHD.

These differing interpretations suggest more work is needed to improve common understanding of what is measured and for what purpose. Some LHD managers suggested creating a platform to share information and records in real time.

Some CMO managers commented on the Camberwell Assessment of Need Short Appraisal Schedule (CANSAS)-P. This is a consumer self-rated tool for assessing health and social needs. From 2019, the CANSAS was no longer mandatory. Some CMO managers said this was a shame. They felt the CANSAS had generated useful data that the mandatory Living in the Community Questionnaire (LCQ) did not deliver. The Ministry noted that the LCQ was introduced as a mandatory instrument after consultation with CMOs and LHDs.

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[36] This is separate to CMO reporting.

In the fieldwork sites, one CMO mentioned that their organisation had a system in place to monitor staff to complete the needs and wellbeing assessments – such as CANSAS and LCQ – together with consumers. The system also monitored that these assessments were uploaded into the MDS.

There were no comments from the fieldwork about other elements of service reporting or annual program reports.

3 Outcomes for CLS-HASI consumers

This section reports evaluation findings about intended program outcomes for CLS-HASI consumers. Program outcomes were identified by the Ministry. There was no program logic available for the evaluation. Findings are based on the qualitative interviews and focus groups, as well as MDS and linked outcome data. The second round of fieldwork offered more evidence of program outcomes than the first round. In the first round, the evaluators had purposely interviewed consumers who had recently entered CLS-HASI.

The data linkage had statistically significant[37] findings across most outcomes and for many consumers. The linkage data were analysed for all consumers together and for subgroups with different demographic characteristics. The subgroups were: gender (men and women), age, CLS-HASI level of support (low, medium, high) and Aboriginal/non-Aboriginal. Often the differences between the subgroups and the entire sample were small. Large differences are mentioned in the text below.

Better integrated care is one of the intended outcome of CLS-HASI. The evaluation had no comparative data about integrated care from before or after consumers were in the programs. Evaluation findings about integrated care are process, not outcome related. They are reported in the sections about program partnerships (**Section 3.1**) and referrals (**Section 3.3**).

3.1 Mental health and wellbeing

A key objective of CLS-HASI is to improve consumers’ mental health and wellbeing. This section reports findings of how well the programs have achieved this goal. It contains experiences from the fieldwork alongside indicators of mental health recovery from the data linkage. The findings show that, overall, mental health improved in CLS-HASI.

3.1.1 Wellbeing and support needs

Most consumers in the interviews clearly stated that participating in CLS-HASI had a positive effect on their wellbeing. It had enabled them to manage their mental health challenges better. Here are a few of many examples:

> I know my case worker. I could ring her up if I'm having a real downer and she'll have a chat to me. (Consumer)

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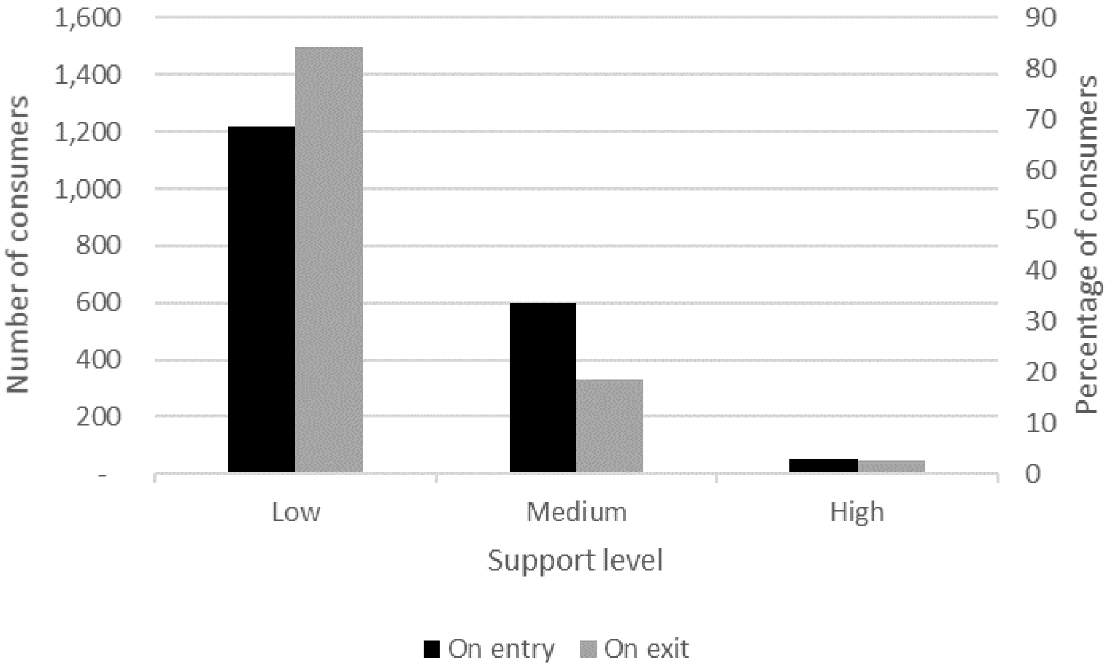
[37] see **Error! Reference source not found.**

> I think positive a lot more than I used to, [my CLS-HASI workers] got me thinking positive. If something's negative, get out the back, cut a tree, get out, run around with your dog. Get that thought out of your head. And I do that one out of three times now, as before I'd never do it. (Consumer)
>
> [My CLS-HASI support workers are] very good at encouraging me to do things, but making me feel what I am doing is a good thing and making me feel almost normal, I suppose. When I'm not feeling great, they're still very supportive and very encouraging. (Consumer)
>
> I'm so happy with HASI - it's changed my life. (Consumer)

Similarly, LHD and CMO managers and stakeholders in the statewide focus groups made consistent positive comments about CLS-HASI's psychosocial support. Some LHD managers said it was the greatest strength of the programs. All LHD managers felt that CMOs were effectively meeting psychosocial support goals. CMO managers said that the effectiveness of psychosocial support in CLS-HASI was particularly evident where consumers with high support needs had transitioned to lower-support situations. They said this indicated progress towards recovery goals and living more independently.

The MDS data support the fieldwork findings. They show that the support level reduced for many consumers during their time in CLS-HASI (**Figure 5**). These data are from the 1,872 consumers who entered and exited the programs during the evaluation. About 600 of these consumers had medium-level support when they entered the programs, and by the time they left, almost half of these 600 had moved to low-level or no support. Therefore, the number of people on low-level support increased from about 1200 on entry to almost 1500 when they exited CLS-HASI. The number of people on high-level support remained at about 50 from entry to exit. **Section 3.5** explains support level categories.

Figure 5: CLS-HASI support level on entry and exit to CLS-HASI



Source: CLS-HASI MDS to September 2019, matched exited consumers n=1,872

In the fieldwork, it was obvious that consumers gained more independence and wellbeing between the first and second rounds of fieldwork. For example, during the first visit at one site, consumers who came for the interviews waited outside the building by themselves. In the second round, they sat in the common room, had morning tea and chatted with each other before and after the interviews.

Success factors

Interview participants mentioned a range of factors that enabled improvements in consumers' mental health and wellbeing in the programs.

Consumers felt it helped their recovery when they had consistent support staff over time. They could form trusting relationships and feel safe. A frequent theme in the consumer interviews was the grief and loss they experienced when long-term staff left. They also felt upset, abandoned or disoriented when CMO staff changed frequently. There was not enough data to explain why staff turnover seemed high in some areas.

CMO managers cited a range of program characteristics that were critical to achieving the consumers' recovery goals. Characteristics included that CLS-HASI were evidence-based; consumer-centred and directed; and able to manage mental illness relapses.

CMOs and LHDs generally agreed that CLS-HASI filled a gap in the system, as it offered short and mid-term support for consumers with severe mental illness. One CMO manager described CLS-HASI as a stepping-stone to independence:

> [For the consumer] just to understand what recovery is. Understand what your mental illness is. How do I cope, what stresses me out? How do I manage my stresses? Who are my supports? Where do I go to if I need help? (CMO manager)

One CMO manager noted that a strength of CLS-HASI programs was giving in-home intensive support. This type of support was not usually offered in other community-based mental health programs. Implied in this comment was that in-home support allowed workers a first-hand insight into how well the consumer was faring. One LHD manager noted the importance 'of early detection of deterioration of health … for quick intervention'.

Both CMO and LHD managers felt strongly that the partnerships between CMOs, LHDs and the Ministry were essential to achieving positive psychosocial outcomes for CLS-HASI consumers (**Section 3.1**). One CMO manager commented that:

> [The partnerships have] been able to … refine and drive the changes that are necessary ... And examples would be that we've had people referred to the programs, both HASI and CLS … who had previously spent long times in hospital, sometimes in excess of 10 years, and since then those people have moved on to much lower support. Their levels of support are right down, indicating that they have progressed in their recovery journeys and [are] living far more independently. (CMO manager)

Some LHD managers said that CMOs were skilled at connecting with other services. This included mainstream medical services and the NDIS.

3.1.2 Mental health outcome scores

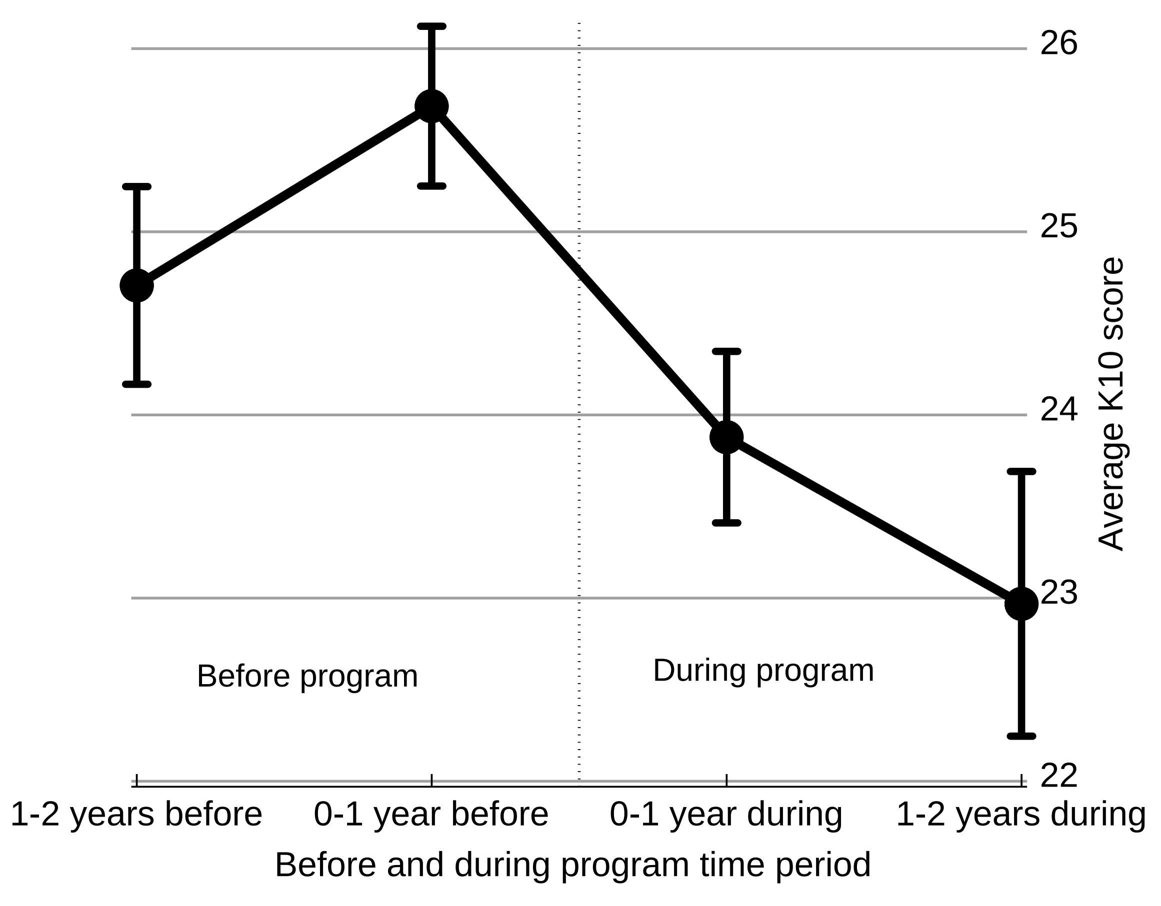
This section reports mental health outcomes from the NSW Mental Health Outcomes and Assessment Tools (MHOAT) database. Consumer outcomes were available from different measures, also called scales. These scales are the Kessler 10 (K10), the Health of the Nation Outcome Scales (HoNOS) and the Life Skills Profile-16 (LSP-16). The findings were for people who had a measure before and during their time in CLS-HASI. There were not enough data available to make statements about people who exited CLS-HASI, as MHOAT reporting is undertaken while consumers have mental health support.

Kessler 10 (K10)

The Kessler 10 (K10) survey is often used in Australia to assess people's psychological distress (Kessler et al., 2003). The K10LM (last month) uses 10 questions and a five-level response scale for each question: 1 is the minimum score (not experienced in the last month), and 5 is the maximum score (always experienced in the last month). This has a minimum possible score of 10 and a maximum possible score of 50 (Australian Bureau of Statistics, 2007-08).

30% of consumers had a clinically meaningful improvement in mental health measured by K10 based on effect size (Table 1 in **Appendix 10**).[38] About 17% had marginally worse levels of psychological distress. For the remaining 53%, scores improved but not enough to be clinically meaningful. The results were consistent across subgroups and showed a higher 37% proportion of clinically meaningful outcomes for younger 19 to 24 year consumers.

Figure 6: Average K10 scores per person



Source: CLS-HASI linked NSW Mental Health Outcomes and Assessment Tools (MHOAT), n=1,579
Notes: Average K10 scores per person per year, before and after program entry with 95% confidence intervals shown as vertical bars.

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[38] Effect size is a statistical measure that emphasises the size of the difference. It indicates the practical significance of a research outcome. A large effect size means that a research finding has practical significance, while a small effect size indicates limited practical applications.

K10 scores of CLS-HASI consumers show that consumers' levels of psychological distress decreased by an average of 1.8 points in the year after program entry, from 25.7 to 23.9 points. This decrease is statistically significant ($p<0.001$, n=1,579), **Figure 6**. For those who stayed in the programs longer than 1 year, the average K10 score fell further to 22.9.[39]

Most demographic subgroups (age, support level and Aboriginal status) had similar K10 scores and improvements. They scored between 24.0 and 27.0 before entry, and between 22.3 and 25.0 after entry (**Appendix 10**). The largest difference within subgroups was between men and women. Women had higher levels of psychological distress than men, both before and after program entry. Both genders showed statistically significant improvement after joining CLS-HASI. Among the age subgroups, the youngest consumers aged between 19 and 24 years improved the most, from 27.7 to 24.1.

Health of the Nation Outcome Scales (HoNOS)

The Health of the Nation Outcome Scales (HoNOS) are about consumer mental health rated by a clinician. HoNOS has12 items across four domains – behaviour, impairment, symptoms and social functioning. For example, HoNOS asks whether the person has problems with drinking or drug taking, or whether they have problems with relationships. Each item has a 5-point scale, where 0 means low and 4 means high. Therefore, a lower HoNOS score means better outcomes than a higher score.

Consistent with the K10 improvement, one third of consumers (33.1%) had a clinically meaningful improvement in mental health measured by HoNOS based on effect size. These positive results are similar to the previous HASI evaluation, which reported improvement in the average HoNOS score of 1.0 and 34.3% of consumers having a clinically significant improvement based on effect size (Bruce, Mc Dermott, Ramia, Bullen, & Fisher, 2012).

Consumer average HoNOS scores improved in the first year following entry to CLS-HASI by 0.8, dropping from 10.6 to 9.8 (**Figure 7**). This is a statistically significant improvement ($p<001$, n=2813). The improvement remained for those who stayed in CLS-HASI longer than one year, at an average score of 9.9. There were no marked differences among subgroups, and detailed findings are in **Appendix 10**.

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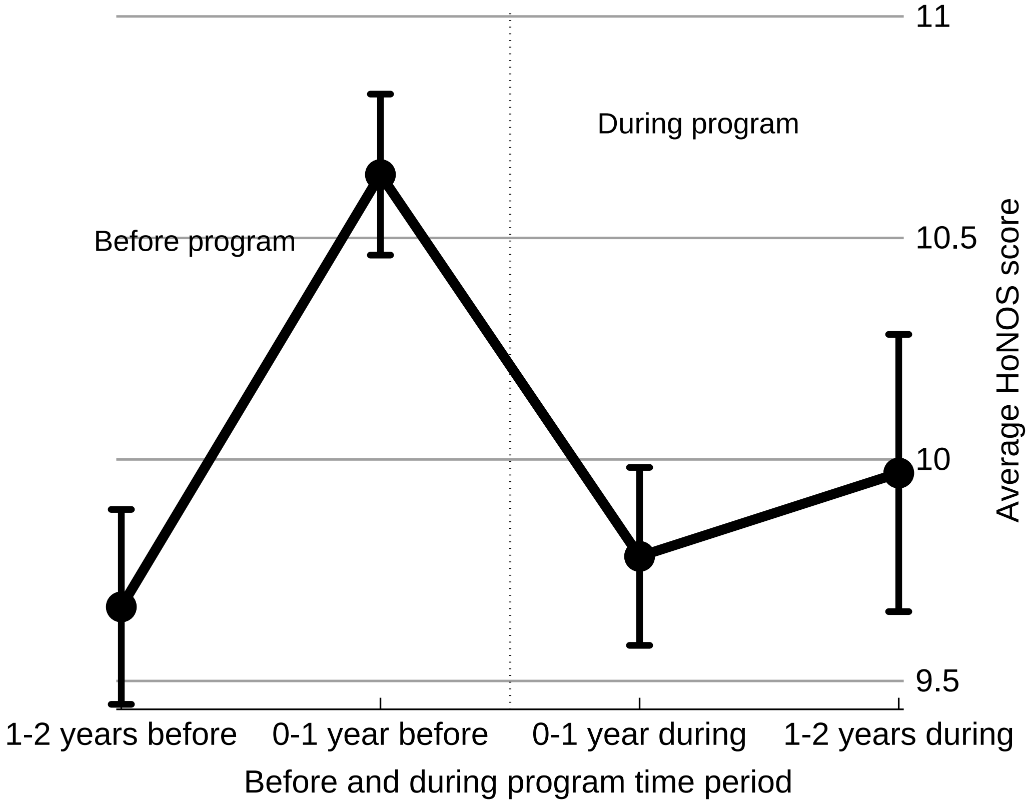
[39] Repeated measures for same consumers, excluding consumers who did not have at least one K10 score before and after entry to the programs.

Figure 7: Average HoNOS scores per person



Source: CLS-HASI linked NSW Mental Health Outcomes and Assessment Tools (MHOAT), n=2,813
Notes: Average scores per person per year before and after program entry with 95% confidence intervals shown as vertical bars.

Life Skills Profile-16 (LSP-16)

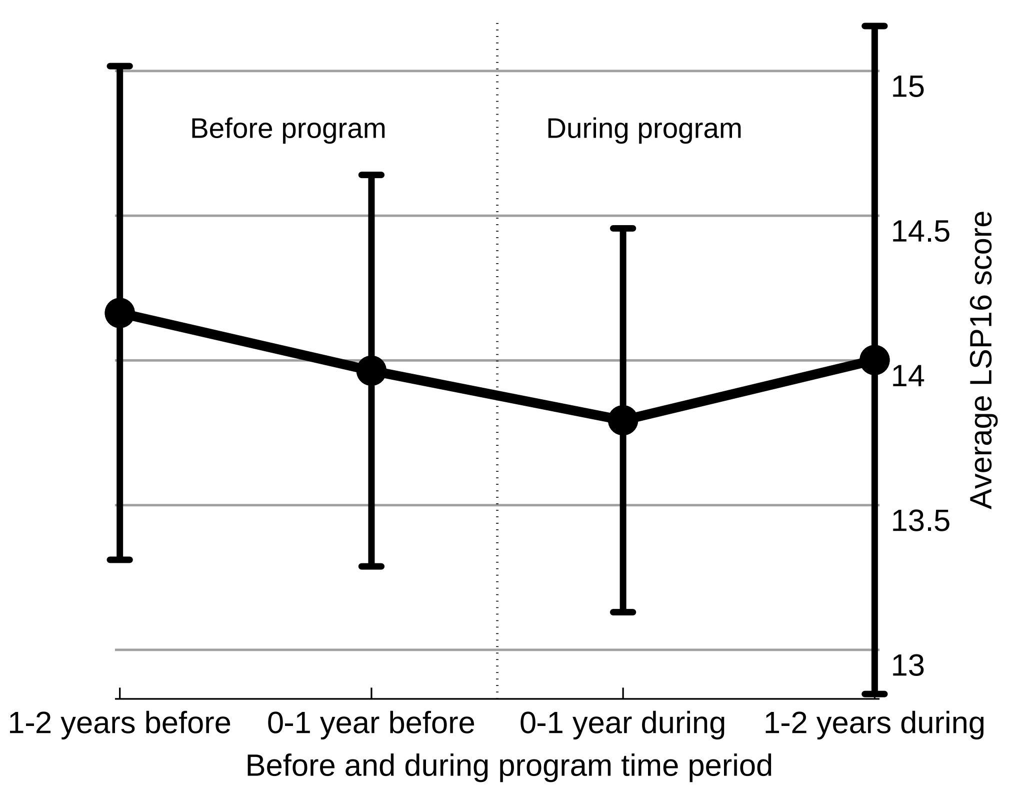
The Life Skills Profile-16 (LSP-16) measures a consumer’s general functioning in life. 16 items are rated by a clinician about a consumer, covering social behaviour and selfcare. For example, the LSP-16 asks whether a person keeps up friendships and whether they generally clean their clothes. Answers are on a four-point scale – 0, 1, 2, 3. Higher scores indicate a higher degree of disability. A total LSP score has a possible range from 0 to 48. Items with missing data are excluded from the calculation.

The LSP data show a low number of responses at entry to CLS-HASI. The missing data restricted the analysis of the before and after comparison of outcomes. LSP scores were measured at entry for less than 1% of consumers compared to about 43% for K10 and 38% for HoNOS.

From the available LSP scores, the slight improvement from 14.0 in the year before program entry to 13.8 in the year following entry was not statistically significant and highly variable, with a standard deviation of 7.1, **Figure 8**. The previous HASI evaluation reported a similarly high variation in LSP average scores of 6.6, (Bruce et al., 2012).

Men had higher (poorer) LSP scores before and after entering the programs. This is the reverse of results for the K10, where men had lower scores before and after entry. The same pattern was reported in the previous HASI evaluation and in other Australian research (Bruce et al., 2012; Eagar, Trauer, & Mellsop, 2005).

Figure 8: Average LSP scores per person



Source: CLS-HASI linked NSW Mental Health Outcomes and Assessment Tools (MHOAT), n=1,510
Notes: Average scores per person per year before and after program entry with 95% confidence intervals shown as vertical bars.

3.1.3 Accessing community mental health services

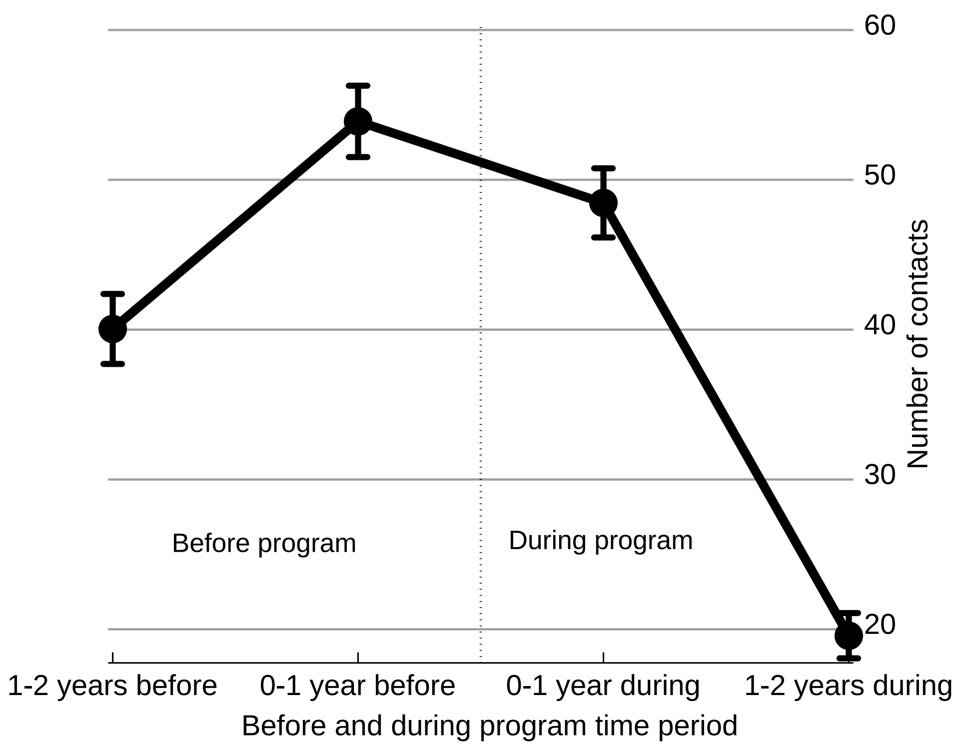
The Ministry's Mental Health Ambulatory data set (MH-AMB) shows how many community mental health services CLS-HASI consumers used before and after entry to the programs. Community mental health services were a range of types, Table 4 in **Appendix 10**:

- acute clinical services – about 20% of community mental health services that CLS-HASI consumers used
- extended clinical services – about 25%
- rehabilitation – about 20%
- the rest were assessment, early intervention, emergency and others.

The number of times a consumer had contact with community mental health services decreased slightly in the first year after entering CLS-HASI by 5.4 contacts (10%), **Figure 9**. In contrast, the previous HASI evaluation showed an increase in contact in the year following program entry (Bruce et al., 2021).

In this evaluation, consumers who remained in CLS-HASI longer than 1 year had much less contact with community mental health services than before they entered the programs (63.7%, or 34 fewer contacts, a drop from 53.9 to 19.6 contacts). The decrease may reflect mental health recovery and less need for support, consistent with **Section 4.1.1**.

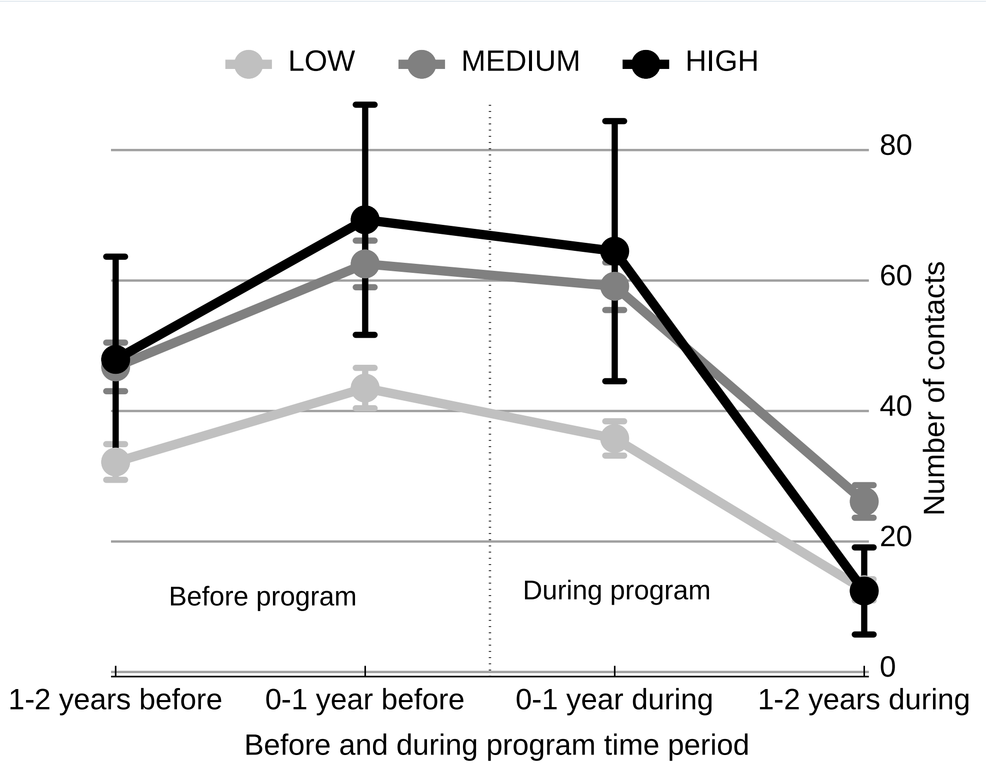
Figure 9: Average community mental health service contacts per person



Source: CLS-HASI linked NSW Mental Health Ambulatory Data Collection. n=3,052
Note: Average contacts per person per year, before and after program entry with 95% confidence intervals shown as vertical bars.

Among the consumer subgroups, consumers with high and medium-level support needs (**Section 3.5**) had more frequent contact, **Figure 10**. They also had the biggest drop in accessing community mental health services following program entry. In year 1 after entering CLS-HASI, contacts of high and medium-level consumers were similar to before the program, while contacts of low-level support consumers reduced by about 8 service contacts per year from 44 to 36 or 18%, which is statistically significant. In year 2 in the programs, high and medium-level support consumers had larger decreases than the total consumer group.

Figure 10: Average community mental health service contacts by support level



Source: CLS-HASI linked NSW Mental Health Ambulatory Data Collection. n=3,052
Note: Average contacts per person per year, before and after program entry with 95% confidence intervals shown as vertical bars.

After consumers left CLS-HASI, their contacts with community mental health services remained as low as at the time of exit (**Appendix 10**). This indicates that recovery was sustained beyond taking part in the programs, although with increasing uncertainty and not a further statistically significant change.

3.2 Physical health

Improved physical health is an intended program outcome for consumers. The Ministry expects CMOs to include physical health in Individual Support Plans. CMOs should then support consumers to access physical health assessments and activities (**Appendix 9**).

Some data were in the MDS about consumers’ physical health but no linkage data. The MDS data show risk factors for physical health. These data were only for while consumers were in the programs, not before or after. During the time in the programs, there was no notable change in consumers’ risk factors. **Section 2.6** shows that the main risk factors were smoking and drug or alcohol. The previous HASI evaluation reported that measures of physical health did not improve during the program (Bruce et al., 2012).

In the fieldwork sites, CLS-HASI offered a range of supports to enhance consumers' physical health. For example, CMOs:

- supported consumers to find affordable gym memberships
- supported cooking and shopping with a focus on healthy eating
- encouraged consumers to go for walks or organised walking groups
- supported visits to GPs and dieticians
- encouraged ageing consumers to keep mobile.

Here are examples of positive consumer and staff comments about physical exercise, addictions and diet.

> HASI have just changed my life. They take me out nearly every day exercising, which was one of my main goals was to get back into being healthy again. They gave me a membership with a gym and a pool to swim. They come to my place, they help me cook meals, they show me how to cook meals. They take me on group walks on the weekends and stuff. (Consumer)
>
> They help me, they support me with the smoking and the drinking and the gambling. They always praise me when I am not doing it. (Consumer)
>
> I'm finding diabetes is a major thing with our consumers, so helping encourage them to make healthy choices. I've taken people to dieticians and stuff, and honestly, the information is overwhelming. So simplifying information that people can manage. (CMO staff)

Some CMOs used other skills of their staff for physical health improvement. For example, staff who were qualified as a personal trainer or yoga teacher offered such activities. A few providers had gym equipment on site that consumers could use. The focus on physical health activities appeared to increase in the fieldwork sites between the first and second round visits.

Interview participants mentioned some challenges to improving physical health. They included ageing, lack of money and consumers not feeling able to make changes:

> Diet food is very expensive. (Family)
>
> I've been trying to quit smoking but it's hopeless. It's hopeless. I've been a smoker for 50 years. (Consumer)

The evaluation had no quantitative or qualitative data about other aspects of health such as cancer screening, dentistry or optometry.

3.3 Social inclusion

One of the central aims of CLS-HASI is to support the social inclusion of consumers so they can live and participate in the community in the way they want to. How CLS-HASI meets this goal is examined in one of the focus reports for this evaluation (**Appendix 2**). The data were analysed through the lens of the social inclusion framework developed by the Australian Social Inclusion Board (ASIB, 2012). The framework takes account of personal, community and structural influences on social participation. This approach is consistent with the United Nations' understanding of social inclusion 'as the process of improving the terms of participation in society, particularly for people who are disadvantaged, through enhancing opportunities, access to resources, voice and respect for rights' (United Nations 2016).

The focus report used the elements of social inclusion according to the framework – engage, learn, work, have a voice – to structure the findings and implications for the CLS-HASI programs. Data came mostly from the fieldwork. There was little MDS or linkage data about social inclusion.

In summary, most CLS-HASI consumers had great capacity to increase their social inclusion when they had appropriate support. A key to improving social inclusion was the relationship with the CLS-HASI support worker. Once the consumer had built trust with their support worker, they often also engaged with other people and with services. Consumers also then participated in more decisions about their lives. Few consumers took part in formal learning and work. They might choose such activities later in their recovery. Key findings from the focus report are below, and the implications of the findings are in the focus report.

3.3.1 Engagement

Among the four domains in the framework, engagement seemed the most prominent for CLS-HASI consumers. How consumers engaged depended on the resources that they could draw on. The resources, also called capital, were economic, human, social and cultural capital. CLS-HASI supported consumers to increase their engagement. Consumers with high support needs generally had more hours of support than other consumers for transport.

Economic capital

Economic capital that CLS-HASI consumers could draw on was financial resources, housing and transport.

Consumers said that having little money limited their social participation, like going out or visiting people. CMOs organised free social activities and advocated for consumers with Centrelink to receive the financial support they were entitled to.

Most interviewees viewed housing as the basis of improved social inclusion. Feeling secure in their home made consumers feel safe to leave their home and engage in activities, such as social outings. CMOs supported consumers to obtain or maintain housing, although the shortage of suitable housing was a challenge. Living away from towns and services restricted consumer access to social activities. One CMO established a remote support worker role to address this need.

Consumers said that transport offered by their support workers increased their social participation. They could go shopping, visit friends and attend appointments. Some consumers worked towards using public transport, but outside towns public transport was often not available. Consumers with higher overall support needs had more transport support than other consumers.

Human capital

Aspects of human capital that were important for social inclusion were mental and physical wellness, knowledge of social services and relationships with family and friends.

Many consumers said their mental and physical wellness had increased since joining CLS-HASI. Consumers could contact their support workers during a mental health crisis. Consumers also said the support workers helped them pursue their physical health goals. Many consumers said that without the emotional support from their workers they may have disengaged from the program.

Consumers’ access and knowledge of social services had increased. This improvement was because support workers gave consumers information on what services were available. Support workers also offered training and practical support to facilitate access. This included support to obtain necessary paperwork such as birth certificates and other forms of ID.

Reconnecting with family and friends seemed to be a key activity of CLS-HASI. Success often came when the consumer had stable housing and mental health in CLS-HASI. Stakeholders suggested that giving families more information about mental illness helped to re-engage with families. Support workers encouraged consumers to engage socially. Some consumers had made friends through CLS-HASI activities. Consumers with high support needs received more support hours to reconnect with family than other consumers.

Social capital

CLS-HASI consumers gained social capital through engaging with other consumers and the wider community, with support workers, with the CMOs and with the wider health and social service system.

CMOs developed flexible and creative ways to support consumers to make social connections, both in CLS-HASI activities and in community groups. For example, support workers attended services and social engagements together with consumers until consumers felt confident to attend on their own. By accompanying consumers, support workers were also able to inform people in the wider community about mental illness and respectful support. This indirect community development may help to reduce stigma and discrimination of other consumers. Consumers with high support needs had more support than other consumers to increase their social capital, such as to access recreational and social activities, other support systems and medical appointments.

Consumers said that developing trust in the relationship with their support worker was essential to their social engagement. The factors that contributed to a mutually positive relationship were:

- professional skills supporting consumers’ mental health and wellbeing
- lived experience of mental illness, trauma or life events
- consistency and longevity in the relationship.

The consumer experience of CLS-HASI support affected their social participation. Positive experiences happened where CMOs were welcoming, reliable and located within easy access of consumers, and when the CMOs managed transitions between organisations well. Drop-in activities and services increased consumer engagement with the CMO.

Most consumers found that their support worker helped them to stay engaged with health and social services and to continue with their mental health plan. Workers also supported the consumers to coordinate their various service providers.

Cultural capital

In the fieldwork, cultural capital examples mostly related to Aboriginal consumers. Aboriginal consumers had varied connections to Country and their mob, and most said they had been offered support to make a connection. The MDS data confirm that CMOs spent about 1 hour of support per month for Aboriginal community participation and Aboriginal cultural reference groups. Consumers and CMOs considered Aboriginal staff important to improve consumers’ cultural connections.

CMOs seemed to offer few specific activities or support for other cultural diversity among consumers, for example sexual preference and ethnicity. Many workers said they treated all consumers the same, that is they emphasised equality rather than equity. They said that few local opportunities for diverse activities were available in regional areas.

3.3.2 Learning

The second element of social inclusion is learning. Learning social skills and daily living skills seemed to be the main focus of learning in CLS-HASI. Few consumers were engaged in formal learning at TAFE or university. Learning social and daily living skills became the basis for many consumers to consider formal learning in the future.

Consumers learned social skills mainly in activities organised by CMOs. Activities included regular events like coffee clubs and drop-in activities. Learning daily living skills happened either one-to-one with a support worker or in organised classes like cooking or gym. Consumers with high support needs had a lot more support hours for learning social and daily living skills than consumers with low and medium needs.

A few consumers in the fieldwork attended TAFE or university, and many mentioned formal learning as a goal for the future or when they were well enough. Program data show that 3% of all consumers were in TAFE, university or other formal learning. CMOs spent about 1 hour of support per consumer per month for educational, vocational or work activities.

3.3.3 Work

About 1 in 10 consumers were employed, and another 2 out of 10 were looking for work. CMOs spent about 1 hour of support per consumer per month for educational, vocational or work activities. Program data also show that CMOs considered most consumers ’totally incapable of work’, or ‘capable only of sheltered work’ [40].

In the interviews, most consumers said they could not work, and their primary focus was managing their mental health. CMO support workers generally agreed. They thought that most consumers were too early in their recovery to work. Some consumers described barriers to work, like caring responsibilities, poor literacy and stigma.

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[40] LSP question 16: What sort of work is this person generally capable of (even if unemployed, retired or doing unpaid domestic duties)? Responses: 0=Capable of full time work, 1=Capable of part time work, 2=Capable only of sheltered work, 3=Totally incapable of work.

CMOs supported some consumers to find work, including open employment, supported employment and volunteer work. Some support workers discussed work as a recovery goal with consumers.

3.3.4 Having a voice

The fourth element of social inclusion is having a voice. Significant aspects of CLS-HASI consumers having a voice were deciding about their support and deciding about contact with family.

Most consumers felt they had a voice in deciding about their support and their life goals. They made decisions about their individual support plan, about changing CMOs, and about how they participated in program activities.

Their voice was stronger when they had support from family or their community, for example Aboriginal services and networks. Decisions about support to reconnect with family seemed to be guided by the consumer. CMOs were aware of complex family relationships.

Overall, many consumers felt their choices were respected. Having a voice helped them to achieve mental health recovery and social inclusion. A few consumers in the interviews felt they were not heard when they raised concerns or dissatisfaction about a service.

3.4 Reduced hospital stays

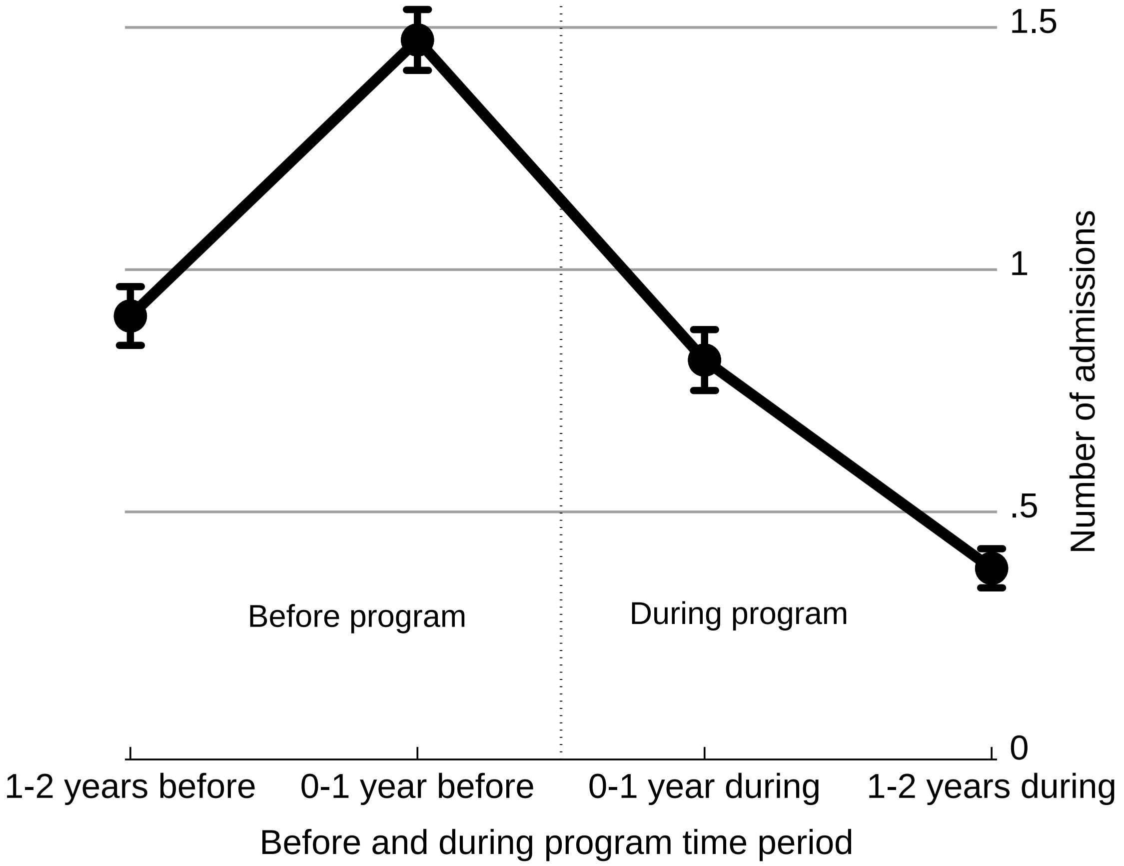
One of the intended outcomes of CLS-HASI is reduced avoidable hospital admissions and inpatient stays for mental illness. The data linkage and fieldwork indicate that CLS-HASI was successful in achieving this outcome. Improvements in emergency department presentations were similar (**Appendix 10**). Other inpatient admissions were few and the change was small.

In the interviews, many consumers, families and carers mentioned that the consumer had been ‘in and out of hospital’ for many years, but that most of them had been out of hospital since joining CLS-HASI. All CMOs in the focus groups said they had observed that CLS-HASI was effective in reducing hospitalisations. When consumers did have to go to hospital, both CMOs and LHDs reported that consumers tended to stay there for shorter periods than in the past.

These observations are reflected in the linkage data. Consumers’ hospital admissions due to mental health challenges dropped in the year after entering the programs by 44.8%, from 1.5 to 0.8 admissions per person per year. This drop was statistically significant ($p<001$, $n=3,338$). Year 2 showed a further 29.2% decrease.

This adds to a total decrease of 74.0% following program entry to 0.4 hospital admissions per year, **Figure 11**. This positive finding is similar to the previous HASI evaluations (Bruce et al., 2012; Muir et al., 2006). Among the consumer subgroups, women had slightly higher rates of hospital admissions than men, both before and after program entry.

Figure 11: Mental health hospital admissions per person



Source: CLS-HASI linked NSW Admitted Patient Data Collection (APDC) n=3,338
Note: Average admissions per person per year, before and after program entry with 95% confidence intervals shown as vertical bars.

A reason for reduced hospital admissions was that CMO staff in the fieldwork sites felt they could work together with consumers to recognise when they might become unwell. Staff then put supports in place to avoid relapse and hospitalisation. They also attempted to prevent and intervene early in relapses. It was part of the individualised psychosocial support (**Section 4.1**), which might include information about managing their mental illness:

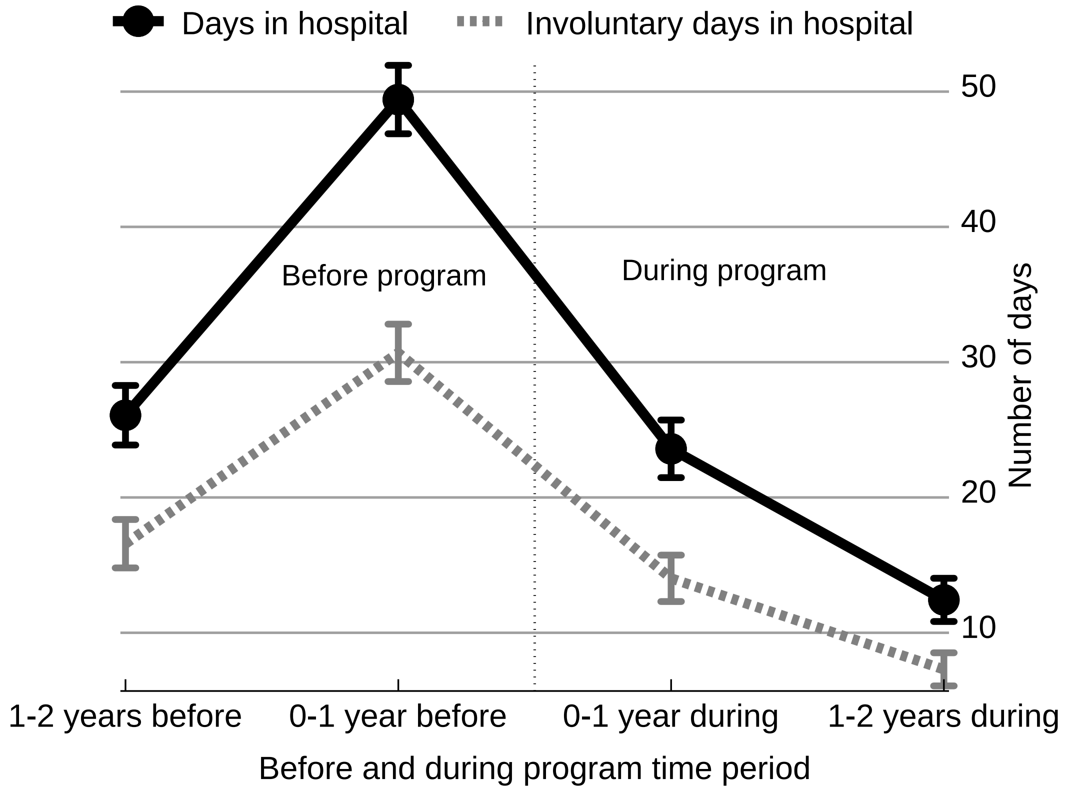
> [For the consumer] coming into HASI and … starting to understand, what are the things that make you become unwell? … What are some of the things that you can look for so you can act on them before you get too unwell and end up in hospital? (CMO manager)

Another factor that seemed to reduce hospital admissions was an effective partnership between the local LHD and CMO (**Section 3.1**). LHD and CMO managers in the focus groups all agreed that the closeness of their partnership was integral to success. A CMO said:

> We have an excellent relationship with the [local LHD] community team. It’s a phone call away … They do respond to that very, very promptly. (CMO manager)

When consumers were admitted to hospital due to mental illness, the average number of days in hospital decreased, **Figure 12** black line. The number of days fell by 52.2% per person in year 1 following program entry, from 49.4 to 23.6 days. This is statistically significant (p<0.001). The consumers who stayed in CLS-HASI into year 2 had a further 22.6% fewer hospital days down to an average of 12.4 days per person per year. This is a total decrease of 74.8%. The decrease is similar to findings in the previous HASI evaluation (Bruce et al., 2012).

Figure 12: Mental health inpatient days per person



Source: CLS-HASI linked NSW Admitted Patient Data Collection (APDC) n=3,338
Notes: Average inpatient days per person per year, before and after program entry with 95% confidence intervals shown as vertical bars.

The number of involuntary[41] days in hospital also decreased. Of the average 49.4 mental health hospital days in the year prior to program entry, 30.7 days were involuntary (62%), **Figure 12** dotted line. There was a significant decrease of 54.3% in year 1 following entry to the program from 30.7 to 14.0 days. Involuntary hospital days reduced a further 21.9% for consumers who stayed in the program into year 2. This represents a total decrease of 76.2% to 7.3 days per person per year.

When consumers did go to hospital, it seemed to help when CLS-HASI maintained contact while a consumer was in hospital:

> For example, we had a man from [town] that went into the inpatient unit in [another town], so [CMO] staff would go out and visit him every couple of days in the unit to keep that level of connection up with services … and then we were able to coordinate that for when he returned home as well, that [CMO] team came and picked him up from [hospital] … I'm a big fan of in-reach to hospitals. I think that works really well and helps people to know that there's someone on the outside. (CMO manager)

It appears that contact with the consumer while in hospital was more common in the second round of fieldwork. CMOs in the fieldwork sites reported they had developed closer partnerships with hospitals, visited the consumers regularly and saw in-hospital support as part of their role. They also reported better coordinated discharge planning than in the past.

The positive outcomes about mental health hospitalisation continued after consumers left CLS-HASI. The number of admissions remained as low as at the time of exit (**Appendix 10**). Average days in hospital also remained as low as at the time of exit and continued to drop slightly after leaving CLS-HASI, although with increasing uncertainty.

3.5 Safe and secure housing

The program aims about consumer housing are to reduce homelessness, find suitable housing and support stable tenancies for program consumers. Some HASI consumers also received support to access housing. Partnerships with DCJ (for public housing) and community housing providers supported CLS-HASI consumers who needed social housing. The evaluation found that the CMO and LHD relationships with housing providers, both public and community housing providers, were mostly informal (**Section 3.1**), with some formal committees (**Section 4.5.2)**. This section presents evidence from the fieldwork and data linkage with DCJ

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[41] Whole or part days that the person was an involuntary patient under the Mental Health Act.

Housing that CLS-HASI successfully supported consumers to access and maintain social housing. No data linkage was available about private rental or ownership.

3.5.1 Accessing housing

Some consumers in the fieldwork interviews described how CMOs had supported them to access housing:

> They helped me with housing too …Yeah, I applied for my housing, and I’ve just got to do my Aboriginality form to prove my Aboriginality, and that goes in, and then I’ve just got to wait on the list to get a house. (Consumer)
>
> Well, prior to [HASI] … I was homeless. (Consumer)

Housing applications

When consumers could afford private rental accommodation, they sometimes encountered stigma from landlords or agents because of their mental illness. CMOs in the fieldwork sites reported that they could sometimes address this barrier by explaining to the private rental agent the consumer’s situation and the support provided through CLS-HASI.

Similarly, CMOs, LHDs and stakeholders in the focus groups felt that CLS-HASI increased consumers’ ability to obtain social housing.[42] CMO managers said this was because they had established good partnerships with community housing providers. Some LHD managers felt that housing applications were more likely to be successful when LHDs used their influence through their partnerships.

The data linkage from DCJ Housing shows that CLS-HASI successfully supported consumers to access housing. About 28% of CLS-HASI consumers (1,539 consumers) had a change to their housing status once they entered the programs. Mostly they moved onto a housing waitlist or obtained housing, or both.

The number of consumers registered on housing waitlists following entry to CLS-HASI increased significantly. The number of DCJ Housing applications increased from 465 in the year before entering CLS-HASI to 711 in the year after entry. Another way to put this is the average number of housing applications per consumer increased statistically significantly in the year following entry to the programs, by 45.3% from 0.28 to 0.41 ($p<0.001$), **Figure 13**. Applications dropped sharply in year 2, possibly because most consumers who needed a housing application had submitted one in year 1.

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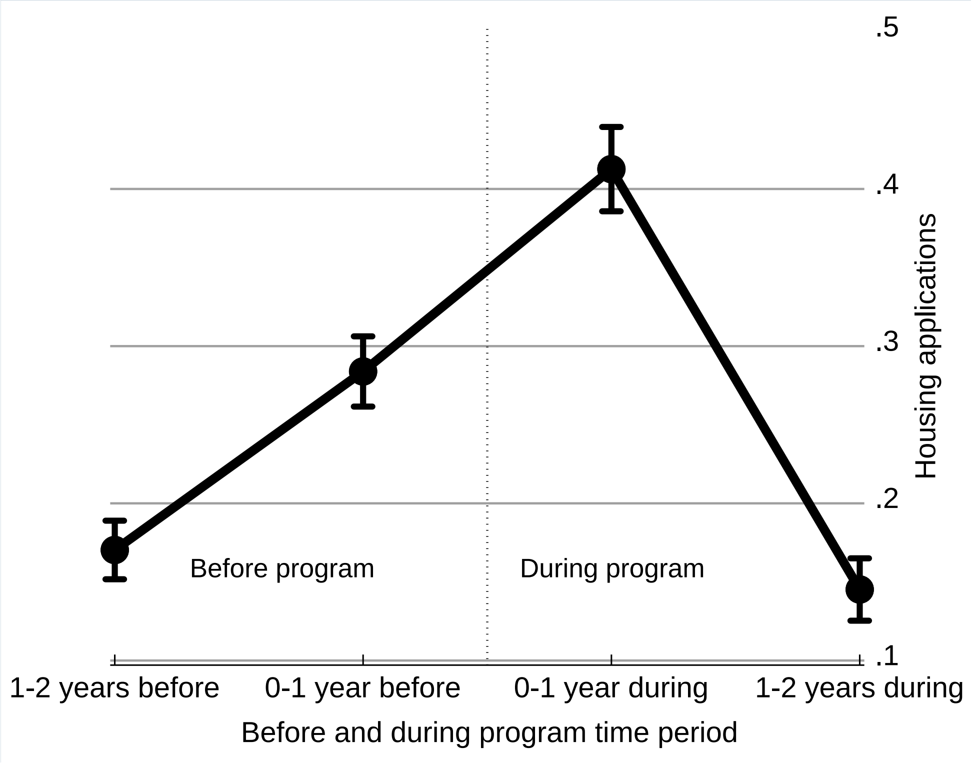
[42] Social housing includes public housing, community housing, Aboriginal public housing and Aboriginal community housing.

Figure 13: Average housing applications per person



Source: CLS-HASI linked NSW Department of Communities and Justice Housing. n=1,539
Notes: Average contacts per person per year, before and after program entry with 95% confidence intervals shown as vertical bars.

Among consumer subgroups, Aboriginal consumers' housing applications increased more than those of non-Aboriginal consumers, **Appendix 10**. In year 1 after entering CLS-HASI, the average number of applications from Aboriginal consumers went up from 0.26 to 0.49, and that of non-Aboriginal consumers went from 0.29 to 0.39.[43] Housing applications from high-level support consumers did not increase following entry to CLS-HASI.

The DCJ case studies of housing pathways demonstrate some good practice, showing the different ways CLS-HASI supported consumers to apply for housing. CMO staff worked with consumers to complete housing applications and to ensure that the required information was included in the application. CLS-HASI also supported consumers to make a case for special consideration, for example when they needed to stay in a particular area or needed a larger house. The DCJ case studies show that housing applications lapsed when the Department could not contact consumers. It might help if CMOs offered to be secondary contacts so that consumers would not miss out on housing offers.

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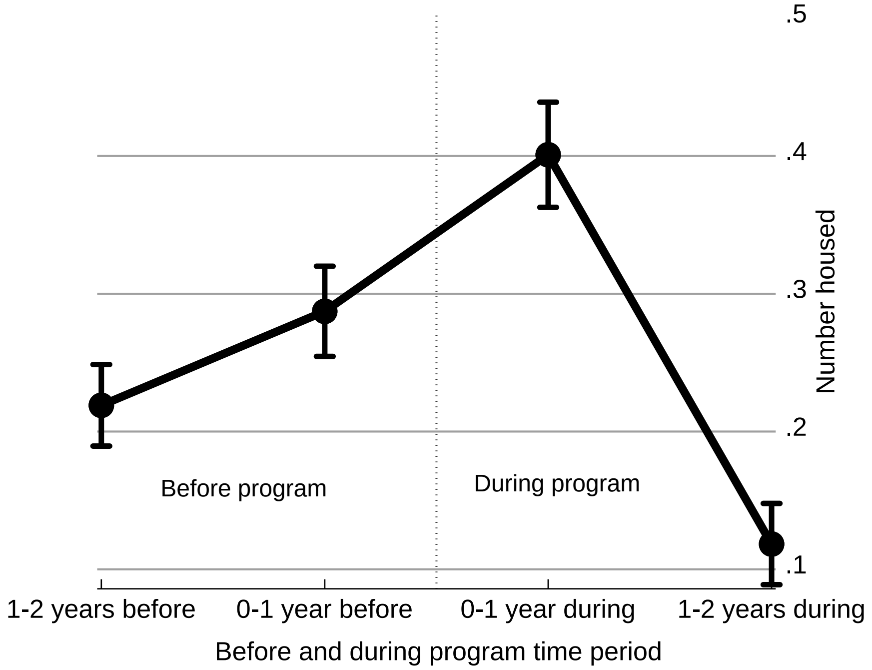
[43] Both Aboriginal and non-Aboriginal consumer increases in year 1 following program entry were statistically significant ($p<0.001$).

Tenancies

Data about private housing tenancies were not available. The data about new public housing tenancies show a similar picture to the housing applications. New public housing tenancies increased by 39.6% after entering CLS-HASI, from 0.29 to 0.40 per person per year (p<0.001), **Figure 14**. Among the consumer subgroups, Aboriginal consumers had higher success with new tenancies than non-Aboriginal consumers, and tenancies among high-level support consumers did not increase after entering CLS-HASI.

Figure 14: New public housing tenancies per person



Source: CLS-HASI linked NSW Department of Communities and Justice Housing. n=1,539
Notes: Average contacts per person per year, before and after program entry with 95% confidence intervals shown as vertical bars.

Shortage of affordable housing

All CMOs, LHDs and stakeholders agreed that a shortage of stable and affordable housing limited transitions in and out of the programs. CMO managers said a lack of housing options meant that people remained in hospital for longer periods before they could join the CLS-HASI programs. They also said that some consumers who had needed hospitalisation for a short while lost their home during that time. They then had to wait for new housing before they could leave hospital. Many LHD managers would like to see transitional housing options attached to CLS-HASI.

There was no change in managing the availability of housing by the second round of fieldwork. Frontline staff still felt constrained by the affordable housing shortage.

They reported that some consumers had to remain in unsafe or unsuitable housing, affecting their mental health recovery:

> The barrier is the availability of housing, the quality of the housing too, especially [given the consumers'] vulnerabilities. (CMO)

CMO staff and managers suggested that CLS-HASI consumers be prioritised for social housing. Statements from stakeholder focus groups and from the DCJ case studies indicate that CLS-HASI consumers informally had high priority. It was unclear how often and how consistently this happened:

> While it is not in our policy that it is automatically priority, it pretty much is. So anyone with that need and with that referral between the agencies and that agreement that we have got in place is considered high priority. (Stakeholder)

Linkage data from DCJ Housing seems to confirm these impressions. Most consumers who received social housing in year 1 were on a priority waitlist (67.3%), **Table 6** in **Appendix 10**. These consumers had an average wait time of 9.7 months, substantially shorter than reported general waitlist times.[44]

In contrast to the DCJ case study quoted above, the Ministry stated that consumer engagement in CLS-HASI could not be used as a condition to obtain housing.

In summary, new housing applications were completed at entry to the programs, and new tenancies mostly started during program support. Data from after consumers exited CLS-HASI did not show further changes in application or tenancy rates.

3.5.2 Maintaining housing

The DCJ case studies indicate that CLS-HASI support enabled consumers also to maintain their housing. In the fieldwork sites, CMOs supported consumers to manage housing issues with cleanliness or with behaviour of neighbours that made CLS-HASI consumers feel unsafe:

> If I have any problems with Department of Housing, [CLS-HASI will] support me in there by helping me go in there and support me talking with them. (Consumer)

Program consumers also accessed additional DCJ housing support. These included:

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[44] The shorter average wait time reflects the high proportion of consumers placed on priority wait lists. Compared to several months for priority housing access, the general housing waitlist may be several years or longer depending on location.

- 68 rental bond loans in year 1 after program entry, a slight decline from the year before entry.[45]
- 17 consumers had Private Rental Subsidies (PRS)[46], an increase from 8 for the year before CLS-HASI.
- 8 consumers accessed assistance for rental arrears in year 1 after entry.[47]
- 5 consumers had support through Start Safely, the DCJ Housing program to support victims of family and domestic violence.

The MDSV2 also recorded that 2 consumers in public housing received an antisocial behaviour warning. No consumer had an antisocial behaviour strike during the reporting period.[48]

One factor that helped maintain consumer housing seemed to be good local partnerships with housing providers. One CMO manager said the local community housing provider recognised that CLS-HASI consumers were successfully retaining tenancy. As a result, the housing provider had allocated between 8 and 10 properties a year for consumers with high support needs of at least 3 to 4 days of support per week. The tenancies would continue after consumers exited from CLS-HASI. It was not clear whether this arrangement reduced access for consumers with lower support needs, who might also need housing.

CMO and LHD managers noted that formal and informal meetings with housing providers supported those partnerships. They built relationships between workers and provided a timely mechanism to resolve housing issues and retain housing for CLS-HASI consumers. These meetings included regional interdepartmental meetings such as Housing and Mental Health District Implementation and Coordinating Committees (DIACCs) and Local Implementation and Coordinating Committees (LIACCs). Some LHD managers said that LIACCs and DIACCs had ceased in their area, so there was no longer a forum to raise systemic issues. LHD managers all agreed on the importance of the review of the Housing and Mental Health Agreement (HMHA) that was underway (**Section 3.1**).

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[45] DCJ Rentstart Bond Loan is an interest-free loan to assist eligible consumers pay a rental bond for a private tenancy.

[46] Private Rental Subsidies facilitate medium-term accommodation for eligible consumers until an offer of social housing.

[47] DCJ provided tenancy assistance to help with rental arrears for eligible private market tenants.

[48] DCJ Housing established a warning and strike system for antisocial behaviour, where a third strike results in accommodation notice of termination.

3.6 Reduced criminal offences

Reduced criminal offences indicate mental health recovery. The data linkage included the NSW Bureau of Crime Statistics and Research's (BoCSAR) Reoffending Database (ROD). The ROD contains legal actions that happen in the NSW Criminal Justice System. Additionally, the data linkage included the NSW Department of Communities and Justice[49] Offender Inmate Management System (OIMS). The OIMS reports community corrections orders for minor offences. A few offences by individual consumers may be included in both datasets.

Both databases show that consumer offences dropped to almost zero after entering CLS-HASI.

3.6.1 Charges in the criminal justice system

Criminal charges decreased after entry to CLS-HASI, from about 0.8 offences per person in the year before entry to almost zero, **Figure 15**. The drop in charges was consistent across all consumer subgroups and was statistically significant (p<001). Charges increased slightly in the second year after entering CLS-HASI.

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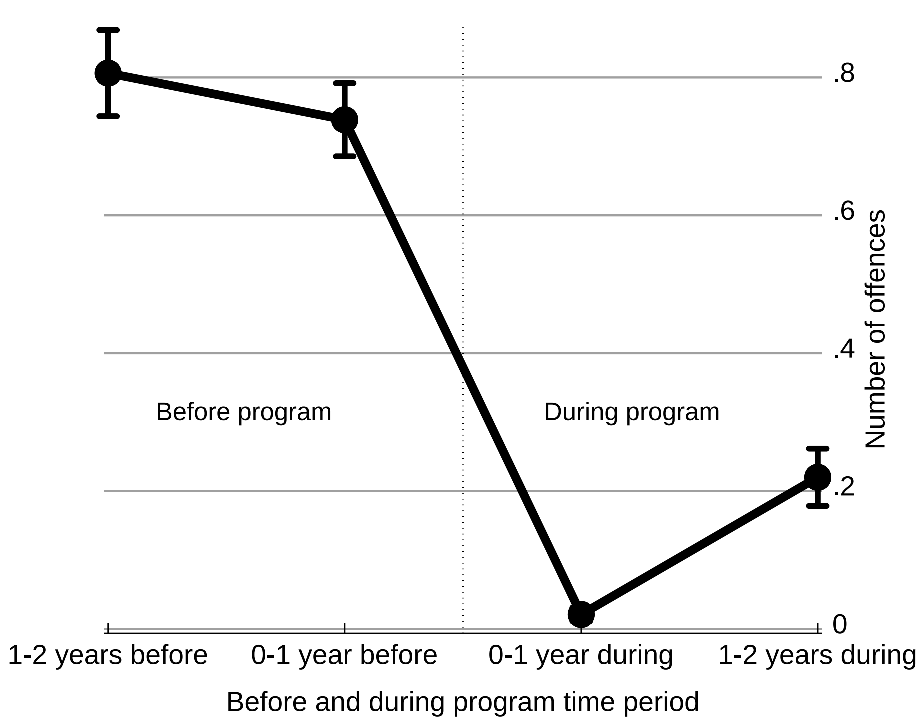
[49] Formerly the NSW Department of Corrective Services

Figure 15: Average number of charged offences per person



Source: CLS-HASI linked NSW Bureau of Crime Statistics and Research's Reoffending Database (ROD). n=401 Notes: Average number of offences per person per year, before and after program entry with 95% confidence intervals shown as vertical bars.

The analysis is based on main offences considered by a court, which in some cases includes secondary minor offences.[50] A total of 830 offences were committed by 401 consumers over the 2 years before and after entry to CLS-HASI. Among consumer subgroups, 70% of consumers charged were men (n=279).

Of the total charges, about 80% resulted in a guilty verdict, and about 15% resulted in mental health dismissals. The remaining small number of cases were withdrawn or found not guilty. The main court rulings were:

- a fine (in about 25% of cases)
- no penalty (20%)
- prison sentence (12%)
- supervised bond (10%)
- unsupervised bond (10%).

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[50] ROD data used is based on court appearances where at least one offence was proven. The linked records use the Principal Offence determined from the most serious penalty in that court matter.

More detail is in **Appendix 10**.

There were fewer than 5 penalties in the year after program entry. At the same time, the offences seemed less severe than before consumers joined CLS-HASI. For example, there were no prison sentences during the first year in the programs, and fines dropped from about $530 on average before program entry to about $320 after entry.

Year 2 after entering the programs saw 34 penalties. The most common was a fine in 10 cases, and there were fewer than 5 prison sentences.

After consumers exited CLS-HASI, charges increased slightly, but to a level well below what it was before the programs.

3.6.2 Community corrections orders

In addition to the penalties above, consumers may be placed on a community corrections order. These are penalties for minor offences that do not justify a severe sentence but are too serious for a fine [51].

Similar to the penalties in **Section 4.6.1**, community corrections orders dropped to almost zero after program entry, **Figure 16**. The drop was consistent across all consumer subgroups and was statistically significant (p<001). Community corrections orders increased slightly in the second year after entering CLS-HASI. More detail is in **Appendix 10**.

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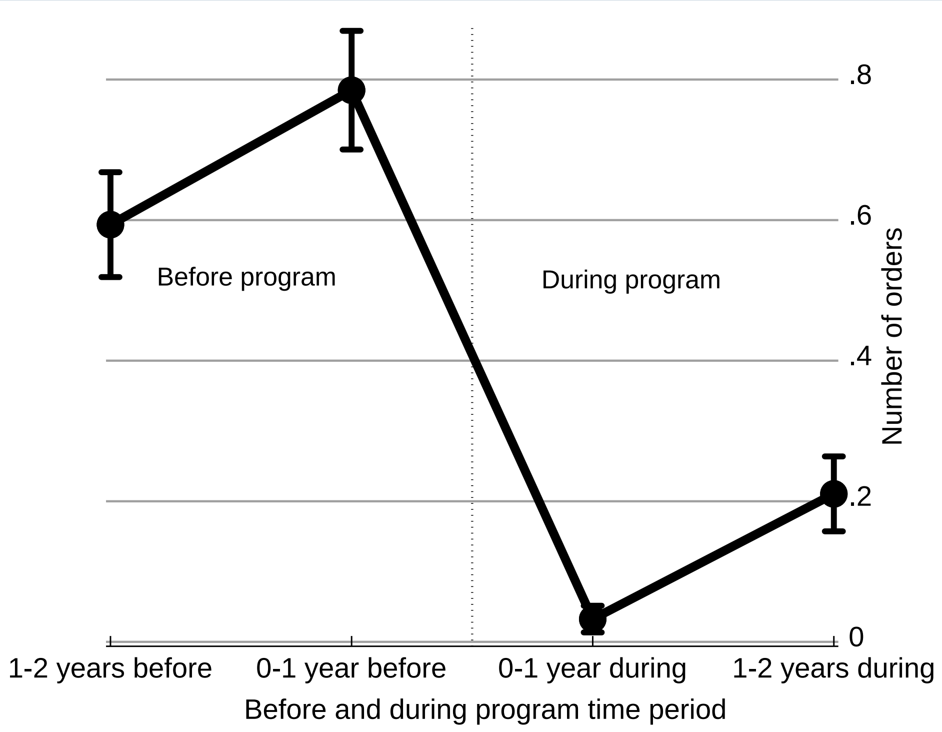
[51] From September 2018, ‘Community Corrections Orders’ replaced ‘Community Service Orders’ and ‘good behaviour bonds’. The OIMS data linkage reports recent order types, as well as prior order types before September 2018.

Figure 16: Average number of community corrections orders per person



Source: CLS-HASI linked NSW Offender Inmate Management System (OIMS). n=185
Notes: Average number of orders per person per year, before and after program entry with 95% confidence intervals shown as vertical bars.

Of the total study group of 5,533 consumers, 185 consumers (3.3%) were placed on a community corrections order within the 2 years before or 2 years after program entry. The most common orders were:

- good behaviour bond (36% of orders)
- parole (30%)
- community corrections orders (12%)[51]
- suspended sentence (8.7%).

There were fewer than 5 orders in the year after program entry, and 10 orders in year 2 in the programs.

After consumers exited CLS-HASI, orders increased slightly to a level well below what it was before the programs.

The data included consumer scores for Level of Service Inventory – Revised (LSI-R). This is an assessment tool to classify an offender's risk of re-offending. The LSI-R scores show that over half of total orders (54.2%) were rated high or medium high risk of reoffending, but the few orders in the 2 years following CLS-HASI entry were rated mostly at lower medium risk. This shows that not only did the number of community based orders drop once consumers entered CLS-HASI, but that their risk rating also dropped.

4 Economic evaluation

The economic component of the evaluation examined the costs of the CLS-HASI programs and the outcomes and benefits to consumers in an economics sense. The first phase collated available program costs to provide total program cost per year and average cost per consumer. The cost analysis also examined cost categories reported by CMOs to assess the relative proportions of costs in the programs.

The program cost analysis was then integrated with the program outcomes and benefits from the data linkage (**Section 4**). These data provided the basis for the cost effectiveness modelling. The modelling estimated cost offsets resulting from CLS-HASI program support, as well as improved mental health and recovery. These benefits include hospital admission and lengths of stay, community mental health, emergency department presentations, charges in the criminal justice system and community correction orders.

The economic modelling is a framework to develop scenarios of program cost effectiveness over various timeframes. This section is a summary of the cost analysis and economic cost effectiveness modelling. Further details are in **Appendix 11**.

4.1 CLS-HASI program costs

The Ministry establishes CLS-HASI funding agreements with each CMO. These agreements include the minimum number of consumers that CMOs are required to support, and the target numbers of Aboriginal consumers and of consumers who need more than 5 hours of support per day. The CLS-HASI programs are delivered within the budget established through the funding agreements with each CMO.

This section presents data about funding from the Ministry and partner agencies for CLS-HASI and data about CMO expenses. Based on the program funding, the evaluators then calculated average costs of the program per consumer and per hour of support.

The cost data were aggregated across sub programs, metropolitan or remote support locations and LHDs to protect confidentiality. Therefore, the figures mask variation across location, individual support levels, support service types and staffing mix.

4.1.1 Program funding per year

The funding agreements and CMO expenses reviewed for the evaluation covered 2016 to 2019.[52] Program funding includes annual CMO funding as well as Ministry costs for managing the programs. These amounts were summed up to calculate total program funding per year, **Table 13**.

Further analysis focused on 2018-19, as this was the only year during the study period with complete funding data as well as complete MDS data for support hours.[53] The total CLS-HASI program funding for 2018-19 was $70.0 million, of which $69.4 million (99%) was CMO funding.[54]

Table 13: CLS-HASI program funding 2016-17 to 2018-19

Cost component	2016-17	2017-18	2018-19
CLS	20,324,593	20,832,708	21,353,526
HASI	-	46,863,000	48,034,575
Program management (Ministry costs)	-	300,000	307,500
Partner agency costs	-	100,000	102,500
Program evaluation	-	200,000	200,000
Total CLS-HASI	20,324,593	68,295,708	69,998,101

Source: NSW Ministry of Health program funding figures.
Notes: Ministry figures report total funding to CMOs per year. The Ministry estimated its project management and partner agency costs. The funding was indexed annually at the Ministry approved rate of 2.5% during the study period. Program evaluation funds were fixed.

The CLS-HASI support offered by each CMO changes over time in response to consumer support needs. CMOs manage the support service mix, staffing and planning to meet target consumer numbers and benchmarks in the funding agreement. HASI funding was not included in 2016-17, as the new program model based on support hours began in 2017-18. RRSP merged into HASI during 2017-18, therefore the HASI funding figure for 2017-18 includes RRSP funds.

Program management by Ministry staff is difficult to estimate, as staff numbers and time spent on CLS-HASI varies. The proportion of costs estimated by the Ministry was similar to that in the previous HASI evaluation. In the current evaluation this

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[52] Program costs for 2016-17 were not complete, because the new contracting model commenced in 2017-18.
[53] The MDSV1 was fully implemented by November 2017.
[54] Based on total funding to CMOs. Annual acquittal reported expenses for each CMO include surplus or deficit figures. The use of unspent funds is subject to Ministry approval.

meant $307,500 in 2018-19, indexed at 2.5% per annum, to cover Ministry staff. It represents about 0.4% of annual program funding.

It is difficult to estimate the funding of program partner agencies (including DCJ housing, NSW Corrective Services and Justice Health) towards CLS-HASI. The program partners offer support services that consumers are eligible for, whether they access CLS-HASI or not. This evaluation included only partner agency costs for additional activity specifically to support CLS-HASI consumers or program management. From discussions with partner agencies, this involved planning and stakeholder meetings. For these activities, $102,500 per year were allocated and indexed at 2.5% per annum. Variation in program management and partner agency costs were tested in the economic modelling sensitivity scenarios, **Section 5.2**.

4.1.2 CMO expenses by category

CMO expenses such as costs for employees, operation and administration are reported by each CMO to the Ministry. The reporting varied widely across CMOs in format, level of detail and cost categories.[55]

In each year, there has been a proportion of unspent funds. The use of unspent funds is subject to Ministry approval. Most are directed towards discrete projects focused on CLS-HASI consumers. Re-allocated projects often span multiple financial years so that analysis becomes complex. Therefore, CMO expenses in this section are based on total CMO funding (Error! Reference source not found.) for 2018-19, where underspend was relatively small (2.7%).

To develop comparable expense groups, the figures were combined into core categories. **Figure 17** shows that about 65% of CMO expenses were for employees (mainly salaries). Operational expenses accounted for about 14%, and administration expenses were almost 9%. Motor vehicles cost about 5%, and ‘other’ expenses made up about 4%. The evaluation period saw employee costs rise consistently from 59.4% in 2016-17 to 63.5% in 2017-18 to 69.2% in 2018-19. The aggregate employee costs include all staff costs across NSW awards and support sector regulations. [56]

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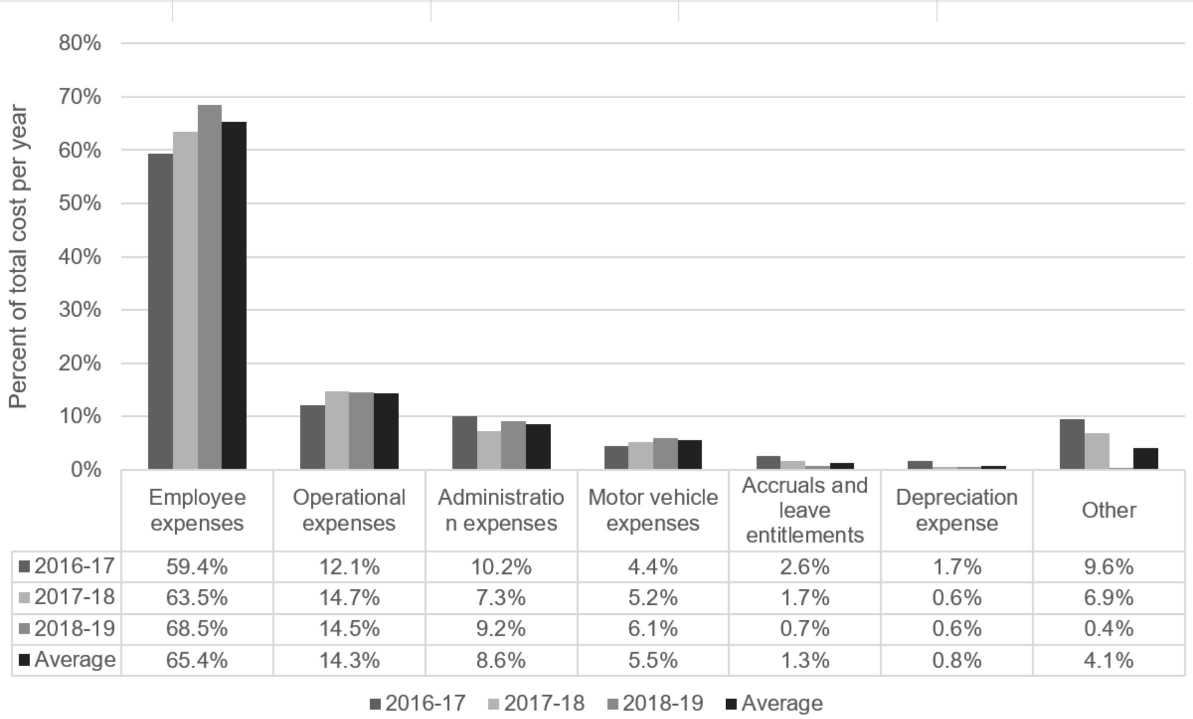
[55] The analysis was based on audited annual acquittal reports from the CMOs to the Ministry.

[56] Employee expenses are total costs reported including salaries, superannuation, leave loadings, workers compensation and staff training in line with NSW awards. Employee costs are aggregated and include all award related costs including Equal Remuneration Order (ERO) indexing. The HASI tender noted that ERO was not factored into the cost of service delivery, and tender respondents needed to demonstrate they could deliver services within the funds budgeted for each LHD. The CLS tender was not specific about ERO arrangements. ERO was around 1.3% of NSW wages in 2018-19.

Figure 17: CLS-HASI program cost percentage by category 2016-17 to 2018-19



	Employee expenses	Operational expenses	Administration expenses	Motor vehicle expenses	Accruals and leave entitlements	Depreciation expense	Other
■2016-17	59.4%	12.1%	10.2%	4.4%	2.6%	1.7%	9.6%
■2017-18	63.5%	14.7%	7.3%	5.2%	1.7%	0.6%	6.9%
■2018-19	68.5%	14.5%	9.2%	6.1%	0.7%	0.6%	0.4%
■Average	65.4%	14.3%	8.6%	5.5%	1.3%	0.8%	4.1%

Source: NSW Ministry of Health CLS-HASI program annual acquittal reports.
Notes: Base figures were indexed at 2.5% per annum to 2018-19 dollars.

4.1.3 Average program costs per consumer

The total program funding in 2018-2019 (**Section** Error! Reference source not found.) was combined with MDS support hours (**Section 3.5**) to calculate average cost per hour and per consumer. This applied only to 2018-19 because it was the only year during the study period that had complete financial and support hour data.

The average annual cost per consumer was $35,622 in 2018-19, **Table 14**. Split by consumer support level, the average cost per consumer was about $10,400 for low support consumers and about $43,000 for medium level consumers. High level support, with over 8 hours per day in some cases, cost about $203,000 per consumer.

Table 14: CLS-HASI average annualised program costs 2018-19

Level of support	Average hours per month	Average cost per month	Average annual cost per consumer
Low	10.7	$864	$10,363
Medium	44.4	$3,584	$43,002
High	209.4	$16,901	$202,807
Total average cost per consumer	36.8	$2,969	$35,622

Source: NSW Ministry of Health CLS-HASI program funding figures.

Notes: Low level of support represents 31.8% of the study group, medium 66.6% and high 1.6% (**Section 3.5**). Figures presented in 2018-19 dollars.

Program data linkage showed that, over time, many consumers stepped down from high and medium support to low level support (**Section 4.1.1**).

Overall, the CLS-HASI average program support costs (**Table 14**) were similar to average NDIS-funded packages in NSW.[57] In 2019, average NDIS cost per year for Supported Independent Living (SIL) packages for people with High support needs was about $230,000, and general non-SIL support was about $33,000 (National Disability Insurance Agency, 2021).[58] NDIS average costs increased about 17% per year from 2018 to 2021, with non-SIL participants aged over 15 years at around $50,000 and high level SIL support at over $320,000 in 2021.

Differences between CLS-HASI and the NDIS do not allow direct comparison between hourly support costs. Most significantly, CLS-HASI operates under a CMO block-funded model, while the NDIS provides funding packages directly per consumer. It should also be noted that any comparison does not take account of the additional in-kind contribution in integrated clinical supports to CLS-HASI consumers made by local health districts as appropriate, which is not available under the NDIS.

4.1.4 Average support cost per hour

MDS data show there were 867,284 hours of consumer support in 2018-19. Based on the program funding, the average cost per hour was $80.71 (**Table 15**). Staffing was the predominant cost category at $55.83 (69.2%), followed by operational costs of $11.74 (14.5%).

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[57] Available NDIS support costs are Australia-wide figures.

[58] NDIS National average annual payments for participants aged 15 and over, non SIL, part 5, figure 52. This aligns with CLS-HASI consumer age range above 15 years. Available NDIS figures are aggregate across consumer diagnoses and support types.

Table 15: CLS-HASI program cost per hour by category 2018-19

Cost component	Percentage	Average cost per hour
Employee costs	69.2%	$55.83
Operational costs	14.5%	$11.74
Administration costs	9.2%	$7.45
Motor vehicles costs	6.1%	$4.88
Other costs	1.0%	$0.80
Total	**100.0%**	**$80.71**

Source: NSW Ministry of Health CLS-HASI program annual acquittal reports.
Notes: Support hours based on CLS-HASI MDS data linkage. Employee cost percentage includes employee expenses (68.5%) and related accruals and leave entitlements (0.7%).

Although it is difficult to directly compare alternative support programs (**Section 5.1.3**), the NDIS price schedule in 2018-19 indicated a starting cost of $48.14 per hour for standard hours of core supports (assistance with daily living, transport and social and community participation), and a start cost of $50.73 per hour for more intensive support where an experienced level 2 support worker is required (National Disability Insurance Agency, 2019b).[59]

The latest NDIA pricing review (National Disability Insurance Agency 2020a) recommended price increases including a rise in ‘overheads’ to 12%.[60] In CLS-HASI, the total non-labour component makes up around 30% of costs. Even separating motor vehicle and other costs of 8%, this leaves around 22% of the CLS-HASI cost to cover operational and administrative costs.[61] There is not enough detail to make valid hourly cost comparisons to the NDIS.

Further, the NDIA has price limits for group support. In comparison, CLS-HASI group support hours were only available for the final 5 months of the evaluation period.[62]

In conclusion, the total hourly CLS-HASI pricing level may indicate sufficient cover for typical cost profiles. However, not enough detailed data were available to assess how well costed the hours of support in CLS-HASI were across individual CMOs, locations, support levels or support types. In the qualitative fieldwork, most CMOs mentioned budget pressures (**Section 3.5**), however it was not possible from the available evaluation data to determine what was driving the budget pressures.

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[59] Base rates for weekday daytime.
[60] This was published after the CLS-HASI evaluation period.
[61] 8% based on motor vehicles, Ministry project management of around 1% and other costs.
[62] Reporting of group support hours commenced in May 2019 with the implementation of MDSV2.

4.2 Program cost effectiveness analysis

Assessing the cost effectiveness of mental health programs such as CLS-HASI increasingly uses methods employed in other areas of the health system. Recent research indicates that mental health measures such as the K10 (**Section 4.1.2**) can help to generate quality of life estimates, which are validated and used in economic modelling (Mihalopoulos, Chen, Iezzi, Khan, & Richardson, 2014). Quality Adjusted Life Years (QALYs) measure health outcomes as length of life and health-related quality of life. In this evaluation, QALYs were calculated using the K10 data. Since the data linkage showed statistically significant improvement in consumer K10 scores, economic modelling of program cost effectiveness was possible without additional data collection.

Ongoing research in health economics consistently indicates that such approaches present a strong economic case to increase investments in mental health care (Luyten, Naci, & Knapp, 2016).

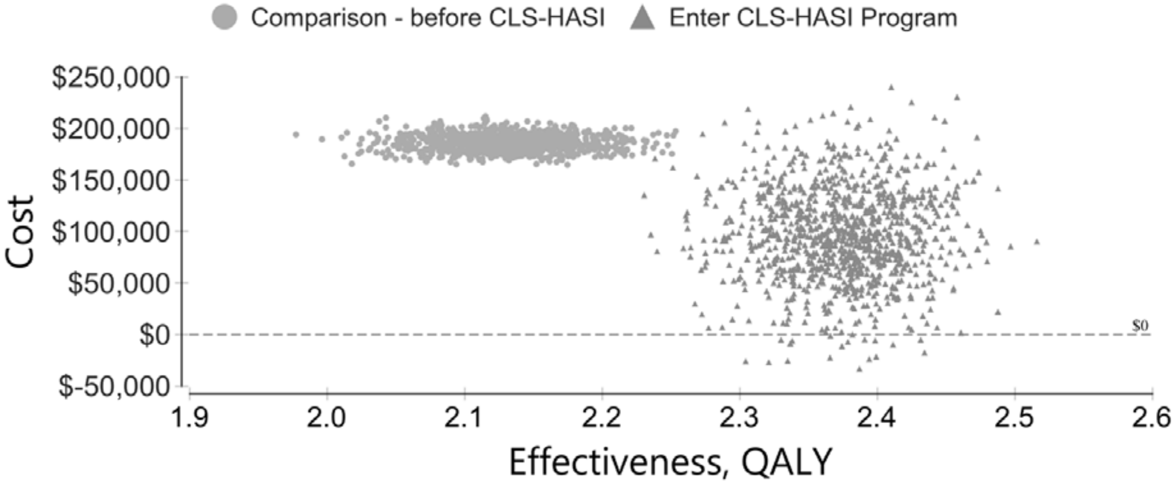
4.2.1 Markov model framework

The economic evaluation developed a Markov model framework, which integrated program costs with the outcomes from the data linkage (**Section 4**). The model allows for variation in average program cost per consumer across levels of support. Further details of the economic modelling methods are in **Appendix 8**.

The Markov model is a framework to establish scenarios based on costs while in the programs and projected outcomes during and following program exit. In this evaluation, the model base case is a 5-year perspective from entry into the CLS-HASI programs, **Figure 18**. The 5-year scenario projects outcomes from the year following program entry over each subsequent year. This is a conservative baseline as most consumer outcomes continued to further improve significantly in year 2 following entry. In other words, the 2 and 5 year economic model scenarios illustrate the likely improving cost effectiveness when improved outcomes are sustained. This even applies with increased uncertainty in forward years. It is not based on how long consumers were in the programs.

As projected outcomes are associated with increasing uncertainty, the model scenarios use conservative parameters. This base case scenario is shown as a scatter plot of estimated costs by QALY for CLS-HASI consumers (right hand side) compared to before entering the programs (left hand side).

Figure 18: CLS-HASI program cost effectiveness: base case 5-year timeframe



Sources: CLS-HASI data linkage, NSW Ministry of Health program cost data.
Notes: Costs and outcomes (QALYs) based on 5-year timeframe. QALYs based on K10 bridging algorithm and shown as cumulative over 5 years.

These results indicate that, over 5 years, the costs per consumer in CLS-HASI are lower than before they entered. The average cost of all health care and corrective services per consumer before program entry was about $185,000 per year. This was nearly double the cost of $99,000 per year when they were in the programs, including the cost of program support.

Further results are in **Table 16**. The program effectiveness is shown as estimated Quality Adjusted Life Years (QALYs)[63] based on the K10 scores. This indicates that in addition to generating lower costs over 5 years the CLS-HASI program is also associated with improved mental health outcomes and estimated consumer quality of life.

When the 5-year estimated costs and outcomes are combined, the incremental cost and effectiveness (change following program entry) were estimated using model probabilistic sensitivity analysis (PSA), **Appendix 11, Figure 2**. The results show an average cost saving of about $86,000 and a positive outcome of 0.25 QALYs. The estimated changes in costs and outcomes reflect the difference between before and after program results (**Figure 18** and **Table 16**). They show the variation in pre-program costs per person of around $185,000 to a lower post program level around $99,000 when cost offsets are included.

In the 5-year scenario, the average costs following entry to CLS-HASI reflect around $35,000 per consumer in program cost per year, minus around $121,000 per person

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[63] A QALY is a measure of health outcome that combines length of life with health-related quality of life. QALYs are used in economic evaluation to help understand how effective health programs are at improving people’s health and wellbeing.

in cost offsets, giving the estimated $86,000 saving. The average cost offsets over 5 years mostly result from reduced inpatient admissions and lower lengths of stay (as high as $113,000 per consumer or 93%), reduced community mental health services of around $7,000 (around 6%) and lower emergency department presentations of around $1,000 (less than 1% of estimated offsets). This shows the estimated cost saving over the projected 5-year scenario, indicated by negative cost. The confidence interval reflects the joint uncertainty in all model parameters with the related variation in point estimates.

4.2.2 Program cost effectiveness scenarios

It is intuitive that CLS-HASI cost effectiveness may improve over extended time. Uncertainty also increases after the initial program investment continues to improve outcomes. The data linkage showed that consumer health care outcomes continued to improve into the second year following entry to the program. That is, outcomes improved further compared to the positive first year. The data linkage also showed that these improvements were sustained after consumers exited the program.

The base case 5-year model took a conservative approach, based on the improved outcomes in the first year following CLS-HASI program entry. If the further improvements in year 2 following entry were included, the estimated cost effectiveness would also increase. However, the economic modelling is subject to limitations related to the uncertainty of sustained outcomes and the before and after study design. For example, consumers often enter support programs during times of higher health care use and mental health outcomes may tend to eventually return to a longer-term average level. This ‘regression to the mean’ could explain some of the improvement after entry to the programs. It might account for as much as 30% of observed outcomes (Schilling, Petrie, Dowsey, Choong, & Clarke, 2017).

To further assess the estimated program cost effectiveness, the additional model scenarios were examined to test the sensitivity of results across shorter timeframes.

Shorter timeframe model scenarios

The recent Productivity Commission Inquiry into mental health examined mental health system service planning and reform and recommended expansion of mental health services in Australia based on outcome effectiveness and related cost effectiveness (Productivity Commission, 2020). The Productivity Commission health economic modelling indicated that service expansion is likely to be highly cost-effective. The modelling approach was conservative based on a single year of outcomes. Such a short timeframe is likely to understate the value of mental health programs.

In this context, CLS-HASI economic model scenarios were developed for 1 and 2 year timeframes, **Table 16.** The current 2-year modelling indicates potential cost saving of about $13,600 per year and a QALY gain of 0.1. These results are due to the predominant cost offset of reduced mental health hospital admissions and lengths of stay following entry to the programs. The significant decrease in health care use following program entry is consistent with the previous HASI evaluation, which reported cost offsets in line with total program costs over 2 years (Bruce et al., 2012).

The further highly conservative 1-year model scenario indicates that the CLS-HASI program is not cost effective within a single year timeframe. The first year following entry indicates an increased cost of about $11,500, although still with a marginally improved QALY outcome. Further details of results are provided in **Appendix 11**.

Almost all the cost saving is to the health system. Cost saving to Corrective Services is marginal due to the limited number of consumers who were in prison before entry to the program and given that this small rate dropped to zero in the year following entry to CLS-HASI (**Section 4.6.1**).

Table 16 CLS-HASI cost effectiveness results

	Cost		Effectiveness		
Base case and potential benefits	Total cost	Additional cost	QALYs	Additional QALYs	Cost per QALY
Base case – 1 year					
Before CLS-HASI	$32,179		0.46		
CLS-HASI 1 year	$43,701	$11,522	0.51	0.05	$220,572
2-year model timeframe					
Before CLS-HASI	$ 72,553		0.90		
CLS-HASI 2 years	$58,901	- $13,652	1.00	0.10	Cost saving
5-year model timeframe					
Before CLS-HASI	$185,820		2.13		
CLS-HASI 5 years	$99,645	- $86,175	2.38	0.25	Cost saving

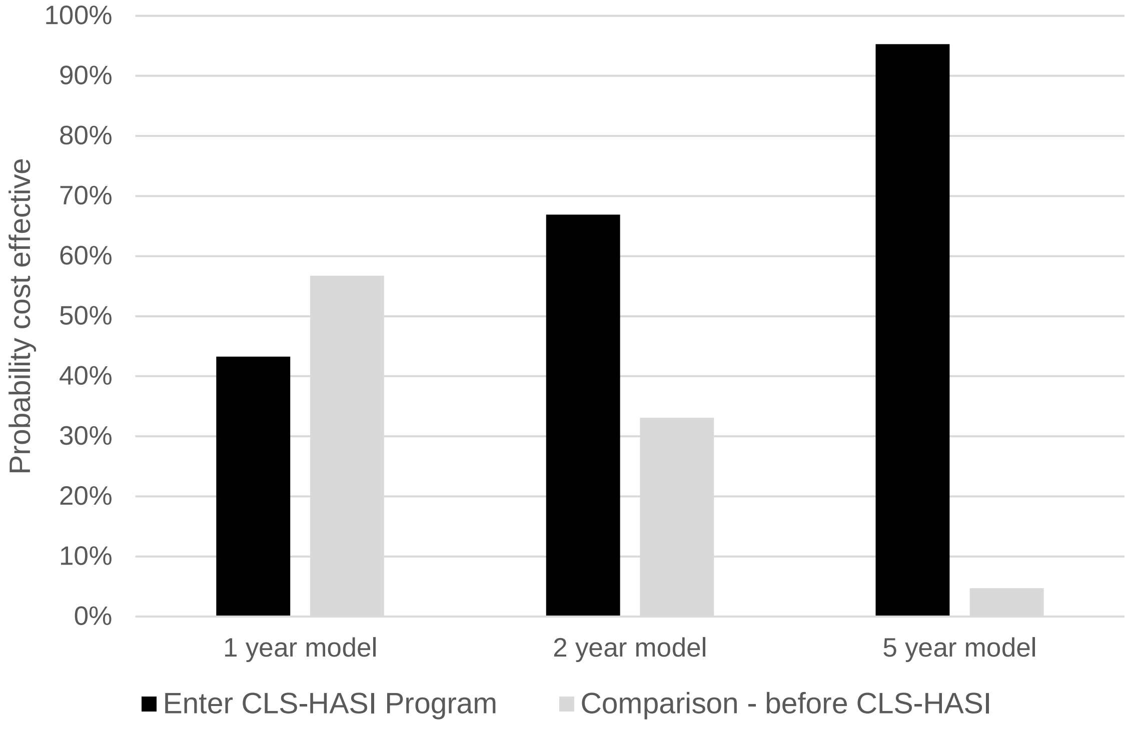
Source: NSW Ministry of Health: program data linkage. CLS-HASI Program cost data.

Notes: Cost effectiveness is the estimated cost per QALY. Estimated over a 1, 2 and 5 year timeframe following entry to the program. Costs indexed to 2019-20 dollars.

The cost effectiveness modelling scenarios estimate the increasing likelihood that the CLS-HASI programs are cost effective over multiple year timeframes, **Figure 19**. The results indicate a low probability of about 43% that the programs are cost effective over 1 year. But as the initial cost investment continues to provide a level of sustained consumer outcomes, the probability that the program is cost effective increases to 67% over 2 years and is estimated at 95.3% in the 5-year model.

The scale of model results across multiple years indicates the CLS-HASI program continues to be highly cost effective. The results incorporate the substantial variation in consumer outcomes and test the joint uncertainty of all model parameters through the probabilistic sensitivity analyses and related 95% confidence intervals. In the case that confounding factors such as regression to the mean are partially influencing outcomes, this could potentially mean the program is cost saving in year 3 rather than year 2. This provides perspective to show that even if additional sources of model uncertainty are discounted, the CLS-HASI program remains highly cost effective.

Figure 19: CLS-HASI cost effectiveness – by model timeframe



Source: NSW Ministry of Health: program data linkage. CLS-HASI Program cost data.
Notes: Cost effectiveness is the estimated costs per QALY. Estimated over 1, 2 and 5 year timeframes.

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Appendix 2: Focus report – Social inclusion

Evaluation of NSW Community-based Mental Health Programs: Community Living Supports and Housing and Accommodation Support Initiative – CLS-HASI Evaluation Report

Prepared for NSW Ministry of Health, 2022

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Contents

Tables

Meanings and abbreviations

In this report, the term 'Aboriginal' includes people from the Torres Strait Islands. We acknowledge the diversity of traditional countries and Aboriginal language groups across the state of New South Wales.

CLS	Community Living Supports
CMO	Community Managed Organisation
DCJ	NSW Department of Communities and Justice
HASI	Housing and Accommodation Support Initiative
LCQ	Living in the Community Questionnaire
LHD	Local Health District
MDS	Mental Health Community Living Programs Minimum Data Set (MDS). During the evaluation, the Ministry implemented a new MDS version. The evaluation study period includes MDS version 1 from November 2017 to April 2019 and MDS version 2 from May to September 2019. Figures in this report are across both MDS versions unless stated otherwise.
Ministry	NSW Ministry of Health
SPRC	Social Policy Research Centre
TAFE	TAFE NSW, a vocational education and training provider
UNSW Sydney	University of New South Wales Sydney

The following words are used in this report when we refer to people who participated in evaluation interviews and focus groups:

- 'consumers' or 'people' are people who received CLS-HASI support or other types of support
- 'CMOs' are CMO managers and staff (frontline workers), both in the fieldwork sites and other areas

- ‘LHDs’ are LHD managers and staff members, both in the fieldwork sites and other areas
- ‘families’ or ‘families and carers’ are formal and informal supporters of the consumers
- ‘stakeholders' are all other interviewees from government and state-level positions, and from Aboriginal Medical Services.

Short summary

This focus report is part of the evaluation of the Community Living Supports and Housing and Accommodation Support Initiative (CLS-HASI), programs that support people with a severe mental illness to live in the community. This focus report examines how CLS-HASI meets one of its central aims, to support the social inclusion of consumers so they can live and participate in the community in the way they want to. The evaluation data were analysed with a social inclusion framework, which says social inclusion means that people can engage, learn, work and have a voice in their communities. The report is based on the experiences of CLS-HASI consumers, their families, CLS-HASI providers and other stakeholders. Program and linkage data are included where available.

Most CLS-HASI consumers had capacity to increase their social inclusion with appropriate support. A key to improving social inclusion was the relationship with the CLS-HASI support worker. Once the consumer trusted their support worker, they often also engaged with other people and with services. Consumers also then participated in more decisions about their lives. Few consumers took part in formal learning and work. They might choose such activities later in their recovery. Implications for the CLS-HASI programs include:

Engagement

- Organise free or low-cost social activities
- Establish relationships with housing providers to prioritise CLS-HASI consumers for social and private housing
- Encourage engagement from consumers' families, including explaining about mental illness
- Supervise support workers through reviewing skills, providing training and asking them what support they need
- Increase, train and support career development of Aboriginal staff and peer workers
- Train staff to support culturally diverse needs

Learning

- Review support for consumers to engage in formal learning, e.g. learning opportunities that prepare for TAFE, vocational and university education

Work

- Identify and address individual consumers' barriers to paid and unpaid work
- Establish relationships with potential employers

Having a voice

- Support staff to encourage consumer participation in decisions about their plan and support
- Review processes for encouraging and managing consumer feedback and complaints.

Executive summary

The Community Living Supports (CLS) and Housing and Accommodation Support Initiative (HASI) are NSW Government programs that provide support to people who have a severe mental illness so that they can live and participate in the community the way they want to. The programs help people to work towards their own, unique recovery goals. The types of support that people receive depend on their individual needs and what they want to achieve.

Support available to program consumers includes support with daily living activities like shopping, meeting people in the community, learning new skills, maintaining their tenancies, and accessing other services such as clinical mental health services. Many HASI consumers are also supported to apply for and access secure housing. The programs are funded by the NSW Ministry of Health (Ministry) and delivered through partnerships between local health districts (LHDs) and Community Managed Organisations (CMOs). The programs also have strong partnerships with the NSW Department of Communities and Justice (DCJ) Housing and community housing providers for social housing.

The Ministry commissioned the Social Policy Research Centre (SPRC) at UNSW Sydney (University of New South Wales) to conduct the evaluation of CLS-HASI.

The evaluation aimed to assess the outcomes of CLS-HASI, to identify what works well in the programs and to determine whether the programs are cost effective. The evaluation ran from November 2017 to January 2020 and adopted a mixed-methods design with two waves of data collection (interviews and data linkage). Among the evaluation outputs are four focus reports, which present detailed findings about particular topics central to CLS-HASI service provision.

This focus report examines how CLS-HASI meets one of its central aims, to support the social inclusion of consumers so they can live and participate in the community in the way they want to. To answer this question, we analysed the evaluation data through the lens of a social inclusion framework developed by the Australian Social Inclusion Board (ASIB, 2012). According to the framework, socially included means that people have the resources, opportunities and capabilities they need to:

- Engage – connect with people, use local services
- Learn – participate in education and training
- Work – participate in employment, unpaid or voluntary work including family and carer responsibilities

- Have a voice – influence decisions that affect them.

These principles structure the evaluation findings about social inclusion and implications for the CLS-HASI programs.

Overall, the findings suggest that most CLS-HASI consumers had capacity for social inclusion when they had opportunities and appropriate resources. The key to better social inclusion was the CLS-HASI support worker. Once the consumer had built trust with their support worker, their capacity to engage with other people increased, as did their capacity to have a voice in decisions about their lives. Few consumers took part in formal learning and work, suggesting that such activities might occur later in recovery.

The evaluation findings have implications for CLS-HASI. These implications could be actioned between the program partners, both at a central level and locally. They could be discussed in meetings or shared as resources to explore further and to improve practice.

The findings and implications are summarised according to the four indicators in the social inclusion framework.

Engagement

Among the four domains in the framework, engagement seemed the most prominent for CLS-HASI consumers. How consumers engaged depended on the resources they could draw on. The resources, which are also called capital, were economic, human, social and cultural capital.

Economic capital

Economic capital that CLS-HASI consumers could draw on was financial resources, housing and transport.

Consumers said that having little money limited their social participation, like going out or visiting people. Therefore, CMOs offered free social activities and advocated for consumers with Centrelink to get financial support they were entitled to.

Consumers and stakeholders saw housing as the basis of improved social inclusion. Feeling safe and secure in their home enabled consumers to feel safe to leave their home and engage in recreational activities, such as social outings. CMOs supported consumers to obtain or maintain safe and secure housing, although the shortage of suitable housing was a challenge. Living away from towns and services restricted their access to social activities. One CMO established a remote support worker role to address this.

Consumers said that transport offered by their support workers increased their social participation. They could go shopping, visit friends and attend appointments. Some consumers worked towards using public transport, but outside towns public transport was often not available.

Implications of economic capital for engagement

- Organise free or low-cost social activities
- Ensure consumers receive the Centrelink support they are entitled to
- Build on good practice supporting consumers to access and maintain housing that is safe, secure and appropriate
- Establish relationships with housing providers to prioritise CLS-HASI consumers for social and private housing
- Consider ways to help consumers who live remotely to access social activities

Human capital

Aspects of human capital that were important for social inclusion of CLS-HASI consumers were mental and physical wellness, knowledge of social services and relationships with family and friends.

Many consumers said their mental and physical wellness had increased since joining CLS-HASI. Consumers could contact their support workers during a mental health crisis, and the support workers helped them pursue their physical health goals. Many consumers said that without the emotional support from their workers they may have disengaged from the program.

Consumers’ access and knowledge of social services had increased. This was because support workers gave consumers information on what services were available. Support workers also offered training and practical support to facilitate access. This included support to obtain necessary paperwork such as birth certificates and other forms of ID.

Reconnecting with family and friends seemed to be a key activity of CLS-HASI. Success often came when the consumer had stable housing and mental health in CLS-HASI. Stakeholders suggested that giving families more information about mental illness helped to re-engage with families. Support workers encouraged consumers to engage socially. Some consumers had made friends through CLS-HASI activities. Consumers with high support needs got more support for reconnecting with family than other consumers.

Implications of human capital for engagement

- Encourage engagement from consumers' families, including explaining about mental illness

Social capital

CLS-HASI consumers gained social capital through engaging with other consumers and the wider community, with support workers, with the CMOs and with the wider health and social service system.

CMOs developed flexible and creative ways to support consumers to make social connections, both in CLS-HASI activities and in community groups. For example, support workers attended services and social engagements together with consumers until consumers felt safe to attend on their own. In doing so, support workers were able to inform people in the wider community about mental illness. This may help to reduce stigma and discrimination of consumers. Consumers with high support needs got more support than other consumers to increase their social capital.

Consumers said that developing trust in the relationship with their support worker was essential to their social engagement. The factors that contributed to a mutually positive relationship were:

- professional skills supporting consumers' mental health and wellbeing
- lived experience of mental illness, trauma or life events
    - consistency and longevity in the relationship.

The consumer experience of CLS-HASI support affected their social participation. Positive experiences happened where CMOs were welcoming, reliable and located within easy access of consumers, and when the CMOs managed transitions between organisations well. Drop-in activities and services increased consumer engagement with the CMO.

Most consumers found that their support worker helped them to stay engaged with health and social services and to continue with their mental health plan. Workers also supported the consumers to coordinate their various service providers.

Implications of social capital for engagement

- Build on existing activities that may reduce local community stigma of mental illness

- Review support worker skills to develop trusting relationships with consumers and offer training and other support when needed
- Increase, train and support career development of Aboriginal staff and peer workers
- Train staff to support culturally diverse needs
- Make schedules of support workers as consistent as possible to increase consumer trust and always inform consumers when schedules or workers change
- Ensure the CMO premises are welcoming and easily accessible
- Build on creative, flexible approaches to engage consumers, such as drop-in activities
- Ensure that consumers have support to coordinate their multiple service providers.

Cultural capital

In the fieldwork, cultural capital examples mostly related to Aboriginal consumers. Aboriginal consumers had varied connections to Country and their mob, and most said they had been offered support to make a connection. The MDS data confirm that CMOs spent about 1 hour of support per month in total on Aboriginal-specific support, such as Aboriginal community participation and Aboriginal cultural reference groups. Consumers and CMOs considered Aboriginal staff important to improve consumers’ cultural connections.

CMOs seemed to offer few specific activities or support for other cultural diversity among consumers, for example sexual preference and ethnicity. Many workers said they treated all consumers the same, that is they emphasised equality rather than equity. They said that few local opportunities for diverse activities were available in regional areas.

Implications of cultural capital for engagement

- Increase the number and support the career development of Aboriginal staff
- Train and support staff to be responsive to cultural diversity (as in social capital above)

Learning

Learning social skills and daily living skills seemed to be the main focus of learning in CLS-HASI. Few consumers were engaged in formal learning at TAFE or university. Learning social and daily living skills became the basis for many consumers to consider formal learning in the future.

Consumers learned social skills mainly in activities organised by CMOs. Activities included regular events like coffee clubs and drop-in activities. Learning daily living skills happened either one-to-one with a support worker or in organised classes like cooking or gym. Consumers with high support needs got a lot more support hours than consumers with low and medium needs.

A few consumers in the fieldwork attended TAFE or university, and many mentioned such formal learning as a goal for the future or when they were well enough. Program data show that 3% of all consumers were in TAFE, university or other formal learning. CMOs gave about 1 hour of support per consumer per month for educational, vocational or work activities.

Implications for learning

Review support for consumers to engage in formal learning, e.g. learning opportunities that prepare consumers for TAFE, vocational and university education, such as adult learning courses and writing activities.

Work

About 1 in 10 consumers were employed, and another 2 out of 10 were looking for work. CMOs gave about 1 hour of support per consumer per month for educational, vocational or work activities. Program data also show that CMOs considered most consumers not able to work, or able to work only in supported employment.

In the interviews, most consumers said they could not work, and their primary focus was managing their mental health. Support workers generally agreed. They thought that most consumers were too early in their recovery to work. Some consumers described barriers to work, like caring responsibilities, poor literacy and stigma.

CMOs supported consumers to find work, including open employment, supported employment and volunteer work. Some support workers discussed work as a recovery goal with consumers.

Implications for work

- Build on good practice about supporting consumers to gain work and share success stories among consumers and CMOs
- Identify and address individual consumers’ barriers to paid and unpaid work

Establish relationships with potential employers

Having a voice

Significant aspects where CLS-HASI consumers had a voice were deciding about their support and deciding about contact with family.

Most consumers felt they had a voice in deciding about their support and their life goals. They made decisions about their individual support plan, about changing CMOs, and about how they participated in program activities.

Their voice was stronger when they had support from family or their community, for example Aboriginal services and networks. Decisions about support to re-connect with family seemed to be guided by the consumer. CMOs were aware of complex family relationships.

Overall, many consumers felt their choices were respected. Having a voice helped them to achieve mental health recovery and social inclusion. Some consumers felt they were not heard when they raised concerns or dissatisfaction about a service.

Implications for having a voice

- Support staff to encourage consumer participation in decisions about their plan and support
- Review processes for encouraging and managing consumer feedback and complaints.

2 Introduction

The Community Living Supports (CLS) and Housing and Accommodation Support Initiative (HASI) are NSW Government programs that support people who have a severe mental illness so that they can live and participate in the community the way they want to. The programs support people to work towards their own, unique recovery goals. The types of support that people receive depend on their individual needs and what they want to achieve.

Support for program consumers includes support with daily living activities like shopping, meeting people in the community, learning new skills, maintaining their tenancies, and accessing other services such as clinical mental health services. Many HASI consumers are also supported to apply for and access secure housing. The programs are funded by the NSW Ministry of Health (Ministry) and delivered through partnerships between local health districts (LHDs) and Community Managed Organisations (CMOs). The programs also have a strong partnership with the NSW Department of Communities and Justice (DCJ) and community housing providers for social housing.

This report is part of the evaluation of CLS-HASI. The evaluation was conducted by the Social Policy Research Centre (SPRC) at UNSW Sydney for the Ministry. Among the evaluation outputs are four focus reports, which present detailed evaluation findings about particular topics central to the implementation of CLS-HASI. The focus reports intend to raise questions that can be explored further with CLS-HASI stakeholders to inform program implementation into the future.

This is one of the focus reports. It examines how CLS-HASI meets one of its central aims, to support the social inclusion of consumers so they can live and participate in the community in the way they want to. To answer this question, we have analysed the evaluation data through the lens of a social inclusion framework that takes account of personal, community and structural influences on social participation. This approach is consistent with the United Nations’ understanding of social inclusion ‘as the process of improving the terms of participation in society, particularly for people who are disadvantaged, through enhancing opportunities, access to resources, voice and respect for rights’ (United Nations 2016).

The sections of this report explain the analysis framework, briefly describe the methodology for data collection, summarise the evaluation findings for each of the framework components and suggest implications of the findings for future implementation of the CLS-HASI programs.

3 Social inclusion framework

The Australian Social Inclusion Board designed a benchmark for how to measure social inclusion, *Framework of indicators for social inclusion* (ASIB, 2012). According to the framework, social inclusion means that people have the resources, opportunities and capabilities they need to:

- Engage – connect with people, use local services
- Learn – participate in education and training
- Work – participate in employment, unpaid or voluntary work, including family and carer responsibilities
- Have a voice – influence decisions that affect them.

In this framework, the term:

- Resources refers to the skills and assets people have (or various types of capital, including economic, human, social and cultural capital)
- Capabilities refers to a person's ability (or agency) to use resources and opportunities to achieve the outcomes they wish
- Opportunities refers to the environment (or structure) that enables people to use their capabilities and resources to achieve the outcomes they wish.

The framework acknowledges that resources, capabilities, opportunities and social participation can impact on one another:

> Resources help to support capabilities and opportunities, allowing people to make choices about how they wish to participate in society. In turn, participation, such as in work, training or connecting with friends, can then help to build people's resources such as work experience, qualifications or support networks, which assists further participation. Gaps in resources, opportunities and capabilities can lead to people not fully participating in society (ASIB, 2012, 12).

As personal recovery is one of the underpinning principles of CLS-HASI, the evaluation findings are assessed with reference to *The National Framework for recovery-oriented mental health services* (AHMAC, 2013). Social inclusion activities are considered good practice if they:

- support a person’s self-determination and self-management
- respond to peoples’ diverse values and identities and
- recognise the social determinants of social inclusion.

We use the elements of social inclusion according to the framework – engage, learn, work, have a voice – as the headings of the findings sections of this report. In each section, we discuss resources, capabilities and opportunities but do not distinguish between them. This makes the text less repetitive and acknowledges that resources, capabilities and opportunities are closely linked and influence one another.

4 Methods

This focus report is based mainly on interviews and focus groups conducted during two rounds of qualitative data collection for the evaluation in 2018 and 2019. Across both rounds of data collection, the SPRC conducted 66 interviews with CLS-HASI consumers and 2 family members in 3 fieldwork sites, which were in rural, regional and metropolitan locations (**Table 1**). We also conducted 49 interviews and 4 focus groups with stakeholders from CMOs, LHDs and statewide organisations and agencies (**Table 1** and **Table 2**). Interviews and focus groups consisted of open-ended questions and informal discussions that explored themes covering the evaluation questions as outlined in **Appendix 7**.

Table 1: Number of interviews in fieldwork sites

	Number of people interviewed	Round 1	Round 2	Repeats (both R1 and R2)	Total number of interviews (Rd1 + Rd2)
Consumers	50	40	26	16	66
CMO staff	25	15	13	3	28
LHD and AMS staff	8	4	5	1	9
Family members	2		2		2
Total	**85**	**59**	**46**	**20**	**105**

Table 2: State-wide stakeholder interviews and focus groups

	Number of interviews	Number of focus groups	Total number of participants
Peaks and government agencies	11	N/A	8*
LHDs and CMOs	1	4	18
Total	**12**	**4**	**26**

Note: *3 people were interviewed twice (in both Rounds 1 and 2)

Interview and focus group findings were supplemented, where available, with information from program data collected by the CMOs (MDS data) and the data linkage. There was little information about social inclusion in the MDS and linked data. There was no information about social inclusion from the economic evaluation, which focussed on the overall cost of the programs.

CLS-HASI program data and linked data were available for 5,533 program consumers in total, from 2015 to 2019. **Table 3** shows the number of consumers by level of support need. Almost all consumers had low or medium support needs, and a small share had high support needs.

Table 3: Number of consumers in MDS and data linkage by support level

Support level	Consumers	Consumers %
High – 5 or more hours per day	111	2.0%
Medium – between 5 hours per week and 5 hours per day	2,715	49.1%
Low – up to 5 hours per week	2,707	48.9%
Total	**5,533**	**100.0%**

Source: HASI CLS linked MDS n=5,533.

More detail about the evaluation design and the methods for data collection is in **Appendix 8**.

5 Engagement

The Social Inclusion Framework defines the domain Engagement to include contact with family and friends, and participation in community groups and events. In a wider sense, this includes engagement with services. Among the four domains in the framework, Engagement appeared the most prominent for CLS-HASI consumers. Interviews showed that individual levels and modes of engagement were closely linked to the resources that the consumers could draw on. Resources include various types of capital, including economic, human, social and cultural capital. This section presents findings on how CLS-HASI supplied these resources or used existing consumer resources to improve consumer opportunities and capabilities for engagement and, as a result, their social inclusion outcomes.

5.1 Economic capital

Economic capital that CLS-HASI consumers drew on to support their social inclusion consisted of money, housing and transport.

5.1.1 Money

Several consumers said that lack of money restricted how much they went out socially, visited or kept in contact with family and, for Aboriginal consumers, engaged with their kin.

At most locations, CLS-HASI offered a range of social activities that were free, including drop-in sessions and outings. Some activities required a nominal fee. Some consumers said that not having enough money made them miss out on attending these CLS-HASI social activities:

> It’s very stressful. Because I have [CLS-HASI] workers saying to me that I need to engage more, and asking me to come to the lunch, but I’m only on the pension, and they have the lunch like at the end of my fortnight pay … so I don’t have the money to go. (Consumer)

Consumers and CMOs said that support workers regularly supported consumers to receive financial support they were entitled to. This included claiming social security benefits and negotiating the release of funds from the Trustee and Guardian for necessary expenses. Support workers saw this kind of support as a core part of their role.

5.1.2 Housing

Most consumers, family members and stakeholders said that stable housing directly improved the consumers’ ability to engage in CLS-HASI. They saw stable housing as the foundation to other social inclusion outcomes and their wellbeing in general. This included the security of housing as well as its quality and location.

> There were a few issues at home where I was looking for housing, myself and straightaway, [CLS-HASI CMO] was the name that came up … they helped specifically with housing needs. Since then, they've really helped me. Yeah, they've made a difference (Consumer)

> So I think that when they do get their house, everything all falls into place. They can deal with their other issues. If they’re homeless and they’re trying to deal with other issues, it doesn’t work for them and they become more mentally ill. (Stakeholder)

Many consumers said that CLS-HASI supported them to secure and maintain housing. Most support workers and stakeholders saw this as a primary activity of the CLS-HASI service.

> Yeah, helped us with forms … we got a house straight away within two months with HASI … We’ve been there for nine years. It's pretty cool. (Consumer)

> So it’s about even at the most basic level knowing that somebody has a HASI support provider that can be contacted if the tenancy looks like it might be struggling. (Stakeholder)

The housing linkage data confirm that CLS-HASI supported consumers to submit applications for public housing, to get new tenancies and to maintain their tenancies (**Appendix 1, Section 4.5**).

Some consumers said that appropriate housing was essential to enable connection to children and family (**5.2.3**) and to be able to care for loved ones.

Almost all consumers, family members and stakeholders reported that when consumers felt safe in their housing, their social participation increased. If they did not feel safe, they tended not to go out socially and not to attend medical and wellbeing activities. In the fieldwork, experiences differed between women and men and between urban and rural areas. Some women said that CLS-HASI had enabled them to leave domestic violence or stressful family dynamics that had made them feel unsafe at home and reduced their mental health.

> I was at my wit’s end. I was ready to leave him probably and leave [town]. Anyway, when [DCJ Housing] realised I was at home with him, they gave me some free accommodation. I [was encouraged] to do the HASI program, as part of my temporary accommodation, so I could get supports, you know, transport, appointments, things like that. (Consumer)

Some men in regional areas said that having a home in town gave them flexibility. From there they could get into the bush to feel well, then return to town for services.

> Just to sit outside in the open to see some mountain range or just to see the bush and the trees and things … when I’ve been out to the farm, I keep my [housing] place to come back to for medical and then I go back out. (Consumer)

Consumers and stakeholders said that physical isolation in rural and remote areas reduced consumer access to CLS-HASI and social participation generally. Some consumers lived away from the regional town where the CLS-HASI provider and other health services were located. Support hours for these consumers included the support workers’ travel time to visit or pick up the consumer. If the support worker did not come to them, consumers had to leave their communities to access services, including Aboriginal consumers.

> But certainly you can go days or weeks between [seeing a] client. You’re not having contact with them just because of their geographical location. They’ve got no phone, they’ve got no way of getting out there. So they just don’t go. It’s too far to go. (Stakeholder)

By the second round of fieldwork, one CMO in a regional area had responded to this issue by offering outreach services to consumers who could not reach the service due to distance and lack of appropriate transport options. One stakeholder suggested that rural and remote CLS-HASI could be funded to account for costs of isolation.

Many consumers living in towns or cities talked about the need to feel safe in their neighbourhood in order to improve their mental health and wellbeing.

> There's a lot of bad influence around the area and I'm trying to get away from that and just get to a place where I can relax and I don't have to be stressed out about neighbours and things like that. (Consumer)

Stakeholders saw available housing as important for engagement to achieve CLS-HASI outcomes. They saw current challenges in the quantity of community housing stock, in maintaining housing when consumers experienced crises, including periods of hospitalisation, and in finding housing to suit consumers’ physical health needs e.g. ageing. They suggested that the NSW Government prioritise housing access for CLS-HASI consumers, and that consumer housing remain secure while they are hospitalised. Since then, DCJ has published a Tenancy Policy Supplement that will consider absences up to 6 months for hospitalisation, institutional care, respite, nursing home care or rehabilitation.

5.1.3 Transport

Most consumers said that the transport offered by their support worker was essential for their social participation. This included transport to attend medical appointments and social service agencies, to participate in social activities including with family and friends, and for daily living activities like shopping. Workers said that they supported consumers to use public transport when that was their goal.

The extent of support with transport varied depending on whether the consumer had independent travel skills, and the consumer's physical and mental wellness.

The MDS data recorded the hours that support workers spent travelling to and from the consumer. This varied by support level, indicating more visits to consumers with higher support needs. The average number of support hours for travel to and from consumers was 5.1 hours per months. This was similar for consumers with medium-level support needs (5.8 hours). Low-support consumers needed less travel time, with 1.7 hours per month on average, while high-support consumers had 35.9 hours per month of support worker travel to and from the consumer.

Consumers in rural and regional areas were more dependent on private or support worker transport than people in towns and cities.

> The support, how they help me a lot, they're there for me, they take me to all my appointments, and I find it very helpful, me not having a car or being able to afford a car to get myself off to appointments, I have a lot of appointments. (Consumer)
>
> It took me a … hour to get here…. It would have been like a 20 minute drive to pick me up and drop me off. I'm hoping to get a lift home because I'm in pain now because of public transport. (Consumer)
>
> No, I don't catch public transport … I don't like it, it goes around too many corners. It goes in loops. It goes to every stop, there's too many stops and too many back streets. (Consumer)
>
> Yeah there's a lot of buses and there is public transport here, but you might find some of our clients don't want to get on the bus. It scares them, or they're

> paranoid, or they've had issues on the bus. Maybe they're not allowed on the buses, things like that. (Stakeholder)

CMOs offered consumers what they called ‘travel training’. This means CMOs assisted consumers to read timetables and map out routes on public transport. Then CMO staff travelled with consumers on public transport until consumers felt safe to do so independently. Staff said that this approach supported consumers to work towards independence.

> I said, "… how about we look at getting the bus at the mall and then you can go anytime you want." So I got it all together, I got the bus timetables, highlighted everything for him, and we did it together last week. So I want to encourage him like that because … to me it's enabling him to think that he can go somewhere without… relying on others (CMO)

5.2 Human capital

Relevant aspects of human capital for CLS-HASI consumers and their social inclusion were mental and physical wellness, knowledge of the social service system and relationships with family and friends.

5.2.1 Mental and physical wellness

Many consumers said that their mental and physical wellness had increased in CLS-HASI and that they now recovered faster from mental health crises than before joining CLS-HASI. The data linkage confirms this, showing significantly better consumer mental health after joining CLS-HASI, **Appendix 1, Section 4.1**.

The key to these improvements seemed to be support workers. They were available as a first responder when the consumer became mentally unwell. Consumers also consistently said that support workers were vital for pursuing their physical recovery goals.

> I can talk to [support workers] if I’m upset or anything or my mental illness if it’s playing up. (Consumer)

> Well it’s changed my life, I just used to sit at home and smoke cigarettes day in, day out, being really depressed and mentally not well. HASI have just changed my life, they take me out nearly every day exercising, which was one of my main goals was to get back in to being healthy again. They gave me a membership with a gym and a pool to swim. They come to my place, … they show me how to cook meals. They take me on group walks on the weekends and stuff. Every Thursday we have an outing, it’s changed my life. I am so

> much happier, mum can see it in my face, I have a smile now and I don't look really depressed. I'm handling life a lot better…. To have someone like [support worker] care about me and saying do you want to go to the gym today – yeah it's really good. (Consumer)

> They come and get me every morning for methadone, they take me up to the hospital to get my methadone, and then they drop me back off home, and then if I've got an appointment or something they come back and get me, they make sure I go to all my appointments. (Consumer)

Consumers valued the availability, consistency and commitment from the workers, and their motivational and emotional support (**Section 5.3.2**). Many consumers said that without this support they may have disengaged from the program.

5.2.2 Knowledge of social service systems

Most consumers said that CLS-HASI had supported them to gain access to basic services and also to gain the knowledge and confidence to independently access social service agencies. Many consumers mentioned that support workers had facilitated them getting their forms of identification, including a birth certificate, Medicare Card, Health Pension Card and a debit card, which they needed to access resources and opportunities for social participation.

> So I'll talk on the phone, like the internet service, she [support worker] made me do it, then the next time I got frustrated because they were just – I couldn't – so I put it on loudspeaker, and she had permission to talk to anybody, we filled out forms and everything for her to be my person to talk to, and that's what she's done. (Consumer)

Most support workers saw assisting consumers to access social services as a core activity of CLS-HASI. For example, CMOs supported consumers to make appointments, they attended initial appointments together with consumers, and they offered training and group discussion about how to navigate service systems (**Section 6**).

5.2.3 Relationships with family and friends

Some consumers in the fieldwork had close, positive relationships with family, and some of these consumers chose not to attend CLS-HASI groups because they felt their social needs were met by their family. MDS data showed family and carer involvement at least once a month for almost 40% of consumers in the MDSV1 and over 50% in the most recent MDSV2.[1]

Some consumers said that CLS-HASI had supported them to reconnect with family and friends. They said successful reconnection was often as a result of stabilising their housing and mental health. Most support workers viewed supporting families and friendships as a key activity of CLS-HASI.

> They had mine and my son's relationship as something of importance and they helped foster that … They used to pick me and my son up one afternoon a week to spend some time together … and they'd take my son back out of town to where he was living at the time. That meant a lot to me (Consumer 22)

> Where clients consent to, we involve families and carers in their care plans and their support plans. So everyone's sort of aware of what's going on and it's all out on the table. Most clients we have do agree to that. Some clients we have don't have family or children and never have, so it's about building their connections with other people so that they're not so alone. (Stakeholder 6)

Some consumers were carers of family members, and in several cases a consumer's relationships with their dependent children had been restored.

> I live with my two youngest [children] and I've actually got my grandson because my oldest son has been in jail for four years, he gets out in a couple of months. (Consumer)

> Because I have a big family, when I first got started … they asked who was in our close circle and then they got to know my mum. She was pretty important to me. They got to know my Nan. They know my family that's close to me and … they know you go to my mum. (Consumer)

MDS data show that support for reconnecting with family varied among consumer subgroups. Consumers with medium-level support need received about half an hour of support per month, and high support consumers got 2.5 hours.

Friends and family relationships were absent for many CLS-HASI consumers, or the relationships were stressful and a cause of trauma and mental illness. Several consumers said they had become isolated and unwell because their parent or family

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[1] MDSV1 reported 37.8% of consumers, increasing to 51.5% in MDSV2.

carer had died. In these cases, CLS-HASI support workers and other CLS-HASI consumers gave emotional support so consumers could engage socially.

> You've got someone to rely on... and I find when I do the groups, there's ... consumers that are in the same boat... they got family but their family are all different … I love my family, but the thing is they all drink alcohol and do drugs. (Consumer)

> In general, I am pretty much their shoulder to pick them up and get them in the community engaging. A lot of clients don't have a lot of family or friendship connections, so I try and get them out more and engage them more in the community. (CMO)

Some stakeholders said CMOs could give families more information about mental illness and that this could contribute to re-engaging families, but the opportunity was under-realised. Information to families was particularly important for consumers who had long interrupted family relationships, for example when they had been in custody.

> I think probably some of the stuff that is really useful for people is giving them – helping them step through making contact again … but also somebody who can … communicate with the family around where they're at and what the challenges are for that individual because it's a bit of a – it's that two-way conversation, almost preparing the family as well so that they are actually open to reconnecting. (Stakeholder)

Some consumers described friendships they had made through CLS-HASI activities. The friendships seemed to generally remain casual and confined to program activities.

> So, just two other guys that did it with me. Like, each week, we kind of became sort of friendlier and then I went away for a holiday in the middle of it and they asked me how that was and genuinely interested in what I was doing and why I wasn't there and things like that. I don't think I would necessarily catch up with them outside of [CMO] or anything like that, but it was good that it was the same people the whole eight weeks. (Consumer 6)

> I've made friends, I say hello and talk while I'm here, but not while out of there. (Consumer)

> Yeah I've met some other guys there, I've seen them around [in the community] a lot of times, they just always yell out. (Consumer)

5.3 Social capital

CLS-HASI consumers gain social capital through engaging with other consumers and the community, with support workers, with the CMOs and with the wider health and social service system.

5.3.1 Engagement with other consumers and the community

CMOs offered a range of ways to increase consumers' social networks. These included modelling engagement in the one-to-one support worker relationship and providing support to attend CLS-HASI social activities and community groups. Most support workers indicated that many consumers had great capacity to build social networks, and some providers had developed flexible and creative approaches to support consumers to make connections.

> We have groups here that help them build relationships or friendships with other participants because most of our participants that we do have, they've got no family support or any friends or anything. Basically, some of them have only got us as support. (CMO)
>
> Facilitating that and helping her being able to do it. That happens from … something they say at the coalface to a frontline worker who comes back and says, 'Oh, such-and-such wants to do this. How can we move forward with this?' Everybody comes together and goes, 'Oh, we could do this. We could do that' … So our own little community comes together to assist someone to reach a goal. (CMO)

The MDS data report how many hours CMOs spent on supporting consumers to access recreational and social activities. The amount of support again reflected the consumer's level of support need. Support hours ranged from 1.3 hours per month for consumers with low support needs, 6.6 hours for medium-support consumers, and 35.5 hours per month for high-level support consumers.

Many consumers said that their social relationships outside CLS-HASI were affected by stigma because of their mental illness. Stigma was a recurring theme in the interviews. Some stakeholders said that stigma was worse in smaller communities and for consumers who had been in forensic institutions or prison.

CLS-HASI supported consumers to make social connections despite observed stigma. For example, support workers attended services and social engagements together with consumers until consumers felt safe to attend on their own. In doing so, support workers were able to inform people in the wider community about mental illness. This may help to reduce stigma and discrimination of consumers.

5.3.2 Engagement with support workers

Most consumers said that they viewed trusting relationships as essential to their social engagement. Therefore the relationship between support workers and consumers had a crucial role in improving social engagement, as it gave consumers an opportunity to develop trust.

> I don’t trust anybody, I find it very hard to trust somebody, especially when I don’t know them ... I would like to get to know everybody that’s helping me, and I hope I get used to them, and I won’t be scared, because I’m very scared, because like I said, I don’t trust any more. (Consumer)

Most consumers and support workers in the interviews saw their mutual relationships as positive. This section outlines facilitating factors for engagement between consumers and support workers: support worker skills, support workers’ lived experience and support worker consistency.

Support worker skills

Support workers generally had experience and confidence dealing with complex behaviours. Several consumers described situations where the worker had adapted support to minimise trauma while enhancing social engagement at a pace and level that felt safe for consumers.

> [My support worker] used to come into Coles with me, because I can’t go in, I’m no good with crowds or people anymore, which I used to be a social butterfly, but now, I have panic attacks walking into shopping centres or crowds … I’ve just got to the stage now where I can walk into a shopping centre at one in the afternoon with [my support worker] with me. (Consumer)

> I’m a bit nervous of being in public by myself. But usually or normally they ring me from the house, from the flats and I almost come straight out. But I just need that at the moment because I’ll get more confidence, but they take me round to the bank and I’ve been shopping with them. (Consumer)

Many consumers spoke about the motivational resource support workers offered. Many support workers said that providing encouragement was a core activity of their role.

> You know, like I’ll get there some days, and I just don’t want to go to the doctor’s. And [support worker] used to … turn up, park out the front door, the driveway, park right at the front door, yell out to me, and I had no choice. She gave me no choice. And then she used to come into the doctors with me, which took a lot of pressure off me. (Consumer)

> The main help I get these days is getting me from out of bed onto a trip around ten-pin bowling, or fishing, we do all that kind of thing, you know? But that's where they help me most … Watching TV and doing nothing's good, but I think I prefer doing something, something you use your brain, you exercise, so doing things instead of just TV. (Consumer)

A few consumers described support workers who appeared disengaged, and a few workers described their difficulties engaging with consumers.

> I had one bloke come round, he was my support worker, and he'd be sitting down on his mobile phone. Wouldn't really ask anything, didn't write nothing down, and all that sort of stuff. And it just sent me so backwards. When I asked to do something, I'd say to him, he'd say, 'Oh, no, it's in the office, I forgot to do that.' … And then when I got with [the new CMO], we've started, 'Just forget about that, we're taking over, now what are we going to do?' And that's what we've done. (Consumer)

> Sometimes you nearly need a crowbar to get them to go [out] because it's, 'No I just want to stay here and sit here and watch the TV and vegetate.' Some of them will just stay in bed. I've had clients in the past that every time I saw them they were just in their jocks and that was it … Every time you offer something, 'No I don't want that.' … So yes, that's a bit hard. (CMO)

Support workers' lived experience

Some consumers said that their capacity to engage was improved if the support worker had lived experience of mental illness, trauma or life events.

> Just for example, there's a couple young ones here that actually went to school with my daughter … I found that both those young men were really good with people, because … they've experienced death. They've experienced poverty. They've experienced hardship in life and completed their year 12, then went to Uni and got in … I'm not saying someone that had a good home, went to school, uni, then into the work, I'm not saying they're not as compassionate, but it is easier to express yourself and to communicate with someone that's … had life skills. (Consumer)

Likewise, stakeholders viewed peer support workers as helpful to increase consumer engagement with the programs and with wider social networks. There appeared to be more awareness of the potential benefits of incorporating peer support workers in the second round of data. Some stakeholders saw peer support workers as key to increasing family participation in the programs as well as increasing culturally competent community involvement.

> I think that the critical element to engagement there is actually talking to the people who are experiencing the problem but also crucially their families and carers and their community and making sure that the sort of support that’s offered is culturally literate in terms of the community being addressed and appropriately codesigned, co-evaluated and ultimately delivered together with the people who need that support and that’s another area where actually that training of peers seems like there’s a great opportunity perhaps to get some great outcomes there. (Stakeholder)

Some CMOs planned to strengthen peer support resources in their organisation. A CMO already had a peer support strategy in place, working towards 50 per cent of support workers being peer workers.

> Our peer support work strategy has been a long-term project starting off with some research we did with [University] looking at how we can be more responsive to embed peer workers in our organisation and embed peer workers … to have a professional identity in our organisation … We have a senior peer worker who provides clinical supervision to our peer workers and importantly also for that peer worker to participate in supervision for our non-peer workers … and we’ve had some pathways developed for consumers in our program that have gone through the program, worked through their recovery and have gone on to be a volunteer and have gone into paid employment within our organisation or paid employment within other peer organisations as well. (CMO)

Support worker consistency

Long-term relationships between worker and consumer contributed to effective consumer engagement with support workers and the positive impact on mental health and social engagement. Conversely, staff turnover had a negative impact, and this was a frequent theme in the interviews with consumers. Some consumers spoke about relationships with support workers that had been developed over long periods of time, for example 6 years, and spoke of grief when these relationships ceased. This happened when the worker moved on or the CMO changed.

Many consumers reported frequent changes of their support workers, and some could not remember the name of their support worker. Many consumers were exhausted by having to re-engage with new workers, and some said that they had given up trying and had disengaged. Consumers asked for better communication from their CMO about staff absences and changes. Some stakeholders were aware of the impact of staff turnover on consumers.

> When I don’t know what’s happening, that brings [panic attacks] on. And I’m, as I said, it’s gotten better with [support worker] ever since I addressed it with her, but if she’s not there, I don’t know what’s happening. And usually when I’ve been left in that, not knowing what was happening, and not knowing if I was getting any help, I was always at a weaker point … So yeah, I think better communication from the other staff when [support worker] is away would ease the panic attacks. (Consumer)

> We've got a big staff turnover. So this chap has had several key workers, he's now become quite disengaged from the program. (CMO)

> I just started getting trust with [support worker 1], she left. I just started confiding in [support worker 2], and she left. It just feels like everyone who’s helping me – and it’s not their fault, I understand, I understand exactly what they’re doing. I did it in my job, I moved to different places. But it’s just, it just feels like everyone’s abandoned me, even though they’re not, it’s just my mental health telling me. (Consumer)

5.3.3 Engagement with the CMO

Consumers had different experiences with their CMO and this impacted on their social participation. Positive experiences happened when CMOs were welcoming, reliable and located within easy access for consumers, and when the CMOs managed transitions between organisations well. Several consumers said their capacity to engage was improved when the CMO was welcoming.

> Like they’re welcoming, they’re warm, when you come up here, they make you feel welcome always, and there’s not much more they could do, to make it comfortable for you. They do everything they say they’re going to do, which is a tick for me. Instead of saying, ‘We’ll do this’, and then two weeks later you’re still waiting, if they say they’re going to do it, they do it straight away. That’s what I like about them … Where with [former CMO], they’re just no good. I didn’t feel comfortable … the lady at the front counter, she seemed rude … So I left. I didn’t go back. (Consumer)

One site had established a drop-in activity service. Consumers described a range of benefits of the drop-in service: it increased their sense of engagement with CLS-HASI, and it offered an opportunity for social participation as well as the usual benefits of group activities. Consumers also reported that it allowed them to decide when they attended.

Some support workers recognised that the responsibility to engage the consumer lay with the providers they interact with, rather than the consumer themselves.

> Where we’re located, it might be easier for them to talk to us, and call us, and call in. Then if we find out that that’s the reason they haven’t gone to [their other provider], we can feed that back to them, and then we can make other arrangements. So I don’t think it’s as simple as they haven’t shown up in a week and we’ll discharge them. It’s really about finding out what they need, and what those barriers are, and addressing them … The worker [from other provider] had been trying to get hold of him on multiple occasions and had told me she’d had no luck. … So then I’ve had to … be a bit more proactive, and kind of have those robust discussions with the service provider, that they need to be more proactive. (CMO)

Transitioning between providers and between programs could cause anxiety, but it was smooth where it was explained and where support staff also transitioned into the new situation.

> Our [support worker] … was pretty cool. He came out and told us [there was a change in CMO] and it was upsetting because, you know, we thought we did something wrong and that’s why we had to go to another program. But he explained it and when we went to [new CMO], we had our old worker, so we got along straight away. (Consumer)

> I thought it went quite well, and I think that has a lot to do with the fact that quite a few [previous CMO] workers got jobs instantly here, and also many of the clients are all the same people. So it made it more comfortable. (Consumer)

5.3.4 Engagement with health and social services

Most CLS-HASI consumers said that their support worker had helped them to stay engaged with health and social services, to continue with their mental health plan, to attend to physical health issues and to get through crises. Most support workers considered supporting consumers to engage with the mental health system a core activity of their role.

> Recently since I have been here at [CMO], the last couple of months they have got me in with other organisations within mental health … which I find was pretty good because no one has ever done that before. (Consumer)

> Interviewer: So they take you to the methadone clinic every day as well?
> Consumer: Yeah, nearly every day, sometimes I get takeaways. And to report as well, because I’m in a bit of strife with the courts and that, and the police. (Consumer)

The MDS shows hours to help consumers access other support systems. Consumers with low support needs got 0.6 hours per month of this type of support, medium support consumers got 2.2 hours, and high support consumers got 3.3 hours. There were similar differences among the consumer subgroups in support for medical and health activities, which includes support to attend appointments. Low support consumers got 0.9 hours, medium support consumers got 3.1 hours, and high support consumers got 6.6 hours.

Consumers who had been in forensic institutions for years often needed particularly intensive support.

> A lot of what you find is the day to day mechanisms that the rest of us take for granted will often be the things that trigger people to say it’s just easier if I go back in [to prison] because I don’t have to think about how to get a feed, I don’t have to talk to anyone to get a bed... That sort of basic stuff is a huge barrier … Any help that [CLS-HASI] can provide to help people negotiate forms and queues and all those sorts of things is massive. (Stakeholder)

Many consumers had multiple providers, and some consumers said they were confused about their various roles. Some used their support worker as a resource to help them manage these other relationships.

> It’s been a bit confusing as to who I call when, or who do I call first, in that sort of order of things. I think that’s been a little bit confusing. (Consumer)

5.4 Cultural capital

Strengthening consumers’ cultural capital by fostering their sense of identity as a member of their cultural group or their cultural connection, increased consumers’ social inclusion according to the consumers and CMOs. Some support workers saw cultural identity as a resource to nurture and support. Few consumers referred to cultural identity, except for some Aboriginal consumers. MDS data show that support for Aboriginal community participation and Aboriginal cultural reference groups[2] was about an hour per month on average for Aboriginal consumers.[3]

Most of the fieldwork contributions about cultural capital referred to Aboriginal consumers. LHDs and stakeholders identified building the cultural capital of

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[2] Aboriginal community participation includes attendance at Aboriginal community events and activities including sporting and cultural events. Aboriginal cultural reference groups include development and maintenance of Aboriginal cultural reference groups. Aboriginal cultural reference group data was only available in MDSV1 to April 2019.

[3] Total average 0.9 hours per Aboriginal consumer per month.

Aboriginal consumers and their communities as a program activity in itself. These stakeholders noted the relationship between using culturally specific practices of healing and improved mental health and community participation.

> Making sure that people have access to social emotional wellbeing and the Aboriginal concepts of healing, I think they would be … one of the most effective enablers for Aboriginal people to return to full community participation. (Stakeholder)

In some locations, CMO stakeholders said that learning about Aboriginal approaches to wellbeing had improved the overall program delivery.

> Aboriginal HASI … influenced the way we supported people in general HASI … we had to relearn the way we communicate and engage with people and understanding that with the person, there's a family, there's a community, there's a whole range of people that were involved. Once we started working with Aboriginal people, we started working like that with general HASI and it just became a better way of supporting people. (Stakeholder)

Aboriginal consumers reported varied involvement with their mob and cultural background, with some having minimal connections. Most consumers said that they had been offered support to make a connection.

> Interviewer: Does [CLS-HASI) meet your cultural needs as an Aboriginal?
>
> Consumer: Yeah, yeah. I've had a few Aboriginal workers that have worked on it, and they've assisted me and yeah ... [CMOs] They've helped me. (Consumer)
>
> We have had and we do have clients that are Indigenous, but they’ve never been very involved with their Indigenous side, although it’s offered, and we know there’s some amazing resources, especially here in [town]. (CMO 2)

Some stakeholders said that cultural responsiveness of CMOs had changed after Aboriginal HASI was merged with CLS-HASI.

> When we had Aboriginal HASI, they were running the men's camps and the women's camps and the men's art groups and the women's art groups, they don't do that anymore. And they were really effective, really effective at building community, and working with some of our chronically mentally unwell Aboriginal people that could make some real gains through that, those creative approaches. And they were able to do that and still meet their KPI’s and we're not seeing that anymore (Stakeholder)

Some Aboriginal consumers said that it was important to have social activities that are particular to Aboriginal consumers because these activities built cultural capital in the Aboriginal community as well as benefitting consumers.

> Generalised programs don’t build cultural resources. (Consumer)

Some support workers discussed the importance of cultural capital to consumers’ wellbeing.

> I think for him [consumer from a minority cultural background], he has … that have a very strong sense of family, and just trying to make sure that we’re very aware of that ... So I had a case conference with the HASI provider and our drug and alcohol service, and the client … it turned out to be nine people attended that meeting, and most of that was his family… It showed that there was a huge lot of support around the client from his family, which is great. (CMO)

Some Aboriginal consumers and stakeholders spoke about the importance of Aboriginal staff for improving consumers’ cultural connections.

> Being an Aboriginal too helps if they know a little more about the culture and our ways. And they do employ Aboriginal people too but I think there could be a little bit more training and I think that's with a lot of departments who actually learn about the culture and our ways because we still do a lot of things differently from non-Aboriginal people and our ways, where some people find that's weird, but that's way we've been brought up.’ (Consumer)

> Yeah, yeah, about Aboriginal culture and stuff like that? Yeah, yeah, they love it. They’re very understanding of the Aboriginal, they take in different breeds, like different cultures, and they’re understanding of your culture, they make sure that they don’t offend you and stuff like that. Yeah, they’re good. (Consumer)

> One of the most effective enablers for Aboriginal people to return to full community participation … I think having very well qualified... preferably Aboriginal staff as well. (Stakeholder)

Many support workers considered themselves ‘culturally neutral’, not distinguishing between equality and equity.

> I think there is a mutual respect … We work with a lot of organisations, so it doesn’t matter if they are Aboriginal, or if they are white, or LGBT, yeah. (CMO)

> We do have a couple of [consumers who identify as [LGBTQI]. To me and to us, they're not treated any differently to anybody else. They all go through the same things - whether it's domestic violence, depression … there's biases surrounding who they are and how they live their lives. But with us, with our roles, all of us, have to be unbiased … We work with anybody who has any kind of mental health issue and has been referred to our service. (CMO)

Some regional areas had restricted opportunities to link consumers to culturally specific groups. Providers suggested forming such groups themselves.

> I think in regional areas as well … we can sometimes struggle with those kinds of resources to be available in the community … there isn't actually anything to link them to. So it's actually having to create a group to link people to as well as the kind of link in from a social inclusion perspective. So I think that is a barrier for HASI and CLS providers. (Stakeholder)

5.5 Summary of engagement

Among the four domains in the framework, Engagement seemed the most prominent for CLS-HASI consumers. How consumers engaged depended on the resources that they could draw on. The resources, also called capital, were economic, human, social and cultural capital. CLS-HASI supported consumers to increase engagement. Consumers with high support needs generally got more hours of support than other consumers.

Economic capital

Economic capital that CLS-HASI consumers could draw on was financial resources, housing and transport.

Consumers said that having little money limited their social participation, like going out or visiting people. Therefore, CMOs offered free social activities and advocated for consumers with Centrelink to get financial support they were entitled to.

Most interviewees saw housing as the basis of improved social inclusion. Feeling safe and secure in their home made consumers feel safe to leave their home and engage in recreational activities, such as social outings. CMOs supported consumers to obtain or maintain safe and secure housing, although the shortage of suitable housing was a challenge. Living away from towns and services restricted consumer access to social activities. One CMO established a remote support worker role to address this.

Consumers said that transport offered by their support workers increased their social participation. They could go shopping, visit friends and attend appointments. Some consumers worked towards using public transport, but outside towns public transport was often not available. Consumers with higher overall support needs got more transport support than other consumers.

Human capital

Aspects of human capital that were important for social inclusion of CLS-HASI consumers were mental and physical wellness, knowledge of social services and relationships with family and friends.

Many consumers said their mental and physical wellness had increased since joining CLS-HASI. Consumers could contact their support workers during a mental health crisis, and the support workers helped them pursue their physical health goals. Many consumers said that without the emotional support from their workers they may have disengaged from the program.

Consumers’ access and knowledge of social services had increased. This was because support workers gave consumers information on what services were available. Support workers also offered training and practical support to facilitate access. This included support to obtain necessary paperwork such as birth certificates and other forms of ID.

Reconnecting with family and friends seemed to be a key activity of CLS-HASI. Success often came when the consumer had stable housing and mental health in CLS-HASI. Stakeholders suggested that giving families more information about mental illness helped to re-engage with families. Support workers encouraged consumers to engage socially. Some consumers had made friends through CLS-HASI activities. Consumers with high support needs got more support for reconnecting with family than other consumers.

Social capital

CLS-HASI consumers gained social capital through engaging with other consumers and the wider community, with support workers, with the CMOs and with the wider health and social service system.

CMOs developed flexible and creative ways to support consumers to make social connections, both in CLS-HASI activities and in community groups. For example, support workers attended services and social engagements together with consumers until consumers felt safe to attend on their own. In doing so, support workers were able to inform people in the wider community about mental illness. This may help to reduce stigma and discrimination of consumers. Consumers with high support needs got more support than other consumers to increase their social capital.

Consumers said that developing trust in the relationship with their support worker was essential to their social engagement. The factors that contributed to a mutually positive relationship were:

- professional skills supporting consumers’ mental health and wellbeing
- lived experience of mental illness, trauma or life events
- consistency and longevity in the relationship.

The consumer experience of CLS-HASI support affected their social participation. Positive experiences happened where CMOs were welcoming, reliable and located within easy access of consumers, and when the CMOs managed transitions between organisations well. Drop-in activities and services increased consumer engagement with the CMO.

Most consumers found that their support worker helped them to stay engaged with health and social services and to continue with their mental health plan. Workers also supported the consumers to coordinate their various service providers.

Cultural capital

In the fieldwork, cultural capital examples mostly related to Aboriginal consumers. Aboriginal consumers had varied connections to Country and their mob, and most said they had been offered support to make a connection. The MDS data confirm that CMOs spent about 1 hour of support per month for Aboriginal community participation and Aboriginal cultural reference groups. Consumers and CMOs considered Aboriginal staff important to improve consumers’ cultural connections.

CMOs seemed to offer few specific activities or support for other cultural diversity among consumers, for example sexual preference and ethnicity. Many workers said they treated all consumers the same, that is they emphasised equality rather than equity. They said that few local opportunities for diverse activities were available in regional areas.

6 Learning

The Learning domain in the Social Inclusion Framework includes formal education and training. Few CLS-HASI consumers engaged in these activities. Learning in CLS-HASI was mainly about social skills and daily living skills.

6.1 Learning social skills

MDS data show that consumers got on average about 5 hours support per month to access social activities and a similar level of support for daily living skills (**Section 6.2**). Consumers with high support needs got a lot more support hours than consumers with low and medium support needs. Regarding social activities, low needs consumers got 1.3 hours of support, medium needs consumers got 6.6 hours, and high needs consumers got 35.5 hours.

The MDSV2 also shows that more than 8 hours of all support per month was as group activities.[4] All fieldwork sites offered social and group activities for CLS-HASI consumers. Some consumers chose not to participate in groups. The majority felt that social activities organised by the CMOs increased their social skills, reduced isolation and improved their mental health.

> On a Friday I go to what they call coffee club, and you just go for a coffee and chat with other people and things like that. (Consumer)
>
> I like it here, I feel free … Because it takes me out of the house. (Consumer)
>
> I found it good for my mental health, like being around other people that knew what it was like, and like doing – having a common interest in something with people that you know understand. (Consumer)
>
> I just like the idea that I can go out somewhere and there’s people who just won’t judge me. (Consumer)

At one site, support workers saw groups as an opportunity to engage consumers with the wider CMO service. Where groups were on-site and consumers could catch up with support workers at the same time, many consumers felt welcome and included.

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[4] MDSV2 for the final 5 months of the study period introduced reporting of the number of hours of support provided as group activities. Group activity hours are therefore indicative based on the available 5 months of MDSV2 data.

> That club style, you know, the lunch being available, being able to just drop in at any time, walk in. I think that practice and that format is really good, really helpful and really engaging. (CMO)

Sometimes, workers supported consumers to engage in social activities outside of the CMO services. These included travel training (as described in 4.1.3) and supported attendance at community venues such as gyms and shops until consumers felt safe to attend in person.

> Meeting people. Yeah, the staff help me by looking after me and I go up and see people are just talk to—the shops are amazing up there. … They take me up and drop me on the streets and I talk to people. (Consumer)

Some CMO staff saw such activities as possible steps towards more independence.

> We may be their social connection, for a long time, and perhaps their social inclusion is going to the shops and interacting with the lady on the [supermarket] checkout; but they are interacting in a social context, and hopefully they're comfortable in that, and maybe with time we can build up to something that's a bit more… I don't know, powerful. (CMO)

6.2 Learning daily living skills

MDS data show that consumers got an average of 4.5 hours per month of support with daily living skills such as cleaning, shopping, cooking, personal hygiene and using transport. Consumers with low support needs got 1.5 hours, those with medium needs got 5.6 hours, and those with high needs got 20.5 hours.

In the fieldwork, some consumers said they learned daily living and wellbeing skills in the CLS-HASI programs. This seemed to contribute to their resources and capabilities. Learning usually happened in one-to-one activities with support workers, such as going shopping.

> It's really little things, in terms of shopping or when we're looking for a place, [support worker] will make helpful suggestions that will make it a bit easier on me … it's just things she's observed about me, the way I do things, and then she'll make suggestions based on what she's observed of me. (Consumer)

Other common and popular activities were cooking classes and gym visits.

> Well, it's better to cook for yourself than just get fast food or eating pizzas, and it's good to have a constructional outcome, with your art or whatever you do, end up getting a job, to have a good chance on the job with that. (Consumer)

> You go to the gym, and you do like the walking machine, the bicycle machine, they've got a heated pool there, and they bought us a six-months gym membership. So I thought that was a nice way of saying, get healthy, you know, without sort of putting anything in your face. (Consumer)
>
> The person who ran the cooking class the first two times was a chef, so he had all the little tricks and stuff with the knives and how to cut different things and then he had told the other workers for the other weeks a couple of different tricks and things. I thought they did that really, really well and that would be beneficial to keep going for other clients. (Consumer)

6.3 Formal learning activities

Recent MDSV2 data show that consumers received almost one hour per month of support for educational or vocational activity or work.[5] This was about the same for different consumer subgroups.[6] In the MDSV2, 81 consumers (1.5%) said they were enrolled in TAFE, 19 consumers (0.3%) were enrolled at University, and 63 consumers (1.1%) said they were in other educational courses.[7] There was no other program or linkage data on consumers' formal learning activities.

Few consumers in the fieldwork sites participated in formal learning activities such as TAFE or university. At one site, a CMO said that several consumers were enrolled in TAFE and some had completed a TAFE course. Another CMO stakeholder said it was rare for a consumer to take up a course. While CMOs supported formal learning, this did not seem a core activity of CLS-HASI. Rather, CMOs seemed to focus on preparatory steps that would enable consumers to do formal learning in the future.

We look at housing, finances, education, their social interaction, any cultural things that they want to do. They are our main four things that we look at and then from there we work out what it is. It could be education, we have had some clients that want to go back to study. (CMO)

Of the consumers interviewed, a few said they were attending TAFE or university, or about to start.

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[5] This is a new item in MDSV2 reporting the number of hours spent to support consumers to access educational or vocational activities or work including employment, volunteer work, workshops, short courses, long courses etc.

[6] Total average 0.74 hours per month.

[7] MDSV2 for the final 5 months of the study period. Based on self-reported LCQ education questions; TAFE includes TAFE, Technical or Vocational training; Other courses include job preparation, adult education and hobby courses.

> I was studying in TAFE College, human something, and then after I didn’t study for six years. I was studying in TAFE College in [place], and now I’m studying in [College name]. (Consumer)
>
> Actually I’m starting up a TAFE course this month. (Consumer)
>
> No, I just want to finish my degree and get some kind of … there is only two jobs I wouldn't hate, being a programmer or an academic. Tutor or something. (Consumer)

Many consumers said that they would like to be involved in more formal and vocational learning in the future or when they felt well enough.

> I’d love to go to university … But yeah, recommend they take me out to the uni a couple of times, and then, you know, I’ll be able to get a bit of [an idea] on what I should be doing at university if I was going to improve myself up a bit. (Consumer)
>
> I wouldn't mind [doing] a computer course when I can down the track. (Consumer)
>
> I've been thinking about going to TAFE but I don’t know what to do. (Consumer)
>
> I don’t think I’ll front up to university but maybe TAFE or something, but I just have to be physically functional on deck and feeling much better than what I am at the moment. (Consumer)

Several consumers had their education interrupted by mental illness, and one spoke about his worry that the pressure of studying would trigger further episodes of illness.

> I’d love to be able to do a TAFE course. Every time I try to do a TAFE course, I end up either in hospital or really sick and can’t go on. Honestly, I’ve tried to finish about nine TAFE courses and because of my mental health I’ve had to leave. (Consumer)

6.4 Summary of learning

Learning social skills and daily living skills seemed to be the main focus of learning in CLS-HASI. Few consumers were engaged in formal learning at TAFE or university. Learning social and daily living skills became the basis for many consumers to consider formal learning in the future.

Consumers learned social skills mainly in activities organised by CMOs. Activities included regular events like coffee clubs and drop-in activities. Learning daily living skills happened either one-to-one with a support worker or in organised classes like cooking or gym. Consumers with high support needs got a lot more support hours than consumers with low and medium needs.

A few consumers in the fieldwork attended TAFE or university, and many mentioned such formal learning as a goal for the future or when they were well enough. Program data show that 3% of all consumers were in TAFE, university or other formal learning. CMOs gave about 1 hour of support per consumer per month for educational, vocational or work activities.

7 Work

Work is significant for social inclusion for three interrelated reasons – it is valued for meaningful engagement in society; work provides economic security through the income earned; and work enables social connections, status and recognition (Meltzer, et al., 2019). Work in the broad sense includes unpaid work. Work is also linked to other social outcomes, such as health and wellbeing (Maynard & Stuart, 2017).

MDS data show that CLS-HASI gave consumers almost one hour of support per month for activities related to work and education. The recent MDSV2 includes the Living in the Community Questionnaire (LCQ), which has questions related to employment. MDSV2 data was available only for the last 5 months of the evaluation. Therefore the LCQ provides an indication of whether consumers had employment. It does not have enough information on whether CLS-HASI makes a difference to consumers' employment status.

The LCQ data suggest that about 10% of consumers were employed, mostly part time (8%). More than 20% were looking for work, again mostly part time work (17%). Around 3 out of 4 consumers were not employed and were not seeking employment, **Table 4**.

Table 4: CLS-HASI consumer employment

Employment category	Consumer (n)	Consumer (%)
Full-time employee	16	1.5%
Part-time employee	84	7.7%
Self-employed - not employing others	8	0.7%
Self-employed - employing others	2	0.2%
Employed - unpaid worker in a family business	4	0.4%
Unemployed - seeking full-time work	47	4.3%
Unemployed - seeking part-time work	190	17.3%
Not employed - not seeking employment	807	73.6%

Source: CLS-HASI MDSV2 from May 2019 to September 2019, n=2,880, LCQ question 12 responses = 1,096 Note: Figures are employment status reported over time in the programs, therefore some consumers had more than one employment status.

The data were reflected in the consumers’ Life Skills Profile (LSP-16) scores (**Appendix 1, Section 4.1.2**). Among all 16 questions, the question about capacity to work had the lowest life skills score by far. It says that few consumers were ‘capable of full time work’ or of ‘part time work’. Most consumers were ‘capable only of sheltered work’ or ‘totally incapable of work’.[8]

Those findings agree with the fieldwork, where few CLS-HASI consumers did paid or voluntary work. The fieldwork data show that most consumers felt their capacity to work was linked to their mental health recovery and their levels of other human and social capital (**Sections 5.2 and 5.3**). The few consumers in interviews who did work seemed to enjoy it.

> I got a job when I was with [previous CLS-HASI provider], and that's a job [in a factory] … I’ve still got the job. … How long have I been working there for? About two years. … Oh, I enjoy it. … It's always good. I'm doing something with my time. (Consumer)

> And I could be off site with [charitable organisation] ... it's not so much the money, I just want something to get up in the morning for... Like, I was going, what do I do today? And I've suffered with that lifestyle for too long, I just want to get up, have something to go to, maybe lead to a job. (Consumer)

CMOs supported consumers with getting or maintaining work. This included connecting consumers with literacy and numeracy programs and vocational training, assisting consumers to apply for work (e.g. helping put together a CV or get appropriate clothes for interviews). Sometimes, CMOs offered voluntary and paid opportunities within the service for CLS-HASI consumers.

> I volunteer. I’ve just started. … HASI helped – my worker helped me along. (Consumer)

> [CMO] helped me get my working with children check ... because I might be starting volunteering at [organisation], but the thing is, I lost the letter so … next week we're going to RTA and get the copy, and then they're going to drop me at [organisation] and I show them my working with children check clearance. (Consumer)

> We’ve had some pathways developed for consumers in our program that have … worked through their recovery and have gone on to be a volunteer

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[8] LSP question 16: What sort of work is this person generally capable of (even if unemployed, retired or doing unpaid domestic duties)? Responses: 0=Capable of full time work, 1=Capable of part time work, 2=Capable only of sheltered work, 3=Totally incapable of work.

> and have gone into paid employment within our organisation or paid employment within other peer organisations. (CMO)

Most people in the interviews felt they did not have the capacity to work, and that managing their mental health was their primary day to day activity.

> Because of my … illness, I feel my situation is a little different. I’m incapable of work. I do struggle with daily tasks. So there are areas of the program which don’t quite apply to me. But in areas as I’ve mentioned, with help with getting to do shopping, medical appointments, help with trying to find housing, and a few material things, they’ve been quite helpful. And I’m grateful for that. (Consumer)

Support workers generally shared the view that many consumers were too early in their recovery to engage in work. Some support workers mentioned discussing work as a recovery goal with consumers. CMOs spoke about consumers who had attained work in the local area, including open employment and supported employment.

> [CMO] got me onto the job. Have you ever heard of an industry called [name of service]? … Well they're a team of people that take an unemployed person with a mental disability, such as myself, put them in a job, see? That's what they do. (Consumer)

> Although I’m not always a fan of supported employment, there is a certain element of people that benefit from the ‘structure but no pressure’ of supported employment. Because if you don’t turn up for work, the world doesn’t end, and if you don’t put in a great day’s work, the world doesn’t end. I don’t really like the level of pay they get, but for some people, it’s just that connection, that feeling of being useful and productive, and that routine that’s helpful. (CMO)

> I’ve worked closely with another service here … they’re a training organisation. I’ve had a couple of clients go through them and they are more than willing to take them on, to help train them. (CMO)

Other consumers spoke about barriers to working, for example one tried to volunteer but could not complete the necessary paperwork. Some consumers had caring responsibilities for family. Others had encountered stigma about mental health and negative past experiences.

> With me, see, being the family person and when nan passed away I took over, you know, I try to hold the family together. The cultural thing that’s mainly important in this family and my family is large. I’m the fifth child out of

> six kids. … I’ve got 32 nieces and nephews and great nieces and nephews. (Consumer)

In summary, about 1 in 10 consumers were employed, and another 2 out of 10 were looking for work. CMOs gave about 1 hour of support per consumer per month for educational, vocational or work activities. Program data also show that CMOs considered most consumers not able to work, or able to work only in supported employment.

In the interviews, most consumers said they could not work, and their primary focus was managing their mental health. Support workers generally agreed. They thought that most consumers were too early in their recovery to work. Some consumers described barriers to work, like caring responsibilities, poor literacy and stigma.

CMOs supported consumers to find work, including open employment, supported employment and volunteer work. Some support workers discussed work as a recovery goal with consumers.

8 Having a voice

The Social Inclusion Framework defines the domain of having a voice as participating in civic engagement activities (such as signing a petition, contacting a Member of Parliament or taking part in a protest or rally). These activities were not reported for CLS-HASI. Consumers and stakeholders talked about having a voice in the sense of consumers being involved in decisions about their CLS-HASI support, including how it fitted into their life and with decisions about their future, and being involved in decisions about their contact with family. Some self-advocacy also occurred, as discussed in **Sections 5.1.1** and **5.1.2**.

8.1 Decisions about CLS-HASI support

Most consumers described their support worker as the primary resource for making decisions about their support and their life plans. Most of them felt their support worker and CMO encouraged their voice.

> I haven't had to really say a lot, but I can guarantee that I would be listened to and that things would be addressed. I can just tell by them. No matter who I asked, I'm pretty sure they'd go above and beyond to work it out. (Consumer)

Generally, consumers with family support tended to have more resources to participate in decision making. Similarly, Aboriginal consumers who were engaged with Aboriginal services and support networks found that a useful resource for their voice. One stakeholder advocated for a culturally responsive approach to involving Aboriginal consumers in decision making.

> I really just think the challenge is to make sure the feedback from Aboriginal people as service users is really approached in a very, very different way. So my colleagues are certainly looking to use Yarn Ups much more effectively to get individual perceptions on what the lived experience is of different services. I think that trying to tailor that sort of consumer feedback process is just so important. (Stakeholder)

The most common aspect of having a voice, for both consumers and support workers, was the consumer's level of participation in the CLS-HASI programs. Many consumers said that they had a choice to participate, that their choice was respected and that support workers encouraged engagement but did not force it.

> [The support worker has] struggled to kind of work out what would be the best help. I definitely need that extra support, it's just not necessarily 100% of the time … I've had days where I haven't felt like coming in and I've said no to

> group catch ups and things like that and they’re very supportive. A few of them have just checked that I’m okay and they’re okay to hang up the phone and actually leave me, and others have just reminded me that there are numbers to call if I need to and things like that. (Consumer)

> They're not always in my face … I phone them if I need anything, and they're there. They've helped me all the time and whenever I need them, and they've given me enough space when I need it and they back off. (Consumer)

Support workers described how participation worked, for example when accessing a different service or changing goals.

> We look at that [individual support plan] every three months to see what their needs might be because they have their up and down days. They could be unwell for a period of time and they don’t want to study anymore, so okay, we’ll get rid of that. Do we want to do something else, or were we just going to forget about it? (CMO)

> We take our cues from the clients a lot; it’s about a lot of that very careful listening about what they want … And if they have kind of alluded to the fact that they’re not quite happy with where they’re getting their care, we can have those conversations with them, and then depending on the functioning level of that client, as to whether we would leave them to go and access that service on their own; you know, basic directions for some of them that may be new to the area, versus ones who are I guess less independent and need a bit more support. (LHD)

Most support workers viewed consumers’ agency about how and when they participated in the programs as important to the recovery approach and to the overall goals of mental health improvement and increased social inclusion. They spoke about responsiveness and flexibility in service provision.

> We don't just go in and do support FOR people, we do it ALONGSIDE people. (CMO)

> We do have a number of consumers who do find it hard in social settings, so we do offer one-on-one in the same type of activity. So, there are consumers who do not feel well enough to participate in, say, our walking group, so we’ll walk one-on-one with them at another time that is suitable for them … So, yeah, we’re flexible. (CMO)

There were some instances of confusion or conflict about the consumer’s agency to participate in program activities.

> And look they basically may not want anything from us, but we're mandated to be here and of course we will say to people they're on CTOs, who again would prefer absolutely not to be involved with us. (CMO)

> So this chap has had several key workers, he's now become quite disengaged from the program … And so I think there's a feeling he doesn't need much, so he doesn't get much, which has made him disengage more … He's an involuntary client and I tried a different tack in recent times and flagging his history of violence and aggression. (CMO)

This tension about participation was evident in comments by staff and consumers. Some consumers felt they had to participate in group activities to remain in the program, and a few CMOs talked about difficulties engaging consumers in any program activities. These CMOs did not suggest solutions other than referring consumers back to hospital care.

Consumers also mentioned when they felt their voice was restricted. Some consumers were grateful to receive support and did not want to put their support at risk.

> Well, we used to go on trips for coffee and that. We're not really doing that as much and—that would be good again … But it's really good though, the crafts and that being with [worker] and [worker] and that. It's really wonderful to come in every week and do a craft with them and just have a talk and that. (Consumer)

Some consumers said they were wary to raise concerns with support workers or CMOs because of negative past experiences.

> Interviewer: Do you feel that you might not be able to share those sorts of things [feedback to improve service quality] with them? Consumer: No, not at all. It's just not on. So it's got to be their way, Hello, I'm fine, I'm great, I'm doing okay but they won't discuss other things. (Consumer)

Consumers described where they had withdrawn from a CLS-HASI service in the past because of a grievance, indicating they had not had the capability or opportunity to resolve problems. A few consumers reported that their support was withdrawn when they complained to a CMO until that problem was resolved.

8.2 Decisions about family involvement

As reported in **Section 5.2.3**, consumers were supported in CLS-HASI to re-connect with family. These decisions were guided by the consumer. CMOs and stakeholders agreed that family involvement was an important area where consumers needed to be supported to have a voice, and where CMOs needed to consider complex family relationships.

> My mum passed away a few years ago and [CMO] took me up to my mum's funeral and, you know, let me stay at the hotel an extra day. So they were very helpful. (Consumer)
>
> We make a point now of when we take somebody on, giving a welcome pack to family and carers, if they want. Not everybody [consumers] will want. Some people are traumatised by family and carers. (CMO staff)
>
> If it's healthy for the person, we encourage it; we have a lot of great families that are involved. [Consumers] love their family, but they also love the fact that they can hide behind us if they need to. They just say, 'Can you just say no?' (CMO)

Consumers and carers said that CLS-HASI could provide further assistance to connect or reconnect with family.

> So if you have any plan we can spend family time together, like me, my daughter, my husband for one day or day a week somewhere we can enjoy, you can arrange that one, because it's a request I'm not saying you do that. We'd like that, you know, some families couldn't afford that one. So if you give them that opportunity, I think the patient will be happy, because some patient want to spend time with the family, but they couldn't afford it. (Family)

8.3 Summary of having a voice

Significant aspects where CLS-HASI consumers had a voice were deciding about their support and deciding about contact with family.

Most consumers felt they had a voice in deciding about their support and their life goals. They made decisions about their individual support plan, about changing CMOs, and about how they participated in program activities.

Their voice was stronger when they had support from family or their community, for example Aboriginal services and networks. Decisions about support to re-connect with family seemed to be guided by the consumer. CMOs were aware of complex family relationships.

Overall, many consumers felt their choices were respected. Having a voice helped them to achieve mental health recovery and social inclusion. Some consumers felt they were not heard when they raised concerns or dissatisfaction about a service.

9 Facilitators of good practice in social inclusion

The findings suggest that most CLS-HASI consumers had great capacity to increase their social inclusion when they had appropriate support. The key to better social inclusion was the CLS-HASI support worker. Once the consumer had built trust with their support worker, they often also engaged with other people and with services. Consumers also then participated in more decisions about their lives. Few consumers took part in formal learning and work. Such activities might occur later in recovery.

The evaluation showed good practice and elements that facilitated good practice in social inclusion. These facilitators could be discussed and actioned among the program partners, both at a central level and locally. The facilitators of good practice, with relation to the four indicators in the social inclusion framework, are:

Engagement:

- Organise free or low-cost social activities
- Ensure consumers receive the Centrelink support they are entitled to
- Build on good practice supporting consumers to access and maintain housing that is safe, secure and appropriate
- Establish relationships with housing providers to prioritise CLS-HASI consumers for social and private housing
- Consider ways to help consumers who live remotely to access social activities
- Encourage engagement from consumers' families, including explaining about mental illness
- Develop approaches to address local community stigma of mental illness
- Supervise support workers through reviewing skills, providing training and asking them what support they need
- Increase, train and support career development of Aboriginal staff and peer workers
- Train staff to support culturally diverse needs

- Make schedules of support workers as consistent as possible to increase consumer trust and always inform consumers when schedules or workers change
- Ensure the CMO premises are welcoming and easily accessible
- Build on creative, flexible approaches to engage consumers, such as drop-in activities
- Ensure that consumers have support to coordinate their multiple service providers.
- Increase the number and support the career development of Aboriginal staff
- Train and support staff to be responsive to cultural diversity

Learning:

Review support for consumers to engage in formal learning, e.g. learning opportunities that prepare consumers for TAFE, vocational and university education, such as adult learning courses and writing activities.

Work:

Build on good practice about supporting consumers to gain work and share success stories among consumers and CMOs

- Identify and address individual consumers' barriers to paid and unpaid work

Establish relationships with potential employers

Having a voice:

- Support staff to encourage consumer participation in decisions about their plan and support
- Review processes for encouraging and managing consumer feedback and complaints.

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Appendix 3: Focus report – CLS-HASI and National Disability Insurance Scheme (NDIS) Interface

Evaluation of NSW Community-based Mental Health Programs: Community Living Supports and Housing and Accommodation Support Initiative – CLS-HASI Evaluation Report

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Meanings and abbreviations

In this report, the term ‘Aboriginal’ includes people from the Torres Strait Islands. We acknowledge the diversity of traditional countries and Aboriginal language groups across the state of New South Wales.

CLS	Community Living Supports
CMO	Community Managed Organisation
COAG	Council of Australian Governments
DCJ	NSW Department of Communities and Justice
HASI	Housing and Accommodation Support Initiative
LACs	Local Area Coordinators
LHD	Local Health District
MDSV1	Mental Health Community Living Programs Minimum Data Set version 1, from November 2017 to April 2019
MDSV2	Mental Health Community Living Programs Minimum Data Set version 2, from May to September 2019
Ministry	NSW Ministry of Health
NDIS	National Disability Insurance Scheme
NGO	Non-government organisation
SIL	NDIS Supported Independent Living program – high level support
SPRC	Social Policy Research Centre
UNSW Sydney	University of New South Wales Sydney

The following words are used in this report when we refer to people who participated in evaluation interviews and focus groups:

- ‘consumers' or ‘people’ are people who received CLS-HASI support or other types of support
- ‘CMOs’ are CMO managers and staff (frontline workers), both in the fieldwork sites and other areas
- ‘LHDs’ are LHD managers and staff members, both in the fieldwork sites and other areas
- ‘families’ or ‘families and carers’ are informal supporters of the consumers
- ‘stakeholders' are all other interviewees from government and state-level positions, and from Aboriginal Medical Services.

Short summary

This report is part of the evaluation of the Community Living Supports and Housing and Accommodation Support Initiative (CLS-HASI) programs. CLS-HASI are NSW Government programs that support people with a severe mental illness to live and participate in the community, the way they want to. The report considers how CLS-HASI and the National Disability Insurance Scheme (NDIS) work together. The report is based on program data and the experiences of CLS-HASI consumers, CLS-HASI service providers and other stakeholders over the first two years' roll out of the NDIS in NSW. NDIS-funded providers were not specifically included in the process.

CLS-HASI and NDIS providers increasingly cooperated to support participants with psychosocial disability. The NDIS became more established during the evaluation and CLS-HASI adjusted to working with NDIS providers. CLS-HASI providers understood the NDIS better as it became established across NSW and supported eligible consumers to access the NDIS. Coordination between CLS-HASI services and NDIS supports improved. Pathways into NDIS assisted consumers to exit CLS-HASI to receive suitable support.

The findings reveal points for discussion on how to continue to improve outcomes for CLS-HASI consumers together with the NDIS about

Access to the NDIS

- improve CLS-HASI providers' knowledge about the NDIS and how NDIS supports can complement CLS-HASI to meet people's needs and goals
- support NDIS providers to learn more about meeting the needs of mental health consumers
- support eligible mental health consumers in CLS-HASI to apply for NDIS funding to meet their support needs if they wish.

Types of support

- build on good practice where CLS-HASI and NDIS providers complement each other's support, so services are used effectively.

Coordination between CLS-HASI and the NDIS

- build coordination from existing relationships between CMOs and NDIS support coordinators and between support workers and providers.

Flexibility of support through service relationships

- invite NDIS service providers, where known, to CLS-HASI networking, capacity building and coordination activities at the local level.

Funding and resources

- allocate time to CMOs to support collaboration in the sector.

1 Executive summary

The Community Living Supports (CLS) and Housing and Accommodation Support Initiative (HASI) are NSW Government programs that provide support to people who have a severe mental illness so that they can live and participate in the community in the way they want to. Many consumers are also supported to apply for and access secure housing. The programs are delivered via partnerships between local health district (LHD) mental health services and Community Managed Organisations (CMOs). The programs also have partnerships with the NSW Department of Communities and Justice (DCJ) and community housing providers.

The NSW Ministry of Health (Ministry) funds the CLS and HASI programs. The Ministry commissioned the Social Policy Research Centre (SPRC) at UNSW Sydney (University of New South Wales) to conduct the evaluation of CLS-HASI.

The evaluation aimed to assess the outcomes of CLS-HASI, to identify what works well in the programs and to determine whether the programs are cost effective. The report primarily reflects the views of CLS-HASI consumers, CMOs and LHDs. NDIS-funded providers were not specifically included in the process. The evaluation ran from November 2017 to January 2020 and adopted a mixed methods design with two waves of data collection (interviews and data linkage). Among the evaluation outputs are four focus reports, which present detailed findings about particular topics central to CLS-HASI service provision.

This focus report explores how CLS-HASI and the National Disability Insurance Scheme (NDIS) are working together from the CLS-HASI perspective. To answer this question, we analysed the evaluation data using a framework developed by the Council of Australian Governments (COAG) in 2015. The framework consists of a set of principles for distributing responsibilities between the NDIS and other service providers, including State and Territory governments. The summarised findings and implications are below.

Access to the NDIS

Program data from the Minimum Data Set (MDS) show that access to the NDIS improved during the evaluation timeframe. By the second round of fieldwork in 2019, consumers, CMOs and LHDs understood the NDIS better. At that time, many CMOs supported consumers through the NDIS application process, and many consumers were optimistic about receiving an NDIS plan.

The proportion of consumers who exited CLS-HASI to NDIS-funded services also went up during the evaluation. CMOs felt that the NDIS was important for exiting consumers successfully from CLS-HASI, when they no longer needed CLS-HASI support, as the NDIS could continue to support consumers in the community. In turn, when a consumer exited CLS-HASI with NDIS support but their mental health deteriorated, CLS-HASI sometimes recommenced temporary intensive support in the community and prevented hospitalisation.

While the NDIS has many benefits, some LHD and CMO managers voiced ongoing concerns. Issues included long wait times for NDIS approval, shortage of appropriate NDIS-funded psychosocial support services, and weak clinical links and case management from NDIS providers.

CMOs, LHDs and stakeholders agreed that receiving an NDIS plan was still difficult for some eligible mental health consumers. This included people in rural areas, older people, people from culturally diverse groups, and from prisons and mental health hospitals.

LHD mental health workers or other referral agencies decided, presumably with input from the consumer, whether to refer a person to CLS-HASI, whether to support them to try to access the NDIS or both. The eligibility for each program did not explicitly guide referrers about how to manage the potential overlap. Decisions seemed to vary between locations and agencies. Further research is needed to explore the reasons why.

Implications for access to NDIS

- NSW Health could suggest that LHDs guide local referrers about how to decide whether to refer consumers to CLS-HASI, the NDIS or both, so that consumers have access to the most appropriate local support for recovery
- Review and fill gaps in NDIS knowledge among CMO and LHD staff about how NDIS-funded supports can complement CLS-HASI to meet people’s needs and goals
- Support NDIS providers to learn more about meeting the needs of mental health consumers[1]
- Develop strategies to ensure all eligible mental health consumers in CLS-HASI are supported to apply for NDIS funding to meet their support needs if they wish.

Types of support

Consumers received different types of support from CLS-HASI and the NDIS. Many consumers received NDIS funding for home services such as personal care, cleaning, lawn mowing and transport, and also for support needs for a physical disability. Consumers often accessed CLS-HASI for psychosocial support and for links to clinical mental health support.

CMOs adjusted CLS-HASI services to complement the support that the consumer could receive from the NDIS. CMOs said complementary support was easier when the CMO provided both CLS-HASI and NDIS support to consumers. This dual role raises questions about conflict of interest.

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[1] The NSW Health NDIS ILC-funded Online Resource *Working with people with mental illness and psychosocial disability* was developed for NDIS and mainstream providers who are not mental health specialists. https://www.health.nsw.gov.au/mentalhealth/psychosocial/Pages/default.aspx

Implications for types of support

- Build on good practice where CLS-HASI and NDIS providers complement each other's support, so services are used effectively.

Coordination between CLS-HASI and the NDIS

Coordination between CLS-HASI and NDIS providers appeared to improve during the evaluation. The findings indicate that coordination resulted in better access by CLS-HASI consumers to NDIS-funded services. CMOs and LHDs identified four periods that required coordination between CLS-HASI and NDIS-funded services.

The first coordination point was when a consumer entered into CLS-HASI. CMOs noted that there was little opportunity for coordination if the consumer already had an NDIS plan. A few consumers were referred to CLS-HASI by NDIS-funded services.

The second time was when consumers applied for the NDIS while in CLS-HASI. Coordination during this process improved during the evaluation, so that consumers were supported more often and had better access to the NDIS. Many CMOs had allocated this task to particular staff members with experience supporting access to NDIS.

Third, when consumers had both CLS-HASI and NDIS support, either consumers or CLS-HASI staff coordinated the different types of support from the two programs. CLS-HASI staff said by the second round of fieldwork in 2019, more NDIS Support Coordinators were available to talk to, for example about avoiding duplication of support. Other improvements were closer relationships between CMO staff and NDIS workers, and local meetings between the service providers. Some LHD staff had a delegated role to liaise between the NDIS and other services.

Finally, services seemed generally well coordinated when consumers exited CLS-HASI. Some consumers exited into more independent living with an NDIS plan. Some consumers with higher support needs were funded for Supported Independent Living (SIL) through the NDIS, which can provide access to 24-hour support.

Implications for coordination

- Build from existing relationships between CMOs and LHDs and NDIS support coordinators, and between support workers and providers to coordinate support with NDIS-funded services
- Further improve exit transitions from CLS-HASI to the NDIS, by
- Assign responsibility for the transition to a CMO worker, including liaising with the relevant NDIS providers
- Stage a prolonged transition and follow up period.

Flexibility of support

Most CMOs, LHDs and stakeholders argued that CLS-HASI support was more responsive to the specific needs of CLS-HASI consumers than NDIS support. They felt this was true both for day to day support, for adjusting support over time and for quickly ramping support up to manage sudden mental health crises. They felt that their flexibility was partly due to the mutual, strong relationships between CMOs and LHDs, where they could discuss and access different kinds of support at short notice.

Implications for flexibility

- Include NDIS service providers in networking, capacity building and coordination activities at the local level if possible
- Consider with the NDIA how to adequately include crisis management in NDIS plans for people with psychosocial disability.

Funding and resources

Most CMOs and LHDs thought that the market funding model of the NDIS was disrupting the ability of the sector to support mental health consumers. They reported that many community-based mental health services had transitioned to the NDIS and were available only to consumers with NDIS packages.

CMOs and LHDs also thought the level of NDIS funding was inadequate to offer high-quality psychosocial support because it was insufficient to fund staff training in supporting this cohort. Further, they felt that collaboration in the sector suffered because of the market-driven culture of the NDIS. By the second round of fieldwork, these concerns had lessened somewhat as they adjusted to the NDIS.

It is not possible to directly compare the costs of different support programs like CLS-HASI and the NDIS. With this limitation in mind, the economic component of this evaluation shows that the average CLS-HASI cost per consumer was $34,889 in 2018-19. That was a similar amount to the average NDIS support package of $33,000 per consumer in 2019, excluding SIL funding (National Disability Insurance Agency 2021).

Implications for funding and resources

- Allocate time to CMOs to support collaboration in the sector.

2 Introduction

The Community Living Supports (CLS) and Housing and Accommodation Support Initiative (HASI) are NSW Government programs that support people who have a severe mental illness so that they can live and participate in the community the way that they prefer. The programs support people to work towards their own recovery goals. The support they receives depend on their needs and goals.

Support for program consumers is for daily living activities like shopping, meeting people in the community, learning new skills, maintaining their accommodation and tenancies, and accessing other services such as clinical mental health services. Many HASI consumers are also supported to apply for and access secure housing. The programs are administered by NSW Health and delivered through partnerships between Local Health Districts (LHDs) and Community Managed Organisations (CMOs). The programs also have partnerships with the NSW Department of Communities and Justice (DCJ) and community housing providers.

In 2017, the National Disability Insurance Scheme (NDIS) became available throughout New South Wales. People with psychosocial disability due to a mental health condition may be eligible to receive support through the NDIS. Many people eligible for psychosocial disability in the NDIS are also eligible for CLS-HASI. This has resulted in a complicated interface between the NDIS and CLS-HASI. According to the CLS-HASI guidelines, NDIS supports should be complementary and not duplicate those offered through CLS-HASI (**Appendix 9**).

This report is part of the evaluation of CLS-HASI. The evaluation was conducted by the Social Policy Research Centre (SPRC) at UNSW Sydney for NSW Health. Among the evaluation outputs are four focus reports, which present detailed evaluation findings about particular topics central to the implementation of CLS-HASI. The focus reports intend to raise questions that can be explored further with CLS-HASI stakeholders to inform program implementation into the future.

This is one of the focus reports. It examines how the CLS-HASI programs were operating in the context of the NDIS and how CLS-HASI and the NDIS were working together. The report primarily reflects the views of CLS-HASI CMOs, LHDs, consumers and their families, and statewide stakeholders. NDIS-funded providers were not specifically included in the process.

We analysed the data using a framework developed by the Council of Australian Governments (COAG) in 2015. The sections of this report explain the analysis framework, briefly describe the data collection methods, summarise the findings for each of the framework components and suggest implications of the findings for future implementation of the CLS-HASI programs.

3 Background

The interface between NDIS and CLS-HASI is informed by the Council of Australian Governments (COAG) principles for distributing responsibilities between the NDIS and other service providers, including State and Territory governments (COAG, 2015). These principles direct that the health system be responsible for clinical mental health treatment and other health issues, while the NDIS be responsible for supporting the consumer's psychosocial recovery. The two systems are intended to 'work closely together at the local level to plan and coordinate' services (COAG, 2015: 6). These principles are used as the analysis framework in this report, as outlined below.

In practice, the interface between CLS-HASI and the NDIS must manage the complex paths of consumers using the systems and difficulties putting the NDIS into practice. Mental Health Australia (2018) highlighted problems for mental health consumers trying to access the NDIS and problems with the quality of NDIS-funded services. In December 2021, the NDIA announced their new Psychosocial Disability Recovery-Oriented Framework. Based on wide-scale consultations, it sets out principles to improve the experience of NDIS participants with psychosocial disability.[2]

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[2] https://www.ndis.gov.au/understanding/how-ndis-works/mental-health-and-ndis?mc_cid=6f026b8d3e&mc_eid=f3f20b223e#new-psychosocial-recovery-oriented-framework

4 Conceptual framework

COAG's 'Principles to determine the responsibilities of the NDIS and other service systems' (COAG 2015) are applied in this report as the conceptual framework to analyse the experiences of consumers, their families and stakeholders of the interface between CLS-HASI and the NDIS. Analytical concepts based on the evaluation questions were allocated to each principle.

Principles for NDIS with other service systems	Analysis concepts
1. *People with disability have the same right of access to services* as all Australians, consistent with the goals of the National Disability Strategy which aims to maximise the potential and participation of people with disability.	Access of CLS-HASI consumers to the NDIS and vice versa – numbers, characteristics
2. *The NDIS will fund personalised supports* related to people's disability support needs, unless those supports are part of another service system's universal service obligation (for example, meeting the health, education, housing, or safety needs of all Australians) or covered by reasonable adjustment (as required under the Commonwealth Disability Discrimination Act or similar legislation in jurisdictions).	Types of support that consumers of both CLS-HASI and NDIS access in each program
3. *Clear funding and delivery responsibilities* should provide for the transparency and integrity of government appropriations consistent with their agreed policy goals.	Coordination between the programs in planning and service delivery – CLS-HASI providers, partnerships and NDIS
4. *There should be a nationally consistent approach to the supports* funded by the NDIS and the basis on which the NDIS engages with other systems, noting that because there will be variation in non-NDIS supports funded within jurisdictions there will need to be flexibility and innovation in the way the NDIS funds and/or delivers these activities.	Flexibility – variations across the state, providers, consumer groups, good practice examples
5. *In determining the approach to the supports funded by the NDIS and other service systems* governments will have regard to efficiency, the existing statutory responsibilities and policy objectives of other service systems and operational implications.	Funding and resources for supports and coordination
6. *The interactions of people with disability with the NDIS and other service systems* should be as seamless as possible, where integrated planning and coordinated supports, referrals and transitions are promoted, supported by a no wrong door approach.	Transitions both ways between CLS-HASI and NDIS, pathways, enabling factors

The analysis concepts form the headings of the findings sections of this report. Their order mirrors that of the framework principles. One exception is Principle 3 Coordination, which also includes findings about Principle 6 Transitions, because they logically fit together in the interface between CLS-HASI and the NDIS.

5 Methods

This focus report is based mainly on interviews and focus groups conducted during two rounds of fieldwork in 2018 and 2019 and program data. Across both rounds of fieldwork, the SPRC conducted 66 interviews with CLS-HASI consumers and 2 family members in 3 fieldwork sites, which were in rural, regional and metropolitan locations (**Table 1**). We also conducted 49 interviews and 4 focus groups with stakeholders from CMOs, LHDs and statewide organisations and agencies (**Table 1** and **Table 2**). Interviews and focus groups consisted of open-ended questions and informal discussions that explored themes covering the evaluation questions as outlined in **Appendix 7**.

Table 1: Number of interviews in fieldwork sites

	Number of people interviewed	Round 1	Round 2	Repeats (both R1 and R2)	Total number of interviews (Rd1 + Rd2)
Consumers	50	40	26	16	66
CMO staff	25	15	13	3	28
LHD and AMS staff	8	4	5	1	9
Family members	2		2		2
Total	**85**	**59**	**46**	**20**	**105**

Table 2: State-wide stakeholder interviews and focus groups

	Number of interviews	Number of focus groups	Total number of participants
Peaks and government agencies	11	N/A	8*
LHDs and CMOs	1	4	18
Total	**12**	**4**	**26**

Note: *3 people were interviewed twice (in both Rounds 1 and 2)

Interview and focus group findings were supplemented, where available, with information from program data collected by the CMOs (MDS data) and the data linkage. CLS-HASI program data and linked data were available for 5,533 program consumers in total, from 2015 to 2019. More detail about the evaluation design and the methods for data collection is in **Appendix 8**.

Limitations of the methods are first, that the qualitative findings in this report are based largely on the perceptions of CMO and LHD stakeholders and the state-wide stakeholders. Most consumers did not distinguish between their experiences of CLS-HASI services and NDIS-funded services, as they did not know how each of their support services was funded. Therefore, the consumer interview data contained few direct references to the consumer experiences of the interface between the programs.

Second, the only NDIS providers interviewed were a few CMO staff who were also offering NDIS-funded services to consumers.

Third, the interviewees did not distinguish between the NDIS scheme, the NDIA and NDIS-funded services, however it was usually clear from the context which they referred to.

Fourth, little quantitative data were available to support the fieldwork findings. The data had limitations in availability, accuracy, and consistency between MDS versions. There were also enhancements of the data items and collection method with the introduction of MDSV2 during the evaluation period. For these reasons, comparative NDIS-related responses between MDS versions should be interpreted with caution.

6 Access to the NDIS

CLS-HASI consumers could apply for access to the NDIS at three points in time: before entering CLS-HASI, during CLS-HASI or as part of the exit plan from CLS-HASI (**Section 8**).

6.1 Before entering CLS-HASI

Before consumers entered CLS-HASI, consumer access to CLS-HASI and the NDIS was considered by LHD mental health workers and other service providers who made referrals. LHD mental health workers mentioned the following considerations when deciding whether to refer to CLS-HASI, or assist someone to access the NDIS, or both:

1) an assessment of the consumer's needs
2) many said they preferred CLS-HASI because of the ease and speed of the referral process and availability of placement, and the high quality of services
3) some thought that consumers could access only one program at a time (either CLS-HASI or the NDIS)
4) some made applications to both CLS-HASI and the NDIS, often approaching the NDIS for disability support that was not related to mental illness
5) some said they referred higher-needs consumers to CLS-HASI and lower-needs consumers to the NDIS.

These findings indicate varied decisions about accessing the programs. Differences may be based on service availability, location and consumer need. The variation might lead to differences across locations and staff about which support consumers might access.

6.2 During CLS-HASI

A major change during the evaluation was that it became easier for CLS-HASI consumers to access the NDIS. CLS-HASI consumers interviewed in the first round of fieldwork reported that the NDIS was largely inaccessible to them because of the complex application process. Often consumers were referring to experiences they had before they entered CLS-HASI. Consumers said the NDIS application was long and difficult, the application process was stressful, it was interrupted when the consumer became unwell, they lost track of the application over time and gave up, or applications were rejected.

> And I started the application off and it was denied because my doctor hadn't put enough information on the sheet. So it was denied. And then I went back to my GP and said 'I really need the NDIS, can you put my illnesses down'. Like it's not just schizophrenia, I have [significant chronic physical health conditions], and they all [impact] my health. (Consumer)

By the second round of fieldwork in 2019, CLS-HASI consumers appeared to have more knowledge of the NDIS and its purpose. They expressed more confidence managing the application process, and said they were better informed about the progress of their application, were more hopeful about receiving an NDIS plan or were looking forward to NDIS support.

> No, we've done the paperwork for NDIS, but we haven't heard back from them as such. They wanted more paperwork, so we stacked up the paperwork, we took the paperwork in personally to the lady at [town], and we haven't heard anything back yet. (Consumer)
>
> No, not yet. I'm expecting something from NDIS … Yeah, [HASI support worker] fixed it up for me. (Consumer)
>
> Yes, I've been granted access [for NDIS] and soon the plan will be put into place. [My support worker] has been looking for people who would be willing to work in [small rural town]. So she's finally found some and we'll be meeting them soon. So that should be helpful as well with cleaning and things like that. (Consumer)

The reasons for greater access to NDIS seemed to be mainly because, by the second round of fieldwork in 2019, CMOs had more knowledge about the NDIS and provided more support to consumers to access the NDIS. All stakeholders emphasised how important this support was, and many CMOs saw support to access NDIS as part of their role.

> One of the challenges is that the most vulnerable [consumers] are not educated enough or have the ability to apply [for NDIS]. So receiving [CLS-HASI] support [to apply] is essential. (CMO)

Program data from the MDS confirm sustained access, and possibly improved access, to the NDIS during the evaluation. Direct comparison of figures from MDS versions 1 and 2 is not possible. Data items and accuracy changed between the versions, and MDSV2 evaluation data covered a shorter time period when the NDIS implementation was more advanced. The share of consumers who were eligible for the NDIS was around 11% during the earlier MDSV1 period and 21% during MDSV2 (**Table 3**).[3] Overall, most CLS-HASI consumers did not initiate an NDIS access request during the evaluation period.

The MDSV2 contained more detailed NDIS questions than MDSV1. It shows that about 31% of consumers submitted an NDIS Access Request Form. 67% of those were deemed NDIS eligible.[4] Of these 607 eligible consumers, most had an approved NDIS plan in place. Two thirds received NDIS support coordination, and a similar proportion received NDIS-funded support services (**Table 3**).[5]

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[3] MDS data limitations may also result from inconsistencies in responses between versions. For example, NDIS eligibility in early MDSV1 collections included CMO responses based on having submitted an access request form, rather than confirmed eligibility by the NDIS.

[4] Based on MDSV2 responses, 607 eligible of 900 submitted access requests.

[5] MDSV2 introduced changed wording to "Received services funded through the NDIS during the reporting period" from "Number of referrals to other services – National Disability Insurance Scheme (NDIS)" in MDSV1.

The MDS did not report the hours of support a consumer received from other programs, such as the NDIS. The Ministry said collection of these data was outside the CMOs' tasks and the scope of the CLS-HASI programs. The MDS did include indicators about what kinds of 'other services' a consumer accessed. This included the NDIS, aged care and drug and alcohol services. The MDS data show that almost half of all consumers (42%) received support for other services.

Table 3: NDIS eligibility and access

	MDSV1		**MDSV2**		**Total**	
	n	%	n	%	n	%
Total number of CLS-HASI consumers	4,619		2,880		5,533	
Submitted an NDIS Access Request Form			900	31.3%		
Eligible for NDIS *	509	11.0%	607	21.1%	948	17.1%
Approved NDIS Plan in Place *			491	80.9%		
NDIS support coordination funded * [1]			407	67.1%		
Received NDIS-funded services * [2]			379	62.4%		
Number of exits	1,495		377		1,872	33.8%
NDIS support after exit (%) [3]	275	18.4%	79	21.0%		

Source: CLS-HASI MDSV1 to April 2019 and MDSV2 May 2019 to September 2019 n=5,533

Notes: Figures based on MDS data include potential data accuracy limitations (Appendix 8 Evaluation Methods).* Mandatory response if consumer submitted an NDIS Request Form.

[1] Does the consumer have support coordination funded in their NDIS plan?

[2] Indicates whether the consumer received funded support through the NDIS in the reporting month.

[3] Number of exits based on complete consumer support episodes, excluding transfers to another service provider, sub program or location.

6.3 Pathway to exit from CLS-HASI

By the second round of fieldwork in 2019, CMOs were more likely to view NDIS support as a possible exit pathway from CLS-HASI. Many CMOs said some consumers had successfully exited because they had NDIS plans appropriate to their support needs.

> There was a period of time when we had three people exited very quickly because they were all just meeting their goals and they had support from NDIS still, so we weren't just leaving them in the cold. (CMO staff)

The MDS shows that among exiting CLS-HASI consumers, about 18% said they went to an NDIS-funded service provider for the MDSV1 period (Table 3). This increased to 21% of those exiting in the latest MDSV2.[6]

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[6] MDSV1 figures from 'Exit destination' question, changed to 'Primary support following exit' wording in MDSV2.

CMOs, LHDs and other stakeholders spoke about the importance of both CLS-HASI and NDIS for consumers from institutional settings. At the time of the interviews, some consumers received CLS-HASI support and later continued living in the community with ongoing NDIS support.

> I think for people who've been institutionalised for a long time who have had multiple tenancy issues, HASI and CLS are a great starting point, just to build up autonomy, independence, interdependence, building your understanding of what your mental health is like, and then getting those social structures and social supports in place before going into the NDIS. (Stakeholder)

Some CMOs, LHDs and other stakeholders also thought that referral back to CLS-HASI could be important for consumers who had exited the programs with NDIS support and who again needed more intensive mental health support than the NDIS could offer. The interviewees implied that consumers might be able to recover in the community with more intensive, short-term CLS-HASI support and return to NDIS support, rather than going to hospital for extended periods.

> Even yesterday I was up at [hospital] and I recognised one of the guys we used to work with who left HASI. Got an NDIS package but now has been in hospital for such a long time but he doesn't have one-on-one support. He'll just, he'll stay in hospital until they think he's ready to go home and then react based on his NDIS package rather than giving him increased support when his complexities flare up and so he doesn't have to spend any time or minimal time in hospital. (CMO manager)

The evaluation interviews were conducted at a time when the NDIS was not yet well established and had not yet addressed psychosocial disability fully in some locations (**Section 3**).

MDSV2 data show that 115 consumers had NDIS support following exit while also continuing to have some CLS-HASI support. This happened when consumers transitioned to a different CMO, sub program or location. These 115 consumers were in addition to the 79 exits who reported NDIS support (**Table 3**). Therefore, a total of 194 consumers seemed to have some NDIS support after exit, which is 24% of total MDSV2 exits.

These results demonstrate the importance of early access to NDIS during a consumer’s time in CLS-HASI to prepare for exit. Without that preparation, delays in approving an NDIS plan could otherwise be a barrier to exit when the consumer was ready (Section 7).

During both rounds of fieldwork in 2018 and 2019, scepticism from CMOs and LHDs remained high about access to appropriate NDIS support. Many LHD managers were concerned that NDIA assessors did not have the experience or qualifications to assess mental health applications. They also worried that NDIS-funded services did not have adequate knowledge, skills and experience to work with people with psychosocial disability or offer appropriate psychosocial supports. Furthermore, many LHD and CMO managers remained concerned about long wait times for the NDIS and a shortage of appropriate NDIS-funded services in some areas, especially rural and remote.

CMOs and LHDs were particularly concerned that, in their view, many NDIS providers and coordinators did not have strong clinical links and case management to support the consumers' needs over time.

> The clinical connections are there [between CLS-HASI and the LHDs]. The [LHD] community mental health teams are part of these programs. Most of the people in HASI have an identified worker with the community mental health team. We have quarterly mental health review processes with our community mental health team. So it's there, you know. NDIS doesn't have the clinical component. I'm not suggesting that someone with a complex mental health issue will always need a clinical component; they certainly don't. But if we're talking about moving them out of that HASI model, it's got to be right. (CMO manager)

Overall, LHDs, CMOs and stakeholders felt that NDIS would have more potential to complement CLS-HASI support if access to NDIS in some areas and population groups was improved:

1. Rural and regional consumers, because there were fewer services overall and fewer choices of services
2. Culturally diverse groups, because NDIS-funded services had less capacity to build cultural knowledge, systems and networks
3. Consumers with complex needs, because the NDIS assessment process did not have capacity to deal adequately with complexity
4. Institutional consumers, because NDIS-funded services did not engage prior to transition out of institutional care and some institutions could not exit consumers without that engagement; and because justice agencies did not have confidence that the supports provided under the NDIS were suitable and safe
5. Ageing consumers with complex health needs who could not receive enough support through existing services but were not eligible for the NDIS.

7 Types of support

This section reports findings about the types of support that consumers received from the CLS-HASI programs compared to NDIS-funded support and how the support types complemented each other.

Several factors were evident from the data that influenced the types of NDIS support that consumers asked for when applying for an NDIS plan, summarised below:

- the knowledge about NDIS of the consumer and the person supporting them to make the application, often a CLS-HASI support worker (**Section 8**)
- the NDIS planner's understanding of the needs of mental health consumers
- the availability of suitable services in the area.

Once CLS-HASI consumers received an NDIS plan, the most frequently funded supports were for domestic services such as personal care, cleaning, lawn moving and transport, and also for physical support needs associated with physical disability. They continued to access CLS-HASI for social and clinical support.

> So, we've found that with NDIS, they're in particular covering for a lot of our consumers those domestic roles. So, supporting consumers in their home, and we've also had a number of consumers who have also been allocated packages for transport, so helping them to more frequently use buses and trains and also taxi vouchers. That has, in turn, given us more range in the psycho-social supports, so supporting consumers to attend social outings and to support them one-on-one with medical appointments. (CMO staff)

The types of support offered by CLS-HASI programs to NDIS consumers differed depending on the consumer's NDIS plan. CMOs said that they tried to adjust the type of services they offered, if possible, to ensure the best outcomes for consumers and to prevent duplication of services.

In a few cases in the fieldwork sites, NDIS-funded services were providing one-to-one social support, for example visiting the consumer in their home to watch television together or taking the consumer on outings in the community. Sometimes NDIS-funded services provided specialist activities that were useful to CLS-HASI consumers, such as nutrition education.

At the time of this evaluation, most CMOs, LHDs and other stakeholders argued that CLS-HASI support was generally more suited to the consumer in quality, type and approach than the NDIS support available in their area. This difference was a frequent theme in the interviews and focus groups in 2018 and 2019. Participants said that CLS-HASI was more likely to:

- support recovery goals and the consumers' independence

- offer clinical support and timely access to specialist support to prevent relapses
- offer case coordination services to all consumers as well as advocacy services
- have staff with specialised knowledge, skills and experience to work with mental health consumers
- support specific groups, such as consumers with additional disabilities, as well as families who had more than one member with disability support needs.

In at least one fieldwork site, the CMO offered both NDIS-funded services and CLS-HASI, sometimes to the same consumers. This might raise perceptions of conflict of interest. CMO support workers in this site saw benefits from providing both types of support, including:

- having access to the expertise and knowledge of disability and mental health workers
- consumers being able to access more group recreational activities
- consumers retaining key relationships and consistency of approach after exit from CLS-HASI.

8 Coordination between CLS-HASI and the NDIS

Service providers discussed coordination and transitions (here called coordination) between CLS-HASI and NDIS-funded services relating to four points during a consumers' service use: at entry into CLS-HASI, when applying for the NDIS while in CLS-HASI, when receiving services by both CLS-HASI and the NDIS, and when exiting CLS-HASI into NDIS support. Coordination appeared to improve during the evaluation from 2018-2019, resulting in better access of CLS-HASI consumers to the NDIS.

8.1 Engaging with NDIS providers at consumer entry into CLS-HASI

According to CMO and LHD stakeholders, some consumers already had an NDIS plan when they entered CLS-HASI. In these cases, most support planning for NDIS-funded services had already occurred, so there appeared to be few opportunities for CLS-HASI to coordinate activities. Such experiences were not mentioned in the interviews.

The MDS data show that few consumers were referred to the programs from the NDIS. MDSV1 started before the full NDIS rollout and did not include NDIS as a source of referral. The MDSV2 used from May 2019 added the NDIS as a source of referral[7]. Fewer than 5 consumers[8] reported the NDIS as a referrer. None of the consumers interviewed in the fieldwork had been referred to CLS-HASI by NDIS-funded services and none had re-entered CLS-HASI from NDIS-funded services. The evaluation interviews and focus groups did not mention referrals from the NDIS, and the possible circumstances when such referrals might occur were not explored.

8.2 Support with applying for the NDIS while in CLS-HASI

Consumers who applied for the NDIS while in CLS-HASI had varying experiences as to who was responsible for supporting them with the NDIS application, depending on their location. However, the process became more consistent by the second round in 2019. In the first round of fieldwork in 2018, assistance with the NDIS application was given by the LHD mental health support workers, the CMOs or other service providers, and there appeared to be no procedures to inform the process. By the second round of fieldwork in 2019, this assistance was usually done by the CMOs (**Sections 6 and 7**).

> We get quite a lot of referrals [from LHD] saying, … 'Can you support the person to get into NDIS?' So we'll sometimes take short-term cases so we can support people

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[7] MDSV2 question 17 Source of referral includes response: 'NDIS-funded provider or National Disability Insurance Agency (NDIA)'. Figure based on MDSV2 194 (table 3) of 796 total MDSV2 exits with a response to exit support question = 24.4%.

[8] We do not report the exact number to protect consumer confidentiality.

> [to access the NDIS]. Because case managers at mental health teams are just overworked. So we'll support people to develop [their NDIS application] with them, in terms of advocacy. (CMO)
>
> So we'll support with doing the plans [for an NDIS application], we'll support with writing a support letter, and then when the plan meetings come up, we'll sit within the plan meetings as well if the participant identifies that they want us to be there. And we can advocate for their needs if they see that as necessary. (CMO)

By the second round of interviews in 2019, it appeared that more consumers were supported to apply for the NDIS, either in addition to their CLS-HASI support or as an exit plan from CLS-HASI (**Section 6**). Most CMOs reported increased knowledge about the NDIS and its application process and more confidence about how to best support consumers to access the NDIS. Many CMOs had developed informal systems to allocate this task, for example:

- Some sites had a formal agreement between stakeholders to allocate the task of assisting with NDIS applications
- Some CMOs and LHDs had nominated a staff member who provided expertise to support workers in the application process
- Some support workers and CMOs had developed good relationships with NDIS-funded services who gave assistance and expertise.

8.3 Coordination when accessing both CLS-HASI and the NDIS

The coordination of services when consumers accessed both NDIS and CLS-HASI appeared to be mostly performed by the consumers. CMOs said consumers often did not have an NDIS support coordinator and that few NDIS service providers participated in coordination meetings about a consumer's services. This meant that the onus was often on the consumer to manage communication with the NDIS provider to get their needs met.

> So when I was at the last meeting with [consumer], I said "Well, why don't you use your NDIS funding for that, and get your NDIS person to do that, you've got a massive amount of funding for this, use that person for that, and then use us for something else, use us for other things that you want us to do, we can still go to the gym with you if you want us to", and things like that.(CMO staff)

There was some change by the second round in 2019, when CMOs mentioned more contact with NDIS support coordinators.

> And everyone sort of worked out … the NDIS support coordinators found their groove, and worked out what their role in the whole big machine was; and definitely a good NDIS support coordinator is critical for someone with HASI in the NDIS space as well. And relationships, relationships, relationships. (CMO staff)

Several new or increased coordination activities were mentioned in the second round in 2019. Some NDIS Local Area Coordinators invited NDIS stakeholders to interagency referral meetings. Closer relationships between NDIS-funded services and CMOs were reported, including CMOs giving informal training to NDIS providers about the support needs of mental health consumers. Some CMO staff had a delegated role to liaise between the NDIS and other services.

> So I'm in charge of HASI Plus, HASI; SILs, which is Supported Independent Living for NDIS, some COS work, which is Coordination of Supports with NDIS. Outreach is mine as well, which is HASI. …. So I'm responsible for meetings in [town] with the partners, discussing transitioning people. (CMO staff)
>
> There's NDIS connections developing, because HASI people have got some NDIS money as well, so the connections and relationships are broadening really, really significantly, because we're now maybe working with NDIS support coordinators, and they could be from a variety of services and NDIS service providers as well. So, yeah, connections now have gone boom. (CMO staff)

As mentioned in **Section 7**, in some areas the CMO was providing both CLS-HASI and NDIS-funded services. Providers said this allowed for better coordination of services, for more services available to consumers and for sharing knowledge, skills and experiences between the service types.

> HASI providers also happen to be NDIS providers in this area … I guess [the consumers] have come to look at the providers in our area as a one-stop-shop. (CMO)

8.4 Coordination when exiting CLS-HASI into NDIS support

The final coordination period was during consumer exit planning. According to MDS data, about 1 in 5 consumers exited CLS-HASI into NDIS-funded services (Table 3). The transition seemed effectively coordinated for some consumers with low support needs.

> In terms of good exits, it's been really, really great. I feel a lot of the exits in [the area] at the moment have been … well people have NDIS now and those supports are there. So we can exit [them] because they've got enough around them to support them. (CMO staff)

In most cases, NDIS support at the point of exit facilitated a step to more independent living. Some consumers whose current NDIS plan and low level of CLS-HASI support did not meet their needs, exited into the higher-support NDIS Supported Independent Living (SIL) program. SIL could include 24-hour supports.

Overall, by the second round of fieldwork in 2019, service providers felt that some coordination problems were temporary and would likely resolve as the NDIS became established.

The research participants suggested that coordination between CLS-HASI and the NDIS could be improved by:

- Encouraging NDIS support coordinators to participate in planning and coordination activities throughout the consumer's involvement with CLS-HASI

- Allocating responsibility for transition to a worker in the CMO, and encouraging NDIS-funded services to do the same, when consumers exit CLS-HASI into NDIS-funded support
- Staging a prolonged transition and follow up period when consumers exit CLS-HASI into NDIS to manage fluctuating need
- Developing mechanisms to encourage stronger relationships between NDIS service providers and LHD Mental Health Teams
- Discussing with consumers and NDIS-funded services to allocate support for crisis management in consumers' NDIS plans, including emergency interventions when required
- Formalising CLS-HASI frameworks to inform coordination activities between CMOs, LHDs and NDIS service providers.

8.5 Flexibility of support

Overall, CMOs and LHDs thought that if NDIS-funded services were flexible, they could better meet the fluctuating needs of mental health consumers during their recovery. In day-to-day support, CLS-HASI providers felt they were more flexible than some NDIS service providers to be able to make sure that schedules and activities did not clash or double up, or that support could quickly be ramped up during mental health crises, ensuring effective crisis management. Their comments might reflect the different funding structures of NDIS and CLS-HASI.

> We tend to be able to facilitate or have a little bit more wriggle room than the NDIS, because NDIS is quite structured. It has to be, because even though HASI's going by the hour now, you still have that … flexibility, that you can move things around a little bit, and still be able to cover your hours, and give them what they want. (CMO)
>
> If someone has a fairly rapid onset kind of challenge with their mental health issue, you put in a [NDIS] plan review request, you could still be sitting there six months later and waiting. What is that person supposed to do if they suddenly need a really big increase in their supports, or even a small increase in their supports? … I hope they are working on a consistent, efficient system, it's … a very frightening space for people with complex mental health issues. (CMO)

In 2018, LHD and CMO stakeholders reported that the strong relationships between LHDs and CMOs were important for CLS-HASI flexibility, as the CMO and LHD staff could discuss and access different kinds of support at short notice. They felt that less established relationships between LHDs, CMOs and NDIS-funded services might mean that NDIS consumers experienced less flexibility, especially if they did not have support coordination as part of their NDIS plan.

> The benefit of the types of CLS support say compared to NDIS support is the ability to work in concert with the clinical mental health team and the ability to provide those case management based services for consumers that might not necessarily get that

> level of support from the NDIS or may even be ineligible for NDIS packages. We do a lot of stepped care in partnership with the Justice and Forensic Health Network Services, so looking at supporting conditional releases and people who are spending a couple of days in the community before returning to the unit. (CMO)

The second-round fieldwork in 2019 indicated that stronger networks between NDIS-funded and mental health services were developing. The mental health services seemed to have better understanding, awareness and knowledge about NDIS-funded services, which still had room for further development. The fieldwork indicated that it might be useful if CLS-HASI included more NDIS-funded services in networking, capacity building and coordination activities at the local level.

9 NDIS funding structure

CMO and LHD stakeholders were adjusting to the new context of NDIS during the period of the evaluation. They were adapting to changes in the capacity of the sector to meet the support needs of mental health consumers. They felt that the market funding model of the NDIS had initially reduced the types and levels of support provided. They were working to address challenges to the:

- principle of fluctuating support according to need
- availability and viability of service providers
- existence of a skilled workforce and
- collaborative culture of the sector.

These topics are explored below. By the second round of fieldwork in 2019, there was evidence of some adjustment as the transition to the NDIS was in progress.

Many CMOs, LHDs and stakeholders thought that the NDIS principle of consumer-directed funding was beneficial for many people with disability. In contrast, they said at the time that pre-NDIS block funding had been more effective for supporting mental health consumers because providers could respond to consumers' changing support needs. They suggested that type of mechanism might be needed in the NDIS context too. The below quotes highlight stakeholder views of the NDIS during its roll out.

> I feel that block funded programs can act as a backstop to NDIS programs, so if there is customers where it's clearly demonstrated that there is no capacity for [NDIS] to understand the CDC framework, like consumer directed care … then it's a matter of referring them to the block funded programs as a back stop. (CMO)

Some LHD and CMO stakeholders said that they thought there were fewer services available to CLS-HASI consumers since the introduction of the NDIS. This was firstly because the Commonwealth-funded community-based mental health services had transitioned to the NDIS and were available only to consumers who had NDIS plans; and secondly because some services had not been replaced. At the time, these thin markets were particularly evident in the regional areas. CMO and LHD stakeholders said that this had led to increased demand for CLS-HASI.

> It's particularly evident in the [LHD] … when we first started there … there was just so many different services. But then funding was taken away or they had to rely on private enterprise to survive and they couldn't. So all these services just kind of disappeared and [consumers] had to apply for NDIS ... But, as a result it's just kind of limited what's available. (CMO)

> The problem is that [NDIS] organisations do market to people who are vulnerable, and subsequently when they find out that person has a significant mental health issue and may be more complex than their staff can handle, they tend to just drop them again and suddenly we have clients in no-man's land. (Stakeholder)

Some CMOs and LHDs were concerned that NDIS funding was insufficient to deliver high-quality services. They said insufficient funding challenged the viability of NDIS-funded services. CMO support workers said that, to survive, some NDIS-funded services took on more consumers than they could adequately support. According to LHDs and CMOs, organisational viability seemed an issue particularly in rural and regional areas with low population density. Having fewer providers reduced choice for consumers.

> The further out you go into smaller places, you know you'd have programs when they had block funding that had the money to go out to there and provide services. Without that, if they've got one person that's a couple of hours away it's not viable to go out and give somebody an NDIS service. I know that it was to provide choice for people but unfortunately in the psycho-social field in that area, choice has been removed from them. (CMO)

By the second round of fieldwork in 2019, the stakeholders reported that some lower-quality NDIS-funded services were disappearing.

The new NDIS funding model also caused concerns about workforce availability and training. Many LHDs and CMOs felt that NDIS funding levels were adequate to employ staff but not to cover training and development. They observed experienced workers leaving the mental health and disability sector, challenging the sector's ability to meet the needs of complex mental health consumers.

Some stakeholders felt they needed to find new ways to rebuild the collaborative culture of the sector in the market-driven culture of the NDIS. They had observed that many NDIS-funded services did not participate in area planning and networking activities, except where NDIS-funded services were run by CLS-HASI CMOs. Second-round data in 2019 indicated an increase in collaboration between NDIS-funded and CLS-HASI services as the NDIS became more established (**Section 8**).

The program cost analysis done for this evaluation shows that the average CLS-HASI cost per consumer was $34,889 in 2018-19, **Section 6.1 Full analysis report**. These CLS-HASI costs are indicative only, as they are an average across locations and across various levels and times of program support. Direct comparison with NDIS support is not possible. With these limitations in mind, the CLS-HASI average support costs appear similar to NDIS average costs per package of about $33,000 in 2019. For higher support provided through Supported Independent Living (SIL) packages, NDIS average cost per year was about $230,000 in 2019, versus $201,185 for high level support CLS-HASI consumers. (National Disability Insurance Agency, 2020).

10 Facilitators of good practice in the interface with NDIS

The findings show that the interface between CLS-HASI and the NDIS evolved during the evaluation period, as the NDIS was established in NSW. The CLS-HASI programs adjusted to working with the NDIS-funded services. This included how to address varying quality and availability of NDIS-funded services that were suitable for mental health consumers.

The evaluation showed evidence of good practice and elements that facilitated good practice in the CLS-HASI and NDIS interface. These facilitators could be discussed and actioned among the program partners, both at a central level and locally. The facilitators of good practice, related to the COAG Principles, are:

Access to the NDIS:

- NSW Health could suggest that LHDs guide local referrers about how to decide whether to refer consumers to CLS-HASI, the NDIS, or both, so that consumers have access to the most appropriate local support for recovery
- Review and fill gaps in NDIS knowledge among CMO and LHD staff about how NDIS-funded supports can complement CLS-HASI to meet people’s needs and goals
- Support NDIS providers to learn more about meeting the needs of mental health consumers[9]
- Develop strategies to ensure all eligible mental health consumers in CLS-HASI are supported to apply for NDIS funding to meet their support needs if they wish.

Types of support:

- Build on good practice where CLS-HASI and NDIS providers complement each other’s support, so services are used effectively.

Coordination between CLS-HASI and the NDIS:

- Build from existing relationships between CMOs and LHDs and between NDIS support coordinators, support workers and providers to coordinate support with NDIS-funded services

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[9] The NSW Health NDIS ILC-funded Online Resource *Working with people with mental illness and psychosocial disability* was developed for NDIS and mainstream providers who are not mental health specialists. https://www.health.nsw.gov.au/mentalhealth/psychosocial/Pages/default.aspx

- Further improve exit transitions from CLS-HASI to the NDIS, by assigning responsibility for the transition to a CMO worker, including liaising with the relevant NDIS providers
- Stage a prolonged transition and follow up period.

Flexibility of support:

- Consider with the NDIA how to adequately include crisis management in NDIS plans for people with psychosocial disability
- Include NDIS service providers in networking, capacity building and coordination activities at the local level if possible.

Funding:

- Allocate time to CMOs to support collaboration in the sector.

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Appendix 4: Focus report – Aboriginal experience of CLS-HASI

Evaluation of NSW Community-based Mental Health Programs: Community Living Supports and Housing and Accommodation Support Initiative – CLS-HASI Evaluation Report

Prepared for NSW Ministry of Health, 2022

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Glossary

Aboriginal-controlled programs	also called Aboriginal community-managed programs. They are initiated by or with, based in, and run by a local Aboriginal community. They deliver holistic and culturally appropriate services to the community in areas such as local government, health, housing, community and welfare.
ACCHS	Aboriginal Community Controlled Health Services
AMS	Aboriginal Medical Service
CLS	Community Living Supports
CMO	Community Managed Organisation
DCJ	NSW Department of Communities and Justice
HASI	Housing and Accommodation Support Initiative
LHD	Local Health District
Ministry	NSW Ministry of Health
NDIS	National Disability Insurance Scheme
SPRC	Social Policy Research Centre
Statistically significant	A statistically significant result (usually a difference) is a result that is very likely not random. More technically, a difference is statistically significant when its p-value falls below a certain threshold, called the level of significance. Most authors refer to statistically significant as $P<0.05$ and statistically highly significant as $P< 0.001$ (less than one in a thousand chance of being wrong). In this report, statistical significance is represented in diagrams as a 95% confidence interval based on a $P<0.05$ threshold.
UNSW Sydney	University of New South Wales Sydney

Terminology

In this report, the term ‘Aboriginal’ also includes people from the Torres Strait Islands to be consistent with NSW Health. We acknowledge the diversity of traditional countries and Aboriginal language groups across the state of New South Wales.

The following terminology is used in this report when we refer to people who participated in evaluation interviews and focus groups:

- ‘consumers' or ‘people’ are people who received CLS-HASI support or other types of support
- ‘CMOs’ are CMO managers and staff (frontline workers), both in the fieldwork sites and other areas
- ‘LHDs’ are LHD managers and staff members, both in the fieldwork sites and other areas
- ‘families’ or ‘families and carers’ are formal and informal supporters of the consumers
- ‘stakeholders' are all other interviewees from government and state-level positions, and from Aboriginal Medical Services.

This report contains comments from managers, staff and stakeholders who identified as Aboriginal and others who did not. Identification is indicated where it is relevant, unless it risks anonymity.

Short summary

This report is part of the evaluation of Community Living Supports and Housing and Accommodation Support Initiative (CLS-HASI) programs in NSW that support people with mental illness to live in the community. The report examines how well CLS-HASI supports Aboriginal consumers and communities. It looks at the experiences of Aboriginal consumers, Aboriginal and non-Aboriginal service providers and other stakeholders. This is supplemented with program data and information from the data linkage where available.

The evaluation data show good program outcomes for Aboriginal consumers, similar to non-Aboriginal consumers. There were many good practice examples in the fieldwork, where CLS-HASI supported Aboriginal consumers well. Different cultural awareness practices were increasing across the sites. This depended on the population of CLS-HASI consumers and local dynamics. Overall, most interview and focus group participants felt that CLS-HASI could engage better with Aboriginal culture, communities and organisations. The facilitators for good practice in CLS-HASI programs were:

Partnerships

- dedicate time towards formalising closer partnerships between CLS-HASI and Aboriginal organisations, and include other relevant government agencies in these partnerships, for example Justice, Housing and NDIS

Employment

- support the career paths of Aboriginal people as staff and managers
- consider employment targets and monitoring of these targets for Aboriginal staff in CMOs
- create Aboriginal-specific roles, for example as advisors and peer workers

Control

- consider how to incorporate elements of Aboriginal-controlled programs into CLS-HASI, to ensure more Aboriginal community control of the services

Cultural responsiveness

- improve cultural responsiveness of services through
    - mentoring and training from Aboriginal organisations
    - including family and community in consumer support and planning when appropriate to the person
    - opportunities for Aboriginal consumers and staff to advise, mentor and train other staff and consumers.

Executive summary

The Community Living Supports (CLS) and Housing and Accommodation Support Initiative (HASI) offer mental health consumers psychosocial support, tenancy support and clinical mental health services. Many consumers are also supported to access secure housing. The programs are delivered via partnerships between Local Health District (LHD) mental health services and Community Managed Organisations (CMOs). The programs also have a strong partnership with the NSW Department of Communities and Justice (DCJ) and community housing providers for social housing.

The NSW Ministry of Health (the Ministry) funds the CLS and HASI programs. The Ministry commissioned the Social Policy Research Centre (SPRC) at UNSW Sydney (University of New South Wales) to conduct the evaluation of CLS-HASI.

The evaluation aimed to assess the outcomes of CLS-HASI, to identify what works well in the programs and to determine whether the programs are cost effective. The evaluation ran from November 2017 to January 2020 with a mixed-methods design of two waves of data collection in 2018 and 2019 (interviews and data linkage). Among the evaluation outputs are four focus reports that present detailed findings about topics central to CLS-HASI service provision. This focus report examines how well CLS-HASI fulfils its program objective to support Aboriginal consumers and communities. Aboriginal people are one of the priority groups for CLS-HASI support.

We analysed the evaluation data using a framework developed by the Lowitja Institute, Australia's National Institute for Aboriginal and Torres Strait Islander Health Research (Kelaher et al., 2018). The framework states principles for Australian governments working with Aboriginal people.

Below are the evaluation findings, which are summarised according to the principles of the Lowitja framework. From the findings we conclude the facilitators for good practice in CLS-HASI. The CLS-HASI evaluation findings are consistent with the findings of the broader NSW Auditor-General's performance audit of NSW mental health services for Aboriginal people (Audit Office of NSW 2019).

Partnerships and shared responsibility with Aboriginal communities

This principle entails partnership and shared ownership in health planning and delivery between Aboriginal people, communities, Aboriginal Community Controlled Organisations (ACCOs), governments and other service providers.

The evaluation found some effective partnerships between CLS-HASI providers and Aboriginal organisations. Service providers found that the best way to develop these partnerships was to build from existing Aboriginal committees and processes. Most connections were informal, and their structures depended on local connections.

Stakeholders suggested that other programs and agencies intersecting with CLS-HASI, such as the NDIS, Corrective Services and DCJ Housing, also needed to develop stronger relationships with Aboriginal organisations and to formalise them for sustainability. That might improve understanding of Aboriginal community needs and improve referrals and support for Aboriginal consumers across agencies.

Facilitators for good practice in partnerships

- dedicate time for CMOs and LHDs to foster formalised partnerships with Aboriginal organisations and communities
- leverage from existing relationships and committees
- include other relevant government agencies in these partnerships.

Engagement with Aboriginal communities

Engagement involves the ongoing participation of Aboriginal people and communities, including ACCOs, in all levels of decision making to ensure that all policy and activity has their support and input.

The evaluation found good practices of engagement with Aboriginal consumers and communities at the service delivery level, through the employment of Aboriginal people, and at the community level, with most CMOs engaging with AMS when supporting consumers who access both services.

Most CLS-HASI providers employed Aboriginal people as frontline staff. Consumers reported that having Aboriginal staff supported them to develop trust and engage with the service. In some sites, Aboriginal staff had roles specific to their Aboriginality, for example they were matched with Aboriginal consumers. Few Aboriginal staff participated in case planning or were managers. Most CMOs tried to recruit additional Aboriginal staff. Recruitment appeared most effective where the staff had connection to the Country or the ‘mob’ where they were working.

CLS-HASI staff generally offered the consumers the option to receive services from a local AMS, leaving the decision whether to use AMS services up to the consumer. Most consumers used an AMS if they had a previous connection or positive experience with it.

Facilitators for good practice in engagement

- Ministry and CMOs to consider benchmarks and incentives to employ Aboriginal staff to work in Aboriginal-specific roles (e.g. linking them with Aboriginal consumers, advisory role, community development) and support Aboriginal staff in their career development for case management and managerial positions.

Capacity building of Aboriginal communities

The capacity building principle refers to developing and providing knowledge, skills, resources and systems to support Aboriginal people and communities to engage in designing and implementing health services.

The evaluation found evidence of Aboriginal capacity building with Aboriginal consumers, including connecting to culture and community, and to live independently. CLS-HASI supported Aboriginal consumers to reconnect with culture and community if they wished to. Aboriginal consumers suggested some future additional activities that could increase consumers' cultural connections. Some CMO staff drew on the knowledge of Aboriginal consumers with good cultural connections to improve their own and their colleagues' cultural practices.

Facilitators for good practice in capacity building

- encourage providers and consumers to pursue collaborative development about culture and community to improve mutual understanding and connections with communities
- develop opportunities for Aboriginal consumers to inform cultural responsiveness of staff and other consumers.

Equity

The principle of equity encompasses physical and cultural accessibility, inclusiveness and equitable health outcomes.

The share of Aboriginal people among CLS-HASI consumers increased since previous evaluations. It is now almost 5 times the share in the general population. Aboriginal consumers in CLS-HASI had levels of support similar to non-Aboriginal consumers in many support types. Aboriginal consumers had more support for accessing other services and for housing. They had less psychosocial support, less support for social activities and less staff travel to and from the consumer.

Linked data show that CLS-HASI had good outcomes for Aboriginal consumers, similar to non-Aboriginal consumers. There were drops in hospital days for mental health issues, in use of emergency departments and in the number of contacts with community mental health services. Applications for housing increased, and so did new tenancies, with bigger increases than for non-Aboriginal consumers in both measurements. All findings were statistically significant.

The fieldwork found good practice examples of how CLS-HASI supported Aboriginal consumers to challenge inequity that consumers experienced at personal and community levels, for example racism or lack of cultural awareness, and at systemic levels, including accessing services such as housing.

Elements of service provision that needed improvement to reduce inequities included difficulties reaching people in remote areas, resulting in access inequities, and cultural awareness regarding the specific challenges faced by Aboriginal consumers. Most CMOs said they attempted to treat all people in the programs the same, or ‘equally’, rather than adapting support to address cultural disadvantage, or equity.

Facilitators for good practice in equity

- increase cultural responsiveness training and reflective practice
- train CMO and LHD managers and staff on the concept of equity and the importance of specific equity initiatives to address disadvantage and achieve equal opportunities for Aboriginal people
- LHD and CMO managers to review approaches to supporting Aboriginal consumers and how cultural disadvantage could be better addressed through the program.

Accountability, evidence based and data governance

Accountability applies to government, mainstream and Aboriginal services and is necessary to understand the effects of program implementation. Evidence-based policy and program approaches necessitate a robust process of program evaluation and the integration of evaluation outcomes into policy making and program design. Aboriginal communities have the right to govern, control and manage the collection and use of their own data for their purposes and in ways that they see fit.

Privacy and use of program data to inform improvements were not discussed directly in the interviews. When consumers join the CLS-HASI programs, they consent to CMOs and the Ministry of Health collecting and using consumer data that is needed to deliver the programs and monitor success. This consent includes outcome measures regularly collected by CMOs.

Some LHD and CMO managers and a few Aboriginal consumers considered that CLS-HASI needed to further adopt elements evidenced as effective from the former Aboriginal HASI program such as brokerage funding, packages of support hours, outreach to remote areas and more Aboriginal staff. These additional resources could address the greater inequity faced by Aboriginal consumers, including access to appropriate support and strengthening links to Aboriginal communities.

Facilitators for good practice in accountability, evidence based and data governance

- reconsider how to learn from the evidence of Aboriginal controlled mental health programs, to adapt current or develop complementary arrangements.

Holistic concept of health

A holistic approach to health recognises the physical as well as the spiritual, cultural, emotional and social aspects of wellbeing and their role in contributing to health outcomes for Aboriginal people and communities.

The evaluation found good practice evidence of how CLS-HASI embraced the concept of holistic health through various approaches. Consumers said the psychosocial support offered by the programs improved their emotional wellbeing. Building stronger connections to family and community also improved social-emotional wellbeing. This holistic approach was successful where staff took a wide cultural view and where Aboriginal staff were available. Other aspects of a holistic approach included supporting physical health and ensuring that Aboriginal consumers retained safe and suitable housing.

Facilitators for good practice in holistic health

- facilitate program-wide discussion and cultural responsiveness training about:
    - the importance of community connections for Aboriginal consumers
    - how CLS-HASI can include consumer communities and families

Cultural competence

Cultural competence recognises the diverse cultures and histories of Aboriginal peoples, the important role of key representative bodies, and local ACCOs.

The evaluation found that employing Aboriginal staff improved the cultural competence of CLS-HASI services. CMOs increasingly considered cultural diversity in program delivery, for example through participating in Aboriginal events. Some CMOs and LHDs included cultural responsiveness training for staff. In 2019, the Ministry of Health made Aboriginal Cultural Competency training available to all CLS-HASI providers. CLS-HASI would benefit from more training and reflective practice about cultural responsiveness overall and to share good practice to develop consistency across providers.

Cultural competence also refers to how the CLS-HASI programs liaise with ACCOs, discussed in the section ‘Engagement with Aboriginal communities’.

Facilitators for good practice in cultural competence

- assess the impact of cultural responsiveness training offered in 2019
- adjust training approach if necessary
- review training needs periodically

Capitalising on Indigenous strengths

Appropriate mechanisms need to be in place to identify community strengths, expertise and skills, allowing communities to capitalise on their strengths.

There were several examples where CMOs involved Aboriginal staff as experts to offer support and cultural advice for non-Aboriginal staff. Most CMOs fostered learning and art activities as part of their cultural programs.

Some service providers, key stakeholders and consumers suggested that facilitating a part of HASI managed and staffed by Aboriginal people could capitalise on Indigenous strengths.

Facilitators for good practice in capitalising on strengths

- foster good practice through exchange between Aboriginal and non-Aboriginal colleagues, such as mentoring, training and advising
- develop strategies to involve Aboriginal people in management of CLS-HASI services.

1 Introduction

The Community Living Supports (CLS) and Housing and Accommodation Support Initiative (HASI) are NSW Government programs that offer support to people who have a severe mental illness so that they can live and participate in the community the way that they want to. The programs support people to work towards their own, unique recovery goals. The types of support that people receive depend on their individual needs and what they want to achieve.

Support available to program consumers includes support with daily living activities like shopping, meeting people in the community, learning new skills, maintaining their accommodation and tenancies, and accessing other services such as clinical mental health services. Many HASI consumers are also supported to apply for and access secure housing. The programs are administered by NSW Health and delivered through partnerships between Local Health Districts (LHDs) and Community Managed Organisations (CMOs). The programs also have a strong partnership with the NSW Department of Communities and Justice (DCJ) and community housing providers for social housing.

An Aboriginal HASI program was introduced in NSW in 2009. The program provided 100 packages of support for Aboriginal people with mental health challenges. In 2017 Aboriginal HASI and the other HASI models (HASI and HASI in the Home) were consolidated into a single HASI program. At the same time, HASI adopted a more individualised approach, providing flexible hours of support rather than the previous HASI fixed-hour packages, with support hours increasing or decreasing as consumer needs change over time. This brought HASI in line with the CLS program, which started in 2016 and has the same structure and target groups as HASI.

To ensure CLS-HASI is supporting Aboriginal people well, NSW Ministry of Health introduced specific contractual requirements in 2016 and 2017 respectively. CLS-HASI providers are required to:

- support a minimum number of Aboriginal consumers
- establish an Aboriginal Cultural Reference Group or consult with and receive guidance from an existing local Aboriginal service or group, such as Aboriginal Community Controlled Health Services (ACCHS), Aboriginal Medical Services (AMS) and NSW Aboriginal Land Councils, to ensure that services are culturally appropriate and respected by local communities
- support Aboriginal people to participate in their community and access Aboriginal services.

In 2019 NSW Ministry of Health made Aboriginal Cultural Competency training available to all CLS-HASI providers. The training started after data collection for this report finished, so its impact could not be assessed.

This report is part of the evaluation of CLS-HASI. The evaluation was conducted by the Social Policy Research Centre (SPRC) at UNSW Sydney for the Ministry. Among the evaluation outputs are four focus reports, which present detailed evaluation findings about particular topics central to the implementation of CLS-HASI. The focus reports intend to raise questions that can be explored further with CLS-HASI stakeholders to inform program implementation into the future.

This is one of the four focus reports. It examines how and to what extent CLS-HASI fulfills its program objectives relating to Aboriginal consumers and communities. We analysed the evaluation data using a framework developed by the Lowitja Institute, Australia’s national institute for Aboriginal and Torres Strait Islander Health Research. The following sections of this report contain a brief description of the data collection methods, explain the analysis framework, summarise the evaluation findings for each part of the framework and suggest implications of the findings for future implementation of the CLS-HASI programs.

The context of this report is informed by two documents relevant to Aboriginal mental health, the Gayaa Dhuwi Declaration and the National Framework for Recovery Oriented Mental Health Services.

Gayaa Dhuwi (Proud Spirit) Declaration (NATSILMH 2015)

The Declaration was developed by the National Aboriginal and Torres Strait Islander Leadership in Mental Health (NATSILMH), which is an independent organisation supported by the four Australian mental health commissions. NATSILMH’s aim is to support the wellbeing and mental health of Aboriginal and Torres Strait Islander peoples and to prevent suicides, by advocating and providing advice and leadership in these areas. The Declaration calls for Aboriginal and Torres Strait Islander concepts of social and emotional wellbeing, mental health and healing to be recognised across all parts of the Australian mental health system and to be supported with clinical outcome measures. In addition, Aboriginal and Torres Strait Islander presence and leadership should be included across all parts of the Australian mental health system.

A national framework for recovery-oriented mental health services: guide for practitioners and providers (National Framework; Australian Health Ministers' Advisory Council 2013)

As recovery orientation is one of the underpinning principles of CLS-HASI, the evaluation findings are assessed with reference to the National Framework, which is the benchmark for recovery-oriented service provision in Australia. It guides what recovery-oriented services should look like, by describing five key areas of practice (domains) and 17 associated capabilities that service providers need in order to effectively support people with mental health issues. Capability 2B is particularly relevant to this report, ‘Responsive to Aboriginal and Torres Strait Islander people, families and communities’:

> Recovery-oriented practice and service delivery with Aboriginal and Torres Strait Islander people must recognise the resilience, strengths and creativity of Aboriginal and Torres Strait Islander people, understand Indigenous cultural perspectives, acknowledge collective experiences of racism and disempowerment, and understand the legacy of colonisation and policies that separated people from their families, culture, language and land. (p.49)

2 Methods

This focus report is based mainly on interviews and focus groups during two rounds of qualitative data collection for the evaluation in 2018 and 2019. In addition, we used program data collected by the CMOs (Minimum Data Set or MDS) and linked data from various government agencies.

Interviews and focus groups were open-ended questions and informal discussions that explored themes covering the evaluation questions as outlined in **Appendix 7**. **Table 1** and **Table 2** show the total number of interviews and focus groups. They also show that 22 people interviewed identified as Aboriginal (13 consumers, 3 CMOs, 5 LHD and AMS staff and 1 stakeholder).

All the consumer interview data included in this report is from consumers who identified as Aboriginal. Interview and focus group data from the other participant groups includes contributions from people who identified as Aboriginal as well as non-Aboriginal.

Table 1: Number of interviews in fieldwork sites

	Number of people interviewed	Round 1	Round 2	Repeats (both R1 + R2)	Total interviews (R1 + R2)
Consumers	50	40	26	16	66
- *Aboriginal*	*13*			*3*	*16*
CMO staff and managers	25	15	13	3	28
- *Aboriginal*	*3*			-	*3*
LHD and AMS staff	8	4	5	1	9
- *Aboriginal*	*5*			-	*5*
Family members	2	-	2	-	2
Total	**85**	**59**	**46**	**20**	**105**

Table 2: State-wide stakeholder interviews and focus groups

	Number of interviews	Number of focus groups	Total number of participants
Stakeholders	11	N/A	8*
- *Aboriginal*	*1*		*1*
LHDs and CMOs	1	4	18
Total	12	4	26

Note: *3 people were interviewed twice (in both Rounds 1 and 2)

CLS-HASI program data and linked data were available for 5,533 program consumers in total, from 2015 to 2019. During that time, 788 consumers identified as Aboriginal, or Aboriginal and Torres Strait Islander, or Torres Strait Islander, or Indigenous, or more than 1 of these groups, Table 3. We use the summary term 'Aboriginal' in this report (see **Terminology**).

Table 3: Number of Aboriginal consumers in MDS and data linkage

Aboriginal status	Consumer number	Consumer %
Neither Aboriginal nor Torres Strait Islander	4,456	85.9%
Aboriginal	716	13.8%
Aboriginal and Torres Strait Islander origin	42	0.8%
Torres Strait Islander	20	0.4%
Indigenous not further specified	10	0.2%

Source: CLS-HASI linked MDS n=5,190.
Notes: Aboriginal status unknown for 340 consumers, 3 chose not to respond. Consumer numbers do not sum to total or to 100% due to 54 reports of more than one status during the study period.[1]

More detail about the evaluation design and the methods for data collection is in **Appendix 8**.

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[1] Aboriginal status is based on the person's self-reporting. New Aboriginal codes were introduced in MDSV2 for 'Indigenous – not further specified', 'Declined to respond' and 'Unknown'.

3 Analysis framework

The main analysis framework used in this report is the *Evaluation Framework to Improve Aboriginal and Torres Strait Islander Health – Users Guide* (Kelaher et al. 2018). Development of the Evaluation Framework was funded by the Lowitja Institute, which is Australia's national institute for Aboriginal and Torres Strait Islander Health Research. Part A of the framework provides a guide to the stated principles of Australian governments for working with Aboriginal people. Each principle includes outcomes and indicators, which can serve as a guideline for analysing evaluation findings. The authors of the framework state:

> These principles have been identified as centrally important in underpinning Aboriginal and Torres Strait Islander health and wellbeing programs. ... [They] should underpin any policy, program or service that aims to improve Aboriginal and Torres Strait Islander health and wellbeing and should be included as part of the evaluations for such initiatives. (p.3)

The principles, including short descriptions, are:

- Partnerships and shared responsibility with Aboriginal organisations and communities

This principle requires partnership and shared ownership in health planning and delivery between Aboriginal people, communities, Aboriginal Community Controlled Organisations (ACCOs), governments and other service providers. Effective partnerships ensure Aboriginal people and communities' central involvement in designing and implementing strategies for better health and wellbeing. Support to develop knowledge, skills and systems is required.

- Engagement with Aboriginal and Torres Strait Islander people and communities

Engagement involves the full and ongoing participation of Aboriginal people and communities in all levels of decision making, to ensure that all policy and activity has their support and input. The engagement of ACCOs is central to improving Aboriginal health outcomes.

- Capacity building of Aboriginal communities

This principle refers to developing and providing knowledge, skills, resources and systems to support Aboriginal people and communities to engage in designing and implementing health services. It may involve employment and training, or encouraging Aboriginal people to take on leadership positions, and adequate representation of Aboriginal communities and organisations on advisory and governance bodies.

- Equity

Equity includes ensuring that programs are physically and culturally accessible, are inclusive of the needs of Aboriginal people, incorporate Aboriginal ways of working, and enable Aboriginal people to achieve equitable health outcomes.

- Accountability, evidence based and data governance

The accountability principle refers to regular program evaluation and measurement against indicators of success. Accountability applies to government, mainstream and Aboriginal services and is necessary to understand the effects of program implementation. It incorporates transparency in the use of funds and adequate funding for necessary services.

Evidence-based policy and program approaches necessitate a robust process of program evaluation and the integration of evaluation outcomes into policy making and program design.

The data governance and intellectual property principle acknowledges that Aboriginal communities have the right to govern, control and manage the collection and use of their own data for their purposes and in ways that they see fit. Data needs to be collected and presented in a format that is useful for communities, and they must retain access to the data.

- Holistic concept of health

A holistic approach to health recognises not only the physical but also the spiritual, cultural, emotional and social aspects of wellbeing and their role in contributing to health outcomes for Aboriginal people and communities. This includes environmental determinants of health such as food, water, housing and unemployment, and social determinants such as education, employment, racism, history of dispossession, and loss of land and heritage.

- Cultural competence

Cultural competence recognises the diverse cultures and histories of Aboriginal peoples, the important role of key representative bodies, and local ACCOs. Such an approach delivers health programs in a culturally safe and respectful way.

- Capitalising on Indigenous strengths

Appropriate mechanisms need to be in place to identify community strengths, unique and valued knowledge, expertise and skills and to allow communities to capitalise on their strengths.

These principles structure the evaluation findings presented in the following sections of this report. As many principles overlap, we chose under which heading to include particular findings. We explain our choices throughout.

4 Partnerships and shared responsibility with Aboriginal organisations and communities

This section reports on findings about the first two principles of the Lowitja Institute Evaluation Framework: ‘Partnerships with Aboriginal and Torres Strait Islander organisations and communities’ and ‘Shared responsibility’. Both principles have the same description, outcomes and indicators in the Framework and are therefore combined here. We include findings about referrals to CLS-HASI under this heading. No consumer quotes were directly relevant to the principles in this section.

In the interviews, staff from the CMOs, Aboriginal Medical Services (AMSs) and LHDs referred to good partnerships between two CMOs in regional areas and the respective local AMS. Generally, good partnerships were more established in areas with a large Aboriginal community:

> I'm sure we've got big differences … here. We are a lot closer to everybody … here, especially in [location], there's a lot more Aboriginal-controlled services there ... There's a higher Aboriginal population. We've got Aboriginal specific workers working at both sites. We recruited those people, we had an Aboriginal liaison officer on the panel. He identified men and women who came from this area, so they understood Country and they were local people. (CMO)

Some service providers knew several Aboriginal organisations in their area to potentially partner with. They found the best way to develop partnerships was to tap into existing Aboriginal committees and processes rather than setting up separate consultation processes for CLS-HASI:

> … each community in each Aboriginal Medical Service has different needs … Given that we have so many different represented language groups and so many different diverse communities with so many different needs … A representative from say [community A] can’t necessarily speak for what’s going on in [community B]. So using the existing Aboriginal consultation methods in those communities we feel is a better way forward rather than another consultation committee. (CMO manager)

Partnerships took on different structures, depending on the local circumstances. They could be formed through other programs run by CMOs, through the employment of Aboriginal staff within LHD services, or through jointly supporting a consumer with a local AMS:

> I think the Yarning Space that we're trying to set up with the Stolen Generations organisations is going to be a very, very different approach for us. Having a round table with them later on this year. It will be a time for us to

> just sit there and listen and to get their feedback about how we can do better. (CMO)
>
> We work closely with the Indigenous worker from Community Mental Health as well as us and an Indigenous support worker … It just gives us a lot of information and a lot of rapport, just instant rapport when [consumers] see two Indigenous support staff. (CMO staff who identifies as Aboriginal).
>
> When our participants do use the [AMS], it will give us a bit more understanding – because they might go in there very unwell, very sick and if [AMS] call for us to go and see the participant, they can let us know what the participant is like before we can go down to meet and greet them and see what's happening with our participant. (CMO staff)

In most cases partnerships appeared to be localised and informal. A barrier to developing more effective, formal partnerships between CLS-HASI and Aboriginal services appeared to be that they were peripheral to the core structure of CLS-HASI, where the main partners were the CMOs, LHDs and NSW Ministry of Health.

> The AMSs are probably more of a tertiary partner than a primary partner in that space. CLS is very much geared towards people involved in the New South Wales mental health system. (CMO manager)

Stakeholders raised the need for other services that intersect with CLS-HASI, including the NDIS, Housing and Corrective Services, to develop stronger partnerships with Aboriginal organisations, so that each part of the intersecting system is effective for the consumer:

> And certainly, with our project work with Aboriginal housing as well, we are trying to get across that [shortage of NDIS Aboriginal specific providers]. I know the links are quite strained at the moment. (Stakeholder)
>
> We try and … build [Aboriginal community] connections in communities where we think [consumers in Corrections] will be returning to but that's the challenge … I would like to think that with CLS and HASI that there's a potential for them to be building some kind of connection in the community where they are but if they're clients of ours exiting out, there's not a whole lot of time to sort of build a rapport prior to them settling into their area. (Stakeholder)

MDS data about referrals into CLS-HASI show that more than half of Aboriginal consumers were referred by a public mental health service, **Table 4**.[2] Almost 20% were referred by a CMO and 3% by a Specialist Aboriginal Service. This is confirmed by the evaluation interviews. A few Aboriginal consumers said they were referred to CLS-HASI by Aboriginal health services, while most said they were referred through

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[2] Figures for MDSV1 and MDSV2 are not directly comparable due to changes in referral source questions. 'Public mental health service' in MDSV1 was replaced in MDSV2 with 2 public mental health service items, 'Public inpatient mental health services', and 'Public community mental health services'.

the NSW Health system. Referral sources of non-Aboriginal consumers were similar overall. More non-Aboriginal consumers were referred by a public mental health service, fewer by CMOs and none by Specialist Aboriginal Services.

The MDSV2 data, which covered the final 5 months of the study period, included different referral sources to MDSV1.[3] One of the new MDSV2 referral sources was public community mental health services. This showed fewer Aboriginal consumers referred to CLS-HASI, 24.9% compared to 42.0% for non-Aboriginal consumers.

This is consistent with the community mental health data linkage, which showed lower rates of community mental health services for Aboriginal consumers (**Section 7**). It is also consistent with fieldwork findings. AMS staff, Aboriginal stakeholders and LHD and CMO managers agreed that many Aboriginal people did not feel comfortable at NSW Health facilities. This meant some Aboriginal people might miss out on referral to CLS-HASI, improving partnerships with AMS might make AMS a more prominent referrer into CLS-HASI, potentially giving more Aboriginal people who need it access to the programs.

Summary of partnerships and shared responsibility

In summary, the evaluation found examples of effective partnerships between CLS-HASI providers and Aboriginal organisations. Service providers found the best way to develop these partnerships was tapping into existing Aboriginal committees and processes. What could be improved was making existing connections more formal and less dependent on local connections. Stakeholders suggested that other programs and agencies intersecting with CLS-HASI, such as the NDIS and Corrective Services, also needed to develop stronger relationships with Aboriginal organisations. That might improve referral pathways into CLS-HASI, giving more Aboriginal people access to the programs. In the most recent data, 3% of Aboriginal consumers were referred to CLS-HASI by a Specialist Aboriginal Service.

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[3] MDSV2 removed codes for ‘Family or friend’, ‘Public Mental Health Service’, ‘Public Health Service’ and ‘Public Housing Provider’. MDSV2 added new codes for ‘Primary Health Network funded service’, ‘Carer, family or friend’, ‘Justice Health – Forensic’, Public Inpatient Mental Health Services’, ‘Correctional Facility’, ‘Public Community Mental Health Services’, ‘Justice Health – Custodial’, ‘FACS - Housing NSW’, ‘Other Public Health Service’, ‘NDIS funded provider or National Disability Insurance Agency (NDIA)’, ‘Specialist Homelessness Service’ and ‘Unknown/ Not stated’.

Table 4: CLS-HASI source of consumer referrals by Aboriginal status

MDSV1					MDSV2				
	Aboriginal consumers		Non-Aboriginal consumers			Aboriginal consumers		Non-Aboriginal consumers	
	n	%	n	%		n	%	n	%
Public mental health service	354	53.2%	2,594	65.6%	Public inpatient mental health service	124	31.6%	815	36.0%
Public health service	30	4.5%	197	5.0%	Public community mental health service	98	24.9%	951	42.0%
Unknown	100	15.0%	474	12.0%	Unknown	55	14.0%	216	9.5%
CMO (different provider)	88	13.2%	458	11.6%	CMO (different provider)	47	12.0%	196	8.7%
CMO (same provider)	45	6.8%	232	5.9%	CMO (same provider)	16	4.1%	82	3.6%
Self	34	5.1%	156	3.9%	Self	25	6.4%	81	3.6%
Community housing provider	10	1.5%	27	0.7%	Community housing provider	8	2.0%	20	0.9%
Public housing provider	5	0.8%	20	0.5%	Housing NSW	19	4.8%	156	6.9%
GP	7	1.1%	17	0.4%	Other public health service	18	4.6%	127	5.6%
Other government department	25	3.8%	57	1.4%	Primary Health Network funded service	7	1.8%	56	2.5%
Specialist Aboriginal service	19	2.9%	0	0.0%	Specialist Aboriginal service	11	2.8%	0	0.0%
Other private health service / practitioner	9	1.4%	25	0.6%	Other	24	6.1%	99	4.4%
Family or friend	7	1.1%	24	0.6%					
Other	<5	<0.5%	12	0.3%					

Source: CLS-HASI MDSV1 (n=4,619) to May 2019, CLS-HASI MDSV2 (n=2,880) to September 2019. Figures for MDSV1 and MDSV2 are not directly comparable due to changes in referral source questions. Some consumers have multiple interim entries to CLS-HASI with different referral sources, due to transfer between programs or CMOs, so total referrals add to more than total consumers.

5 Engagement with Aboriginal people and communities

Engagement and participation of Aboriginal people in the programs was evident in the service delivery through the employment of Aboriginal people, usually as frontline staff. Engagement between Aboriginal consumers and local AMSs was also common. Some evaluation participants also reflected on the impact of the shift away from an Aboriginal HASI. This shift had put more emphasis on the general CLS-HASI engagement with Aboriginal people and communities.

5.1 CMO Aboriginal staff

There were no data available on how many CLS-HASI staff identified as Aboriginal. The interviews and focus groups indicate that many CMOs employed one or more Aboriginal support staff. Aboriginal consumers reported that having Aboriginal staff in the service supported them to develop trust to initially engage with services, which in turn assisted them to also trust non-Aboriginal staff and continue to engage:

> Yeah, she's down to earth. She's an Aboriginal woman. She had similar upbringings to me, you know, with drugs and alcohol in her family. We've got a lot of similarities with Aboriginal families. Like I've explained things to her and she said, "I know what you're talking about babe" … She's experienced it. She's great. (Consumer)

> Because if it makes you feel better, if you need someone to talk to and you've got a special problem, you feel better talking to an Aboriginal person that can relate and understand. (Consumer)

> I had my own experience being a client [of a support program] years ago and I found that I had more rapport with the Indigenous worker than somebody that I didn't know or some sort of other culture and I found that after a while, through my Indigenous support worker, I got to know other support workers and that let my guard down a bit to seek help from them as well. (CMO staff who identifies as Aboriginal)

> I've worked in Aboriginal communities for many, many, many years. I do feel that they do feel more comfortable with an Indigenous worker, I feel that we need more Indigenous workers, even if it's only to break the ice … (CMO staff)

How CMO Aboriginal staff were involved in service provision varied, which affected their level of engagement with Aboriginal consumers and the local Aboriginal community. At some sites Aboriginal staff had roles specific to their Aboriginality and/or were matched with Aboriginal consumers:

> … we're lining up, Indigenous workers with Indigenous clients, this is good – you know, some of them might say, "I'm not working with … [name], I want to work with one of my elders". (LHD)

> … at least with [the CMO] we had the positives of the good engagement with their Aboriginal worker who has very good relationships with my client … And so that was very good from my perspective. We don't have an Aboriginal worker on our [LHD] staff here ... So I did rely very much on their key worker to help us. (LHD)

At other sites, staff who identified as Aboriginal did not have a role specific to their Aboriginality. They occupied frontline positions doing daily support work and had little involvement in case planning for Aboriginal consumers. Such arrangements risked that Aboriginal consumers missed out on opportunities to make cultural connections:

> Well, I'm not too sure [what happens in the case plan meeting] because I haven't been to one. It's only just the recovery and rehabilitation staff that go in and sit it on those meetings … [they] just let us know what they need, if they need transport or if they need something done out in the community, we go and do it for them … it would be good to have an R&R Indigenous worker because there's cultural connections out there that some of our participants don't engage with or don't even know about (CMO staff who identifies as Aboriginal).

At one site, where most consumers were Aboriginal, the CMO manager during the first fieldwork was also Aboriginal. By the second round of fieldwork, the new manager was not Aboriginal. Two staff who identified as Aboriginal remained, both employed at the support worker level only. This position appeared to generate pride among the Aboriginal consumers:

> And they've got Aboriginal staff, see, and the boss is Aboriginal. (Consumer)

Some sites did not appear to have any staff who identified as Aboriginal, and interview participants at most fieldwork sites said that more Aboriginal staff were needed:

> I wish there was more Aboriginal workers here. (Consumer)

> There's just too many [Aboriginal consumers] in the case load [for the Aboriginal worker]. Yeah. Like more Aboriginal workers I feel would be amazing. (CMO staff who identifies as Aboriginal)

Some CMOs were actively training and recruiting Aboriginal staff. Some CMOs and LHDs had staff targets, although they said CLS-HASI budgets limited their ability to realise these targets:

> Well we need more Aboriginal employees, which they're working on. They're getting there. You need a degree of some sort to work here, so that limits it a

> bit. We do have trainees, some Aboriginal trainees – a program running at the moment. (LHD staff)

> We generally would prefer to recruit more Aboriginal people to the role, and we have an active Aboriginal recruitment strategy in our organisation. (CMO manager)

Employing staff who identified as Aboriginal appeared most effective where the staff had connection to the Country or the 'mob' where they were working:

> With our … team, being an Indigenous support worker … we could even make a yarning group up which consists of older Aboriginal participants and the younger Aboriginal participants, like a men's group and a sisters' group … That's my understanding with my tribe because my tribe is the … people here. (CMO staff who identifies as Aboriginal)

Conversely, some staff who identified as Aboriginal had little or no lived experience of their Aboriginal culture. Arguably this might be a useful peer position from which to empathise with Aboriginal consumers users who might also have experienced disconnection from culture, however these staff did not appear to have such a role.

5.2 CMO engagement with Aboriginal Medical Services

As mentioned in **Section 4**, engagement with AMSs at an organisational or strategic level was mostly informal and limited to few locations. At the time of the evaluation, this was consistent across the state. The fieldwork indicates that engagement was more common at an individual consumer level. It involved collaboration around case planning and support for a consumer. The fieldwork showed no evidence of intentional support for Aboriginal consumers to engage with an AMS.

In the recent MDSV2 data, almost 20% of Aboriginal consumers visited an Aboriginal Community Controlled Health Organisation (ACCHO) or AMS.[4] In the MDSV1 data, it was 10%, although there were fewer responses to this question.[5]

For the most part, CMOs left the decision up to the consumers, and engagement mostly depended on the consumer's prior knowledge of the AMS:

> If I don't want to go to [the AMS], I can change to another service if I want. But I'd rather stick with [the AMS]. (Consumer)

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[4] 77 of 400 MDSV2 responses indicating visiting an Aboriginal Community Controlled Health Organisation (ACCHO) during the reporting period.

[5] MDSV2 question changed from "Number of referrals to other services – Aboriginal Community Controlled Health Organisation (ACCHO)". MDSV1 - 10.2% based on 23 ACCHO referrals from 225 responses.

> I went [to the AMS] and got my blood test done, and they cured my Hep C … so I go and see them, they help me out. (Consumer)
>
> We have a few of our Indigenous participants that use the [AMS] and we also have a few of them that use the mainstream clinic. So, it's whatever they want, so wherever they feel more comfortable and what sort of service can help them or what they feel can help them more. … Some of our participants are already linked in with the services before they get engaged with us and we just keep following where they want to go. (CMO staff who identifies as Aboriginal)
>
> I go to the [non-Aboriginal] medical centre just up the road here. […] I've been with him for about five, six years now. (Consumer)

Some consumers chose not to engage with the AMS due to confidentiality, lack of trust, or because their trust was broken and CLS-HASI had not encouraged them to try again:

> I used to [go to the AMS] … I went into a bad depression and I was drinking a lot. My liver played up and they helped to get me into detox ... So, I did eight weeks detox and got out. Then I went there complaining about my liver because it was still playing up and the next thing you know, I ended up in hospital after talking to them. (Consumer)
>
> Yeah, because our community is very small … Everyone knows everyone in the Aboriginal community and that's why a lot of our participants don't use that medical centre. It's just basically they've got no trust with the confidentiality and things that happen there. (CMO staff who identifies as Aboriginal).

5.3 Summary of engagement

In summary, engagement with Aboriginal people and communities was primarily evident at a service delivery level. CMOs employed some Aboriginal people as frontline staff. In some sites, Aboriginal staff had roles specific to their Aboriginality, for example they were matched with Aboriginal consumers. Few Aboriginal staff participated in case planning or occupied managerial positions. Consumers reported that having Aboriginal staff assisted them to develop trust and engage with the service. Most CMOs tried to recruit additional Aboriginal staff. Recruitment appeared most effective where the staff had connection to Country or the 'mob' where they were working.

Consumers engaged with an AMS where they had a previous connection or positive experience. CLS-HASI staff generally left this decision up to the consumer and did not actively foster engagement with an AMS. Consumer engagement with AMSs seemed to increase at the end of the study period.

6 Capacity building of Aboriginal communities

The main evidence of Aboriginal capacity building in CLS-HASI programs related to Aboriginal consumers. It included capacity to connect to culture and community, and to live independently. Building the capacity of staff through employment and training was discussed in **Section 5**.

Some Aboriginal consumers had strong connections with their communities and did not need CLS-HASI support for this:

> Yeah. I'm an elder now, yes ... I'm a member of the Land Council. I've got a Land Council meeting coming up … and they decide. There's a board, there's members and everything has got to be voted on. (Consumer)
>
> I've always been a cultural person, so I know much about it. (Consumer)
>
> Yeah, no, no, I'm doing good in my culture every day, like if you come to my house and you'll see spears and boomerangs and all that, and just recently we had a family gathering where we had three porcupines and mum cooked Johnny Cakes. It was just like a corroboree …Yeah, really connected. (Consumer)

Consumers and CMOs gave examples of how CLS-HASI was connecting Aboriginal consumers to culture and community:

> But when we got switched to [a new CMO] … our first worker, she recognised the need to do something … so she got me hooked up to the Aboriginal Women's Group. And that's a big part of my thing now and they listen to me too, so they understand. [Now] I'm in training to be an elder. (Consumer)
>
> Yeah, she [CLS-HASI staff] helped me find out about the men's group. … Yeah, she found out, she inquired for me and she gave me the details. (Consumer)
>
> When we've got Indigenous events on … it's good when we do get the Indigenous people to go there because it's like they connect. It's like that they feel at home with everyone … So we actually held a Reconciliation Day down at one of the parks here. And we had a smoking ceremony and it was really good. (CMO staff who identifies as Aboriginal)

Aboriginal consumers suggested additional activities that CLS-HASI might support them with to increase their cultural connections:

> Maybe a bush tucker group, learning how to gather and use the bush tucker, like cook it, prepare it, how to do all of that. I don't know, a cooking group. (Consumer)

I'd like to see, when cultural things come up, that they take us to more cultural gatherings and that. (Consumer)

Many Aboriginal consumers did not have a strong connection with community or much knowledge of Aboriginal culture. Some of them wanted to increase that connection; others did not or were not ready to reconnect with community, or they were not sure what that meant:

> I'm just Koori, I've got a little bit of Koori in me, Aboriginal in me, … I think that's probably just – that's all that I know…. I don't know much of my family. (Consumer)
>
> No, I don't really know [if I'd like more connection with the Aboriginal community] – I don't really, I don't think I really know them that well. (Consumer)
>
> I'm just not … a connection person?… [I like] just to sit outside in the open to see some mountain range or just to see the bush and the trees and things. (Consumer)

Most Aboriginal and many non-Aboriginal CMO and LHD managers and staff and state-wide stakeholders felt it was important to support Aboriginal people to reconnect with community and culture when they wanted to.

Some CMOs drew upon the knowledge and experience of Aboriginal consumers who were well connected, to build capacity and understanding of staff and consumers who had less knowledge or connections:

> I suppose I educate a few of them, like one case worker, she asked me, "Is it rude to do certain things?" As I said to her, "Yeah, it is." If an Aboriginal person's having a conversation with an Aboriginal person, if they choose to use their lingo or broken words, it's not polite to correct a person. (Consumer)

The general psychosocial support that CLS-HASI offered also built the capacity of Aboriginal consumers. Examples include having basic needs met, connecting consumers with other services, building confidence to leave the house, to participate in activities and to ask for support:

> But they're making me start to believe that I've got a voice, that my voice is worthy of talking. I just like them, I reckon they're good, they're good up here. And I'm going to start coming up here on Wednesdays and doing the group … and start getting more involved. Because I want to get more out of it. (Consumer)
>
> They offer and they recommend you get in touch with your spiritual side, you know. …the ones that I've been doing, art and crafts, we've all been doing for the last maybe four and half years with the art teacher, she's really good …

> She's pretty aware about the Aboriginal culture … it does help, like, what they do, does help with our, I suppose, building our self-esteem. (Consumer)
>
> Well, recently since I have been here at [CMO], the last couple of months they have got me in with—other organisations within mental health … which I find was pretty good because no one has ever done that before. (Consumer)
>
> I think myself that it's working well because a lot of my people are not confident enough to go to Housing or go and speak for themselves. That's when a lot of our support workers do advocate for them. (CMO staff who identifies as Aboriginal)

There seemed to be some barriers to making successful reconnections. First, staff might be wary of asking people about their origins or be seen to push people into finding out more about their culture. When one Aboriginal consumer was asked 'So has HASI helped you at all to reconnect with your culture?' their response was: "No. Maybe because I never asked for it." (Consumer). Second, tenuous connections with Aboriginal organisations and shortage of Aboriginal staff (sections 4 and 5) meant that CMOs might not have the capacity to offer consumers opportunities to reconnect and learn more about their culture.

In summary, the evaluation found evidence of Aboriginal capacity building with Aboriginal consumers. CLS-HASI supported Aboriginal consumers to reconnect with culture and community if they wished to. Some Aboriginal consumers suggested additional activities to increase their cultural connections. Some CMOs drew on the knowledge of Aboriginal consumers who had strong cultural connections to build capacity of staff and other consumers. The programs also supported Aboriginal consumers, like all consumers, to live independently.

7 Equity

In the Lowitja framework, the principle of equity encompasses physical and cultural accessibility, inclusiveness and equitable health outcomes. Sections 5 and 6 above include examples of how CLS-HASI providers tried to make their services culturally accessible and inclusive. Data about equitable access to appropriate support and about equitable wellbeing and health outcomes are available from the MDS and the health service linkage, and from the fieldwork.

7.1 Equity of access to appropriate support

The proportion of Aboriginal CLS-HASI consumers increased since previous evaluations to 15.2% (**Appendix 1**). This was above the share in the Australian general population of 3.3% and the NSW estimated resident population of 3.5% (Australian Bureau of Statistics, 2016c). The numbers indicate that the CLS-HASI programs were reaching into Aboriginal communities as one of their priority groups.

The types of program support in the MDS differed somewhat between Aboriginal and non-Aboriginal consumers, **Figure 1**. Support was similar across the main support types: support planning and group activities. Aboriginal consumers had more support than non-Aboriginal consumers in 4 support types. The difference was statistically significant. The support types were:

- accessing other support systems
- tenancy and accommodation support
- supporting attendance of Aboriginal community activities including sport and cultural events.[6]

Aboriginal consumers received fewer hours of support for three support types (statistically significant):

- psychosocial interventions
- social activities
- service provider travel to and from consumers.[7]

Aboriginal and non-Aboriginal consumers used similar levels of all other types of support

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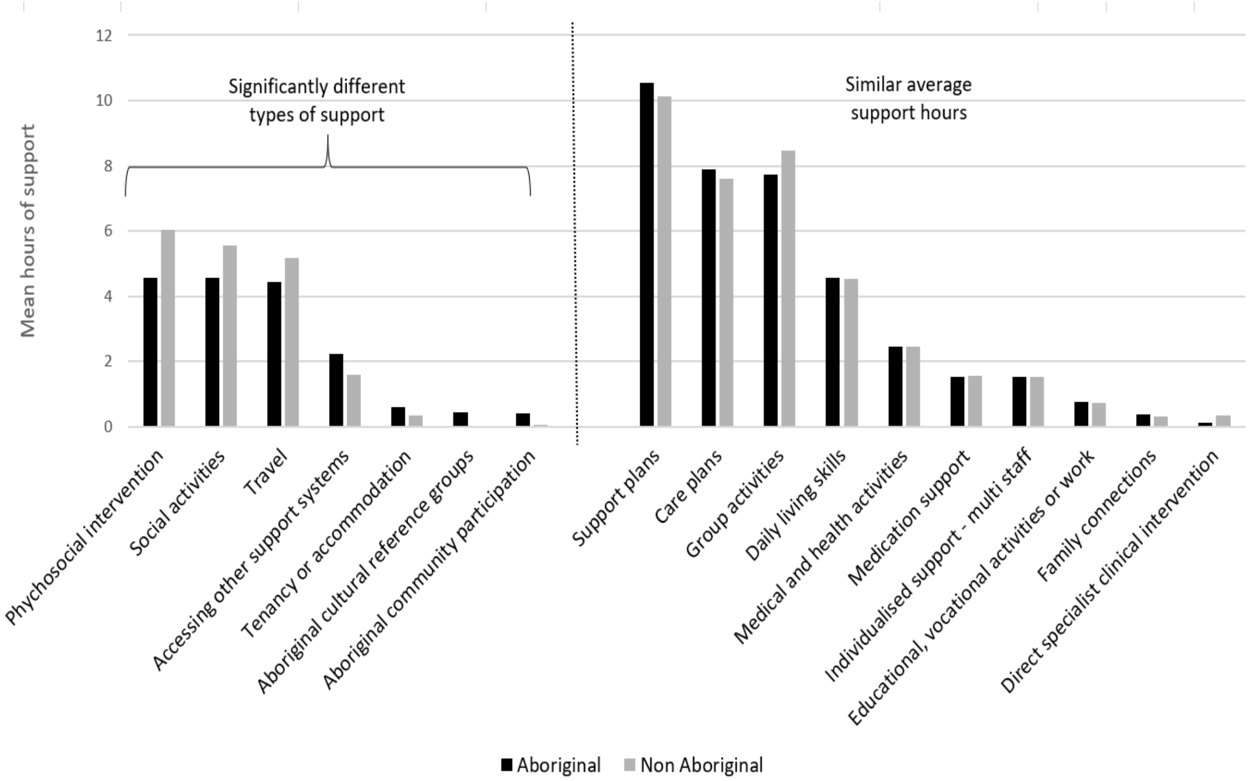
[6] Reporting for hours of support in Aboriginal cultural reference groups only through MDSV1 to April 2019.

[7] psychosocial interventions (this is a catch-all or ‘other’ category) 4.6 vs 6 hours, social activities 4.6 vs 5.6 and service provider travel 4.4 vs 5.2, all differences p<0.001.

Figure 1: Aboriginal consumers average hours by support type



Source: CLS-HASI MDSV1 (n=4,619) and MDSV2 (n=2,880) to January 2020 (total n=5,533) Notes: Statistically significant difference based on t-test of average support hours ($p<0.05$)

As discussed in **Section 5**, interview and focus group participants felt that the Aboriginal workforce made a strong contribution to equity within CLS-HASI. At the same time, LHD and CMO staff thought that the number of current Aboriginal staff was too low to support all Aboriginal consumers adequately.

The evidence from interviews and focus groups suggests that the programs addressed some disadvantages that Aboriginal consumers faced. At the same time, the evidence indicates that local programs were often not directly targeted or adapted to Aboriginal people. Some good examples of learning from Aboriginal HASI had been adopted in the fieldwork sites (**Sections 5.1** and **10**), such as focussing more on family and community rather than mostly the individual consumer, and making efforts to employ more Aboriginal staff. But there did not seem to be any consistent effort to address inequities specific to Aboriginal people.

Most CLS-HASI service providers and some consumers considered equity and equality as the same concept, stating that the program intention was to treat all people equally. They did not mention cultural disadvantage and any systemic challenges that Aboriginal people might face:

> I think [working with Aboriginal or non-Aboriginal consumers] they're all basically the same from what I see … so all of our support is just basically around that individual, whatever they need. They could be Aboriginal with their issues and we support them. There's also the Caucasian where whatever they need, we support them. (CMO staff who identifies as Aboriginal)
>
> I think, well everyone should be treated equal and not set one group of people sort of differently to the others. It should all be equal. … everyone should be treated on an equal footing instead of trying to set one group aside from the rest of them and treated differently. …Yes, it all should be one. (Consumer)

Another inequity raised in the interviews was the difficulty in providing services for people from remote areas:

> We don't cover out there at the moment because we can't deliver it effectively. It's actually in our local service level agreement that we don't cover [an outlying area] currently because we can't do it appropriately. (CMO)

The proportion of Aboriginal consumers exiting CLS-HASI was below that of non-Aboriginal consumers, 33% versus 37%. In contrast, the 2012 evaluation reported more Aboriginal consumers exiting compared with other consumers (27.1% versus 17.7%).

7.2 Equity of consumer outcomes

Aboriginal consumers had good outcomes in CLS-HASI, similar to non-Aboriginal consumers. Aboriginal mental health outcome scores were similar to all consumers. The Aboriginal sample was not large enough for the difference to be clinically or statistically significant (**Appendix 10**)[8].

Some significant differences in the health care and other service outcomes between Aboriginal and non-Aboriginal consumers were evident in the data linkage. Data were available for hospital admissions due to mental health issues, emergency department use, contacts with community mental health services and housing.

Mental health hospital admissions for Aboriginal consumers decreased significantly following program entry, like for all consumers. The average length of stay for people admitted to hospital was much lower for Aboriginal consumers compared to non-Aboriginal consumers, both before and after program entry, **Figure 2**. Aboriginal consumer days in hospital dropped in the year following program entry by 17.2 days

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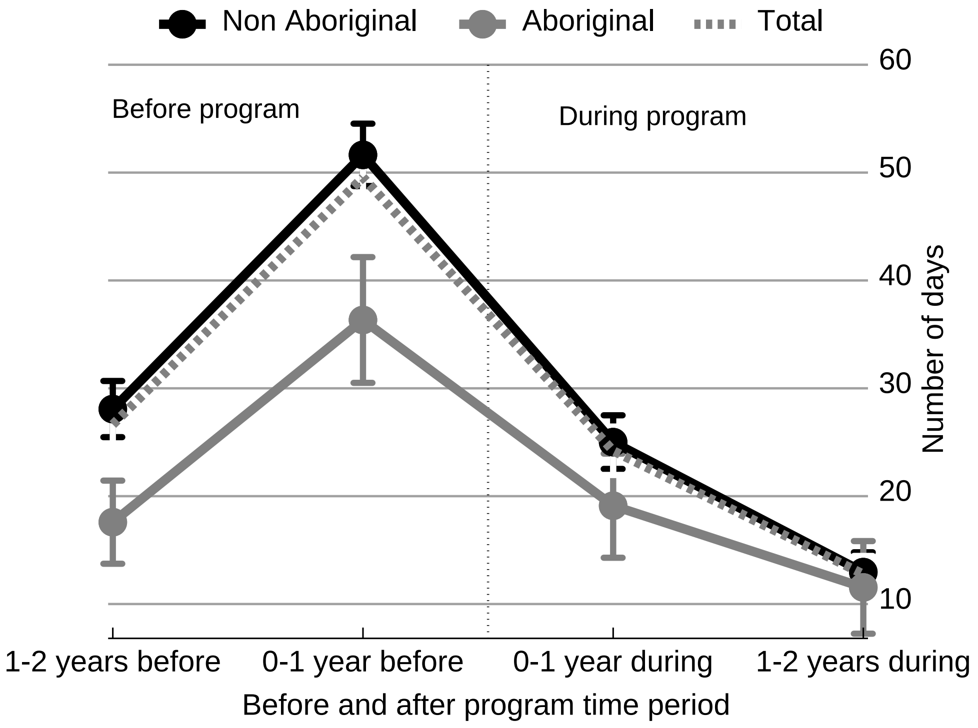
[8] The evaluators note that the quantitative outcome scales used in CLS-HASI were not specifically designed for use with Aboriginal consumers and were therefore not necessarily culturally appropriate. These data include the Kessler 10 (K10) scale, which assesses serious mental illness. The modified K5 is used with Aboriginal people, but not in CLS-HASI. It is unclear whether the K5 would offer statistically significant findings for CLS-HASI due to the small sample size of Aboriginal consumers in the programs.

compared to 26.6 days for non-Aboriginal consumers. The drops were a statistically significant improvement.

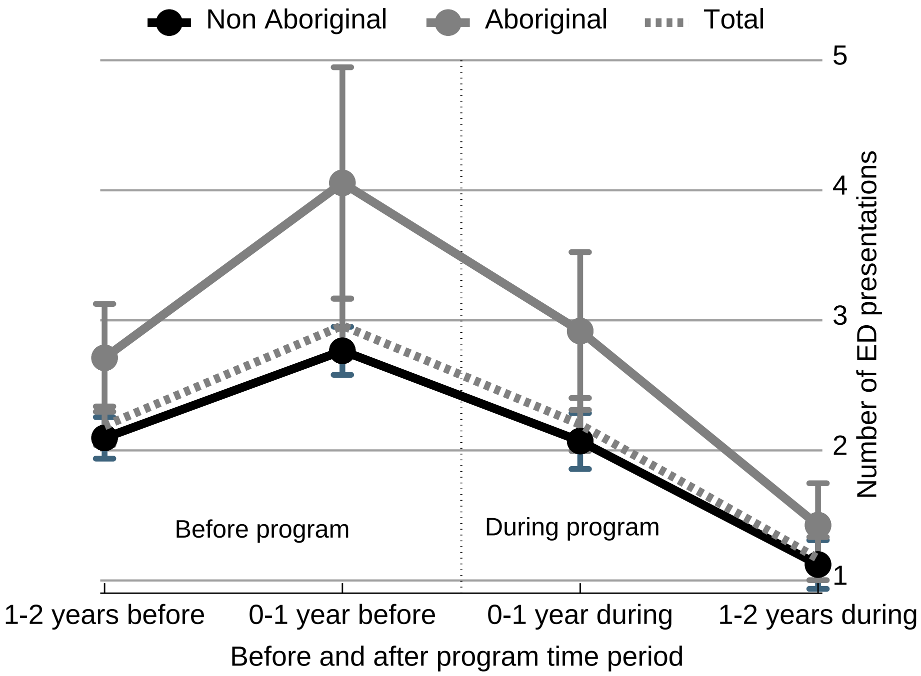
Figure 2: Mental health hospital days by Aboriginal status



Source: CLS-HASI linked NSW Admitted Patient Data Collection (APDC) n=3,338
Notes: Average inpatient days per person per year with 95% confidence intervals shown as vertical bars.

Use of emergency departments (ED) generally indicates an urgent episode and may occur more often if a consumer does not receive suitable mental health support. Before program entry, consumers identifying as Aboriginal had more ED presentations than non-Aboriginal consumers, about 4 compared to about 3 presentations, **Figure 3**. During the programs, the numbers dropped by statistically significant levels for both Aboriginal and non-Aboriginal consumers. By year 2 in the programs, both groups had similarly low numbers, 1.2 ED presentations for Aboriginal consumers and 0.7 for non-Aboriginal consumers.

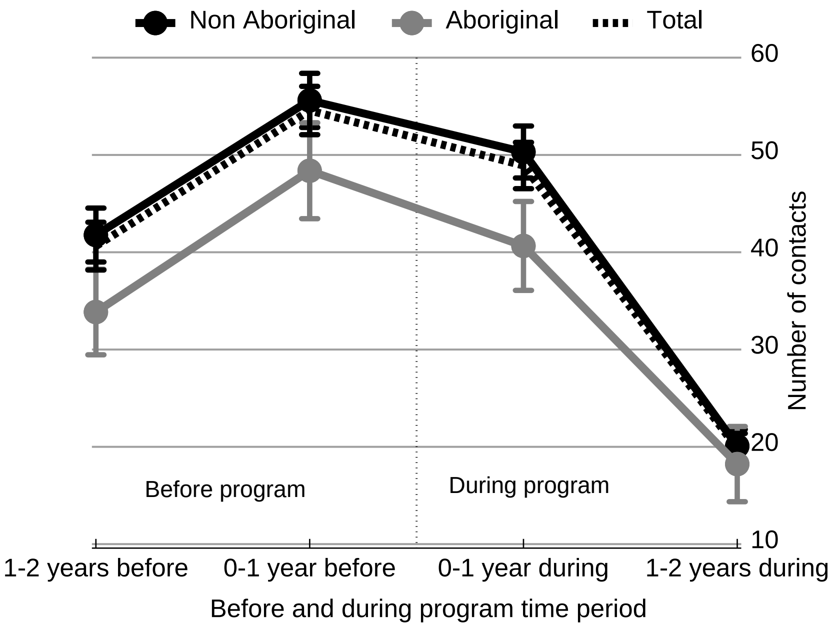
Figure 3: Emergency department presentations per person by Aboriginal status



Source: CLS-HASI linked NSW Emergency Department Data Collection (EDDC) n=4,192 Aboriginal n=589. Note: Average ED presentations per person per year with 95% confidence intervals shown as vertical bars.

Aboriginal consumers had fewer contacts with community mental health services than non-Aboriginal consumers, both before and after program entry. Contacts dropped for both groups from a high of about 50 in the year before entry to about 20 in year 2 of CLS-HASI, **Figure 4**. In year 1 in the programs, Aboriginal consumers had about 10 contacts per year less than non-Aboriginal consumers (40.6 compared to 50.3 contacts).

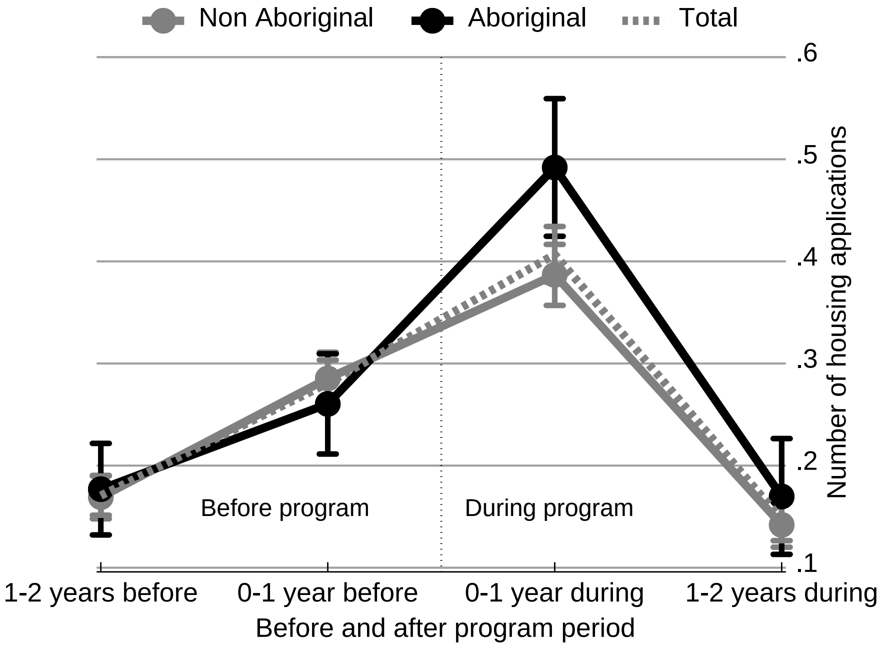
Figure 4: Community mental health service contacts by Aboriginal status



Source: CLS-HASI linked NSW Mental Health Ambulatory Data Collection. n=3,052
Notes: Average contacts per person per year with 95% confidence intervals shown as vertical bars.

Aboriginal consumers received significantly more support for public housing tenancy and accommodation than did non-Aboriginal consumers, **Figure 1**. This is reflected in housing data linkage showing more new public housing applications for Aboriginal consumers than for non-Aboriginal consumers, **Figure 5**. Housing applications for Aboriginal consumers increased from 0.26 to 0.49 in year 1 in CLS-HASI. This was higher than the increase for non-Aboriginal consumers, from 0.29 to 0.39. Both increases were statistically significant.

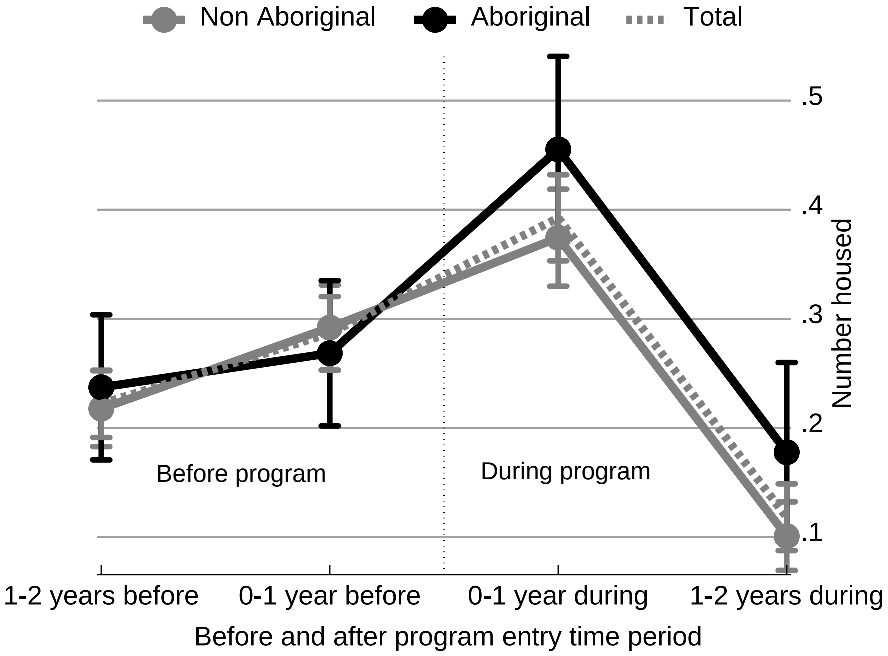
Figure 5: Average public housing applications by Aboriginal status



Source: CLS-HASI linked NSW Department of Communities and Justice Housing. n=1,539 (Non-Aboriginal n=1141, Aboriginal n=301, Aboriginal status not known n=97)
Notes: Average contacts per person per year with 95% confidence intervals shown as vertical bars.

After the public housing applications, there was a corresponding increase in the number of new public housing tenancies, **Figure 6**.

Figure 6: New public housing tenancies by Aboriginal status



Source: CLS-HASI linked NSW Department of Communities and Justice Housing. n=1,539 (Non-Aboriginal n=1141, Aboriginal n=301, Aboriginal status not known n=97)
Notes: Average contacts per person per year with 95% confidence intervals shown as vertical bars.

Aboriginal and non-Aboriginal consumers had similar drops in criminal offences. In both groups, offences dropped to almost zero following entry to CLS-HASI (**Table 53**, **Appendix 10**). As the number of offences following entry was below 5, no further details are presented to protect consumer confidentiality.

7.3 Challenging inequity

The evaluation found good practice evidence of how CLS-HASI supported Aboriginal consumers to challenge inequity that might be caused by lack of cultural responsiveness. Consumers experienced and challenged inequity at personal and systemic levels; and within the CLS-HASI and in the community. Personal level inequity was sometimes addressed in collaboration with the CMO staff:

> I was talking to a person and instead of saying cousin I used ‘cuz and I had this worker turn around and say, "I'm really sorry but the right way to pronounce this is cousin." And … I explained to this worker I said “I know it's actually in English it’s cousin but we say ‘cuz, we cut it short.” And I found that offensive. … Well I had a word to my case worker and he actually went and sat down with that other case worker and explained to her because my case worker was actually an Aboriginal person and got on with everyone in the

> building … and he came back and he said “she understood and she's sorry”. And I thought that in the end she was sincere. (Consumer)
>
> I do feel that they [Aboriginal consumers] are more disadvantaged because of the stigma that they have and that's against them … It kind of annoys me sometimes when people make comments, you know, like I was in the doctor's the other day with a participant. He had a full packet of chocolate biscuits, not opened. But he brought them with him for the waiting room, which was really, really kind and generous. He's there saying to the girls behind the counter, “Do youse want a bickie?” The woman standing next to me, she goes, “Oh my God, oh those biscuits would be so mangled and crushed, look at him”. I went, “excuse me”, I said, “… he's being very, very polite and kind, and you're being very, very rude.” (CMO staff)

CMO staff also supported Aboriginal consumers to address systemic barriers to accessing services. Consumers and CMOs gave examples of how CLS-HASI supported consumers to obtain documents for access to services like housing:

> [CMO supported me to] get my ID, because I’ve got no ID. But I’ve nearly got it all now. Photo ID. I just filled out for my photo ID. I’ve got my birth certificate, I’ve got my Medicare, I’ve got my health care pension card, key card, and now I’m filling out for my photo ID. But they helped me with housing too. Yeah, I applied for my housing, and I’ve just got to do my Aboriginality form to prove my Aboriginality, and that goes in, and then I’ve just got to wait on the list to get a house. (Consumer)
>
> I think if there was more acceptance within our own society we wouldn't be having these kind of issues and barriers for [Aboriginal consumers]. I think housing is a huge issue for them, the overcrowding, the couch surfing. I think there should be more and more support there for the families with housing, and more social supports for them. (CMO staff)

7.4 Summary of equity

CLS-HASI supported an increasing number of Aboriginal consumers, more than four times the proportion of Aboriginal people in the NSW population.

Aboriginal consumers in CLS-HASI had levels of support similar to non-Aboriginal consumers in many support types. Aboriginal consumers had more support for accessing other services and for housing. They had less psychosocial support, less support for social activities and less staff travel to and from the consumer.

Linked data show that CLS-HASI had good outcomes for Aboriginal consumers, similar to non-Aboriginal consumers. There were drops in hospital days for mental health issues, in use of emergency departments and in the number of contacts with community mental health services. Applications for housing increased as well as new tenancies, with bigger increases than for non-Aboriginal consumers in both measures. All findings were statistically significant.

The fieldwork found good practice examples of how CLS-HASI supported Aboriginal consumers to challenge inequity that consumers experienced at personal and community levels, for example racism or lack of cultural awareness, and at systemic levels, including accessing services such as housing.

Elements of service provision that needed improvement to further reduce inequities included difficulties reaching people in remote areas, resulting in access inequities, and cultural awareness regarding the specific challenges faced by Aboriginal consumers. Most providers said they attempted to treat all people in the programs the same, or ‘equally’, rather than adapting support to address inequity or cultural disadvantage.

8 Accountability, evidence based and data governance

The principles of accountability, evidence based and data governance are combined here because they align closely. The principles require robust Aboriginal governance that involves Aboriginal people and organisations, and that evaluation findings inform program improvement and future policy.

Privacy and use of program data to inform improvements were not discussed directly in the interviews. When consumers join the CLS-HASI programs, they consent to CMOs and the Ministry of Health collecting and using consumer data that are needed to deliver the programs and monitor success. This consent includes outcome measures regularly collected by CMOs:

- CLS-HASI Minimum Data Set (MDS) provides data on consumer outcomes including program exits, hospital admissions and assessment scores relating to support needs.
- Living in the Community Questionnaire (LCQ) was developed in response to the Fourth National Mental Health Plan priority area of ‘social inclusion and recovery’.

These data were analysed for the evaluation, along with other health and outcome data collected across NSW Government agencies[9], and with the interview data gathered during the fieldwork.

In 2017 the separate Aboriginal HASI program became part of the general HASI after evaluation evidence from both. Interviewees had mixed views on how this had affected engagement with Aboriginal consumers and communities. Some thought that some elements of Aboriginal HASI could be further incorporated into the mainstream model to make services more responsive to Aboriginal people. These aspects included brokerage funding, packages of support hours, outreach to remote areas and more Aboriginal staff:

> I think it's just the flexibility that came with some of the brokerage funding that was attached to Aboriginal HASI, and we had similar type programs running here focused on cultural connectedness and things. (LHD)
>
> We certainly have got high engagement of Aboriginal people in HASI still, but I think it's about the quality, it's about the actual participation in … cultural

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[9] The evaluators note that the outcome scales used in CLS-HASI are not specifically designed for use with Aboriginal consumers and therefore not necessarily culturally appropriate (Section 7.2).

> activities, and obviously around the workforce. ... yeah, the workforce doesn't reflect the number of Aboriginal participants in the program. (LHD)

A few consumers and providers reported that some Aboriginal consumers received less appropriate support now than they did when on Aboriginal HASI:

> I found that the Aboriginal package was a lot better and a lot more supportive than the mainstream one. … Because I don't get out as much as I used to and before I was a lot more confident and... yeah, I was out a lot more, and I suppose since it has cut back a lot since the funding, I'm not as confident. (Consumer)
>
> … previously there were so many hours allocated to my client under the Aboriginal HASI package, now that doesn't seem to be the case. … I think there's a feeling he doesn't need much, so he doesn't get much, which has made him disengage more. (LHD)

Some Aboriginal consumers, CMOs and LHDs, and stakeholders said an advantage of reinstating Aboriginal HASI would be to address the inequities Aboriginal people faced by employing more Aboriginal staff:

> That'd be a great idea to bring that [Aboriginal HASI] back. They'd have so many clients…. Then your workers, like you could employ Aboriginal workers. I mean you don't really want to keep things separate, but I think it's a good idea … I think when the gap is big, you need to do something special. (LHD)

Summary of accountability, evidence based and data governance

Some LHD and CMO managers and staff and a few Aboriginal consumers considered that the general HASI needed to further adopt evidenced elements from the former Aboriginal HASI program such as brokerage funding, packages of support hours, outreach to remote areas and more Aboriginal staff. These additional resources could address the greater inequity faced by Aboriginal consumers, including access to CLS-HASI and appropriate support, linking to the Aboriginal community.

9 Holistic concept of health

Throughout the interviews and focus groups there was evidence that CLS-HASI support applied a holistic concept of health, entailing nurturing the consumers' social-emotional wellbeing, fostering connections with family and community, dealing with physical health issues, and addressing environmental determinants of health such as housing. This section presents aspects of where the holistic concept was implemented.

9.1 Personal and collective wellbeing

The concept of social-emotional wellbeing seemed well understood in the CLS-HASI programs, with service providers viewing their main role as providing psychosocial support to consumers to improve their social-emotional wellbeing:

> So, this sort of wider consideration of what actually represents mental health, it is quite a different issue for Aboriginal people compared to non-Aboriginal people. So really trying to broaden out mental health to include a wider concept of social-emotional wellbeing and healing is certainly important. (Stakeholder)

Aboriginal consumers gave examples of how CLS-HASI support had improved their social-emotional wellbeing in the context of their mental health:

> Yeah. They know that I like art and sometimes if you're stressed out and you're having a bad day, when they're in town it's like, "Just come down and you can do a bit of art work", and the bad troubles go away. (Consumer)

In addition to the individual focus of CLS-HASI, some CMOs emphasised collective wellbeing, that is the social-emotional wellbeing of the community or family group that Aboriginal consumers belonged to:

> So the main thing is they need to understand I've got a large family I look after … that's my number one cultural respect … we've always got family, we just choose to be individuals. Just mainly, like, listen to us, understand and put your feet in our shoes. (Consumer)

> …making sure that people have access to … the Aboriginal concepts of healing, I think they would be most effective, one of the most effective enablers for Aboriginal people to return to full community participation (Stakeholder)

There were some examples of a focus on collective wellbeing, such as a collaboration by one CMO to be involved in NAIDOC week. Similarly, some CMOs worked with the consumers' family members:

> Because I have a big family, when I first got started they asked who was in our close circle and then they got to know my Mum. She was pretty important to me. They got to know my Nan. They know my family that’s close to me. (Consumer)
>
> … and they helped me [reconnect with my son]. Family means a lot to me, not my brothers or sisters but my circle, my children and their children. (Consumer)
>
> I feel working with their families is a huge benefit. You know because they're at their wit's end about what to do. So they appreciate it as well. (CMO)

Factors that supported a collective perspective beyond the individual consumer were staff taking a wider, cultural view and having staff who identified as Aboriginal:

> She doesn’t look down on me and she’s someone I can trust … I’m a swearer, [my partner’s] a swearer … [The Aboriginal worker] just laughed it off because she knows we’re Aboriginals and that’s the way we sometimes speak to each other. (Consumer)
>
> You get some [families] that are really involved. And then you get some that aren't. So it really all depends because there can be two Aboriginal families and we've got one that's really, really involved and supportive, and then there's another one that's not so much involved so it kind of varies on the person … It would be to not only focus on the individual, it'd be to help their family out as a whole. (CMO staff who identifies as Aboriginal)

One CMO described a mapping tool developed with Aboriginal elders that the CMO used to understand and incorporate family and community connections:

> Yeah, to really identify what’s going on for the client in their life, who are the relevant people in their life, who are strong networks? It’s not necessarily based around bloodlines as genograms are. This is more based around your social and emotional wellbeing network, so who are important supports for you in your life, where you could strengthen some supports … whereas I suppose white models, for lack of a better term, are based around seeing the individual in isolation. This is really looking at the individual in context there in community. (CMO)

9.2 Physical health and housing

As another aspect of a holistic approach, CLS-HASI service providers worked with consumers to improve their physical health. Consumers spoke about how they were supported to be healthier – for example by participating in accompanied walks and group activities:

And we used to do boxing together … Yeah, we done that, we just done stuff like pads and doing the lap around the oval and all kinds of things. (Consumer)

A holistic approach was also evident in CLS-HASI ensuring consumers’ basic needs were met, especially to gain and retain safe, appropriate housing (**Section 7**):

> Yeah, they help me actually … because there was a time when I had a falling out with the people I was leasing with. I had nowhere to go, and they helped me get into accommodation and they pushed through to get me my housing commission house. … So, if it wasn’t for them, I would still be on the street. (Consumer)
>
> HASI helped me [to get Aboriginal housing], directed me to a few places and I popped my name down for the Aboriginal housing. (Consumer)

9.3 Summary of holistic health

CLS-HASI embraced the concept of holistic health through various approaches. Consumers said the psychosocial support offered by the programs improved their emotional wellbeing. Building stronger connections to family and community also improved social-emotional wellbeing. The holistic health approach was successful where staff took a wider, cultural view and where Aboriginal staff were available. Other aspects of a holistic approach included supporting physical health and ensuring that Aboriginal consumers retained safe and appropriate housing.

10 Cultural competence

Aboriginal consumers appreciated signs of cultural competence in CLS-HASI services:

> They’re very understanding of the Aboriginal, they take in different breeds, like different cultures, and they’re understanding of your culture, they make sure that they don’t offend you and stuff like that. Yeah, they’re good. (Consumer)

As discussed in previous sections, having Aboriginal staff in services appeared to assist in improving cultural competence:

> Being an Aboriginal too helps if they know a little more about the culture and our ways. And they do employ Aboriginal people. (Consumer)

> Well, I think it’s good being Aboriginal and working with Aboriginal people that deliver a service …They’re culturally aware. (Consumer)

> There is a few [name of Aboriginal nation] people here themselves, so they know what the go is. (Consumer)

Consistent with previous sections in this report, there was evidence of increased consideration of cultural differences. In many cases this shift appeared to have started recently and usually involved participating in events and offering art making. There were some examples of broader cultural responsiveness, such as inviting people from the community to support Aboriginal consumers:

> We recently had, a couple of weekends ago, there was an event out [town] way, where we supported I think one or two consumers to go up there, it was an Aboriginal cultural day…. We also have had … one of our Aboriginal support workers organise for a painting, which we’ve got now hanging up in our office. So, she organised that with some of our Aboriginal consumers, to work on, in-office, to paint…. Yeah, we’re sort of only just starting to branch out with that particular subgroup. (CMO)

According to one CMO, some providers had improved their cultural competence through managing the Aboriginal HASI program:

> After getting Aboriginal HASI, I think it influenced the way we supported people in general HASI. Before, when I first started in HASI in 2003, '04, all of those years ago, everything was around supporting the individual. Getting a person into individual housing and it was making a person independent. As soon as we got Aboriginal HASI and the way we were taught ... Because, we had to relearn our language, we had to relearn the way we communicate and engage with people and understand that, with the person there's a family, there's a community, there's a whole range of people that were involved. (CMO manager)

Some consumers spoke about lack of cultural knowledge in other support services such as housing:

> So we had a problem here in this community, and we still do at the moment, with Department of Housing because they’ve stuck all Aboriginal people in one housing area, and then you’ve got people from different tribes … where traditionally, even a hundred, two hundred years ago this tribe didn't get along with that tribe … and I've actually said to my Aboriginal manager at Housing, I said that you need to educate some of these workers a little bit more. You need to get them out in the field and understanding our ways. (Consumer)

To improve cultural competence, it seems that Aboriginal staff could be given more leadership opportunities and have a formal cultural advisory component included in their role. Aboriginal staff also reported some misunderstandings about their role in the local community and the activities and time commitment involved:

> There's only myself and [the other Aboriginal worker] here now that are Indigenous. … I wish we could attend all the groups and all the Aboriginal events, but it's hard because sometimes other staff just don't get [that it is important]. (CMO staff who identifies as Aboriginal)

It appeared that many CLS-HASI providers had provided cultural competency training to staff, but there was room for consistency across the state and for more training generally:

> I think there could be a little bit more training and I think that's with a lot of departments to actually learn about the culture and our ways, because we still do a lot of things differently from non-Aboriginal people … but that's the way we've been brought up. (Consumer)

> Yeah, it’s really complicated, yeah. But … we get a lot of training to help us, you know, a lot of cultural awareness. I mean, I know a lot of it anyway but it’s good to know that your colleagues go and are interested. (LHD)

Summary of cultural competence

The evaluation found evidence of how the inclusion of Aboriginal staff improved the cultural competence of CLS-HASI services. Some CMOs increasingly considered cultural difference in program delivery, for example through participating in Aboriginal events. There was some cultural responsiveness training for staff, with room for more training overall and for consistency across providers.

11 Capitalising on Indigenous strengths

The evaluation found evidence of how CLS-HASI capitalised on Aboriginal community strengths and expertise. The main examples were asking Aboriginal staff and consumers for cultural advice and supporting Aboriginal artists to develop their skills. Also, many participants referred to the strengths of the former Aboriginal HASI program. Employment of Aboriginal staff to develop community strength was discussed in section 5.

CMO staff who identify as Aboriginal reported some good examples of non-Aboriginal staff calling on Aboriginal colleagues for training and advice:

> There's also some of the case workers here that aren't Indigenous and they get along with [Aboriginal consumer] well, but I feel like sometimes they come to [other Aboriginal case worker] or myself and try and get that connection and try to understand a little bit more. (CMO staff who identifies as Aboriginal)
>
> We have Aboriginal workers that can provide supervision, support and mentoring in that space, particularly cultural supervision in understanding those kinds of kinship structures and networks, particularly we use cultural consultants and communities to support us connecting Aboriginal people to the appropriate campaigns as well. (CMO)
>
> I really think the key thing too is to really empower Aboriginal people to tell us what they think … with their lived experience, rather than government telling them what cultural safety looks like. (CMO)

Some Aboriginal staff said they were interested in playing a larger role advising non-Aboriginal staff in cultural competence:

> I consider myself as a good asset to my team and yeah, I'd like to educate some of my co-workers about what our beliefs are and other little things that may help them engage with the participants. (CMO staff who identifies as Aboriginal)

There was a strong understanding of the importance of art in Aboriginal culture, with examples of CLS-HASI connecting Aboriginal consumer artists to opportunities to learn or practice art:

> Yeah, well when I was with that first one with [CMO], he took me up to [regional town] and displayed the teacher's art, he lined me up with him and I was going up there doing art lessons and I could still go back up there if I want. (Consumer)

Some service providers, key stakeholders and consumers thought that building from the strengths of a program run and staffed by Aboriginal people could better capitalise on Indigenous strengths, similar to the previous Aboriginal HASI program:

> I think it would be a great idea to have its own HASI program for Indigenous people. And especially to have Indigenous workers as well to be able to connect with them people … When you see someone that's Aboriginal or you connect with someone that's Aboriginal it's just like you know each other. You get along so well. (CMO staff who identifies as Aboriginal)
>
> I think having very well qualified ... preferably Aboriginal staff as well. We could support Aboriginals through that journey. I think that is true of a whole range of government services, whether it’s My Aged Care or NDIS as well. I think that preference for Aboriginal people to work with Aboriginal people – people who really understand the lived experience, it makes an incredible difference. (Stakeholder)

Summary of capitalising on Indigenous strengths

The evaluation found several examples where CMOs involved Aboriginal staff as experts to offer support and cultural advice for non-Aboriginal staff. CMOs fostered Aboriginal art practice and learning. Some service providers, key stakeholders and consumers suggested that a part of the HASI program run and staffed by Aboriginal people could capitalise on Indigenous strengths.

12 Facilitators of good practice in Aboriginal experience

The data show that, at the time of the evaluation, CLS-HASI met all principles in the Lowitja framework to some extent. Aboriginal good practice examples existed across the fieldwork sites. Acting on a commitment to improving cultural awareness seemed to be increasing. But responsiveness to cultural difference seemed to not be generally understood or embedded into service provision. Most participants acknowledged that CLS-HASI needed to engage better with Aboriginal culture, communities and organisations.

The facilitators of good practice in Aboriginal experience of CLS-HASI could be discussed and actioned among the program partners, both at a central level and locally. The facilitators of good practice, related to the Lowitja principles, are:

Partnerships:

- dedicate time for CMOs and LHDs to foster partnerships
- leverage from existing relationships and committees
- include other relevant government agencies in these partnerships.

Engagement:

- Ministry and CMOs to consider benchmarks and incentives to employ Aboriginal staff to work in Aboriginal-specific roles (e.g. linking them with Aboriginal consumers, advisory role, community development) and support Aboriginal staff in their career development for case management and managerial positions.

Capacity building:

- encourage providers and consumers to pursue collaborative development about culture and community to improve mutual understanding and connections with communities
- develop opportunities for Aboriginal consumers to inform cultural responsiveness of staff and other consumers.

Equity:

- increase cultural responsiveness training and reflective practice

- train CMO and LHD managers and staff on the concept of equity and the importance of specific equity initiatives to address disadvantage and achieve equal opportunities for Aboriginal people
- increase support types for Aboriginal consumers to match that of non-Aboriginal consumers, such as travel time to and from consumers
- LHD and CMO managers to review approaches to supporting Aboriginal consumers and how cultural disadvantage could be better addressed through the program.

Accountability, evidence based and data governance:

- reconsider how to learn from the evidence of Aboriginal controlled mental health programs, to adapt current or develop complementary arrangements.

Holistic health:

- facilitate program-wide discussion and cultural responsiveness training about:
    - the importance of community connections for Aboriginal consumers
    - how CLS-HASI can include consumer communities and families

Cultural competence:

- assess the impact of cultural responsiveness training offered in 2019
- adjust training approach if necessary
- review training needs periodically

Capitalising on strengths:

- foster good practice through exchange between Aboriginal and non-Aboriginal colleagues, such as mentoring, training and advising
- develop strategies to involve Aboriginal people in managing CLS-HASI services.

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Appendix 5: Focus report – Recovery-oriented support in CLS-HASI

Evaluation of NSW Community-based Mental Health Programs: Community Living Supports and Housing and Accommodation Support Initiative – CLS-HASI Evaluation Report

Prepared for NSW Ministry of Health, 2022

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Contents

Meanings and abbreviations

In this report, the term ‘Aboriginal. Includes people from the Torres Strait Islands. We acknowledge the diversity of traditional countries and Aboriginal language groups across the state of New South Wales.

CLS	Community Living Supports
CMO	Community Managed Organisation
DCJ	NSW Department of Communities and Justice
HASI	Housing & Accommodation Support Initiative
LHD	Local Health District
Ministry	NSW Ministry of Health
NDIS	National Disability Insurance Scheme
NGO	Non-government organisation
SPRC	Social Policy Research Centre
UNSW Sydney	University of New South Wales

Terminology

When referring to people who participated in evaluation interviews and when quoting from interviews, the following terminology is used in this report:

- ‘consumers' to refer to people who received CLS-HASI support
- ‘CMOs’ to refer to CMO workers, managers and frontline staff in the fieldwork sites
- ‘LHDs’ to refer to LHD staff members in the fieldwork sites
- ‘stakeholders' to refer to interviewees from government and other state-level positions.

Short summary

This report is part of the evaluation of Community Living Supports and Housing and Accommodation Support Initiative (CLS-HASI) programs that support people with severe mental illness to live in the community. This focus report examines how a recovery-oriented approach is applied in CLS-HASI.

CLS-HASI use a recovery-oriented approach, which means that service providers support people to recover or reduce the impact of their mental illness. Consumers take responsibility for their wellbeing and define their own goals for their lives. The evaluation data demonstrate many good practice examples where CLS-HASI supported consumers' preferences about recovery.

Findings are structured according to *A national framework for recovery-oriented mental health services: guide for practitioners and providers 2013*. The findings reveal points for discussions on how to continue to improve CLS-HASI:

1. Promoting a culture and language of hope and optimism
    - Support staff to focus on small steps together with the consumer to achieve longer term recovery goals.

2. Person first and holistic
    - Explore structures that can foster individual support rather than group support, where appropriate, such as incentives in the funding structure, collaboration with NDIS providers and targeted staff training
    - Create opportunities for all consumers who identify as Aboriginal to access a local Aboriginal support worker when they choose to
    - Build on links with communities and organisations that support people from diverse backgrounds.

3. Supporting personal recovery
    - Exchange good practice about strengths-based support and about balancing the program goal of consumer independence with the consumer's choice and need, for example for support with daily living tasks such as transport.

4. Organisational commitment and workforce development
    - Consider targets for lived experience workers
    - Exchange good practice to develop and maintain family involvement
    - Consider structures for sharing good practice among program partners and other providers, such as joint training and resources.

5. Action on social inclusion, social determinants of health, mental health and wellbeing
    - Consider how to incorporate systemic advocacy and community development within CLS-HASI roles.

Executive summary

The Community Living Supports (CLS) and Housing and Accommodation Support Initiative (HASI) are NSW Government programs that provide support to people who have a severe mental illness so that they can live and participate in the community the way they want to. The programs are funded by the NSW Ministry of Health (Ministry) and delivered through partnerships between local health districts (LHDs) and Community Managed Organisations (CMOs). The programs also have strong partnerships with the NSW Department of Communities and Justice (DCJ) and community housing providers for social housing.

CLS-HASI use a recovery-oriented approach, which means that service providers support people to recover or reduce the impact of their mental illness. Program consumers take responsibility for their own wellbeing and define their own goals, wishes and aspirations for their lives.

This report examines how a recovery-oriented approach is applied in CLS-HASI. The purpose is to raise questions that can be explored further with CLS-HASI stakeholders to inform how the programs are delivered into the future. This report is an output of the CLS-HASI evaluation conducted by the Social Policy Research Centre (SPRC) at UNSW Sydney for NSW Health. Three other focus reports, a final report and a summary report are also available.

The report is based on interviews from the first round of qualitative data collection for the evaluation in 2018: 40 interviews with CLS-HASI consumers in three fieldwork sites; and 21 interviews with CMO, LHD and other, statewide stakeholders.

Findings are structured according to *A national framework for recovery-oriented mental health services: guide for practitioners and providers* (the National Framework) (Australian Health Ministers' Advisory Council 2013). The National Framework is widely recognised as the benchmark for recovery-oriented service provision in Australia. It provides guidance on what recovery-oriented services should look like, by describing five key areas of practice (domains) and 17 associated capabilities that service providers need in order to effectively support people with mental health issues.

The five key practice domains in the National Framework are (Australian Health Ministers' Advisory Council 2013, 28pp):

- Promoting a culture and language of hope and optimism

  A service culture and language that makes a person feel valued, important, welcome and safe, communicates positive expectations and promotes hope and optimism—this is central to recovery-oriented practice and service delivery

- Person first and holistic
  Putting people who experience mental health issues first and at the centre of practice and service delivery; viewing a person’s life situation holistically
- Supporting personal recovery
  Personally defined and led recovery at the heart of practice rather than an additional task
- Organisational commitment and workforce development
  Service and work environments and an organisational culture that are conducive to recovery and to building a workforce that is appropriately skilled, equipped, supported and resourced for recovery-oriented practice
- Action on social inclusion and the social determinants of health, mental health and wellbeing
  Upholding the human rights of people experiencing mental health issues and challenging stigma and discrimination; advocating to address the poor and unequal living circumstances that adversely impact on recovery.

The findings from the evaluation interviews about each of the five National Framework domains are summarised below, along with the implications of the findings for the implementation of CLS-HASI. Implications could be actioned centrally and locally between the partners, in meetings and as resources available to share. Further implications are identified in the final evaluation report, including from the quantitative data.

In brief, the interviews revealed evidence of good practice that supported recovery. It also demonstrated trade-offs and practices that compromised the recovery-oriented approach to some extent. It found gaps in program implementation, where some National Framework capabilities appeared to be addressed only to some extent or not at all.

1. Promoting a culture and language of hope and optimism

Consumers and other stakeholders described good practice in CLS-HASI that generated hope and optimism, celebrated achievements and improved consumers’ lives. They reported some difficulties setting individual, recovery-oriented goals, particularly for long-term consumers. Other difficulties were where support seemed service-driven rather than consumer-driven and where it focused on practical day-to-day support rather than longer term goals.

Implications for CLS-HASI: The findings indicate that CLS-HASI could further improve their service practice and capabilities by supporting CMO and LHD staff to keep their focus on incremental steps to achieve longer term recovery goals with the consumer, in addition to supporting consumers with practical, day-to-day activities.

2. Person first and holistic

In the second National Framework domain, interview data was relevant to three of the six National Framework capabilities.

Capability 2A Holistic and person-centred treatment, care, rehabilitation and psychosocial and other recovery support

Interview participants generally felt that the flexibility allocating support hours in CLS-HASI facilitated person-centred support, as it allowed tailoring to the needs of each person. Holistic service provision generally focused on improving consumers' physical health.

Some challenges were apparent, such as balancing consumer choice with equity for all and with the service's need for structure and budgeting. For example, many service providers relied on group activities as the mainstay of support, and within that constraint, some of them applied good person-first practice into small groups for people with diverse needs. In this way, consumers could be supported to slowly recover social skills.

Discussion points for CLS-HASI:

- Examine the role of group activities in reaching individual recovery goals
- Explore program funding structures to give providers incentives for individual support rather than group support, when required
- Explore the possible effects of NDIS funding on the operation of CLS-HASI services in organisations that offer both to leverage new opportunities
- Consider staff training and resources about holistic recovery, the objectives of CLS-HASI and psychosocial support so that all staff fully embrace the approach.

Capability 2B Responsive to Aboriginal and Torres Strait Islander people, families and communities

CMOs generally responded to the needs of Aboriginal consumers through employing

Aboriginal workers and through supporting connection of Aboriginal consumers with their culture, community and Aboriginal-specific services. These processes were still in development and well received by Aboriginal consumers and both Aboriginal and non-Aboriginal workers.

Discussion points for CLS-HASI:

- Create opportunities for all consumers who identify as Aboriginal to access a local Aboriginal support worker when they choose to
- Consider Aboriginal support worker roles to incorporate cultural competency, community liaison and partnership building
- Build on links with local Aboriginal communities, such as Aboriginal services, Elders, community leaders and Aboriginal workers with local connections
- Build cultural competency of all staff, for example training and advice from local community leaders and Aboriginal staff
- Consider ways to replicate the strengths of the past specialist Aboriginal HASI to inform community collaborations.

Capability 2C Responsive to people from immigrant and refugee backgrounds, their families and communities

Some services adapted to support the preferences of culturally and linguistically diverse consumers, and some also recognised the importance of family in diverse communities. Overall, most CMO staff felt that people from diverse backgrounds did not necessarily need tailored services because recovery is already an individually driven process, incorporating preferences from a person’s cultural and linguistic background.

Discussion points for CLS-HASI:

- Exchange good practice about responding to consumers’ cultural group identity with a personal recovery approach
- Consider staff training and resources to support staff to recognise and address consumers’ cultural needs
- Build on links with communities and organisations that identify with and support people from diverse backgrounds.

3. Supporting personal recovery

The findings indicate that CLS-HASI generally supported personal recovery well. Some balancing was evident between promoting consumers’ independence and respecting their choice and need for support with daily tasks, including scheduling and transport. Some services managed this balancing through focusing on incremental steps towards individual recovery goals and the changing of these steps and goals over time.

Discussion points for CLS-HASI:

- Exchange good practice about negotiating balances between promoting autonomy and individual choice and need
- Consider training and resources for staff and service providers on strengths-focused practice and language
- Prioritise reliability of service provision, for example turning up on time, and communicating with consumers if scheduling needs to change
- Exchange good practice about how to develop and support a culture of reflective practice with staff and consumers.

4. Organisational commitment and workforce development

Organisational stakeholders at all levels voiced a strong commitment to recovery. One way they implemented this commitment is through increasing employment of support workers with a lived experience of mental illness (mental health peer support workers). This strategy seemed to be in its early stages in most workplaces.

Involvement of family members and communities appeared occasional rather than consistent. An explanation was that many consumers had lost contact with their families.

Service partnerships seemed to be generally strong between local LHDs and CMOs, and less so with other local service providers and at the state-wide governance level. Strong partnerships were attributed to goodwill and dedicated funding for collaboration.

Discussion points for CLS-HASI:

- Consider strategies for inclusive, collaborative decision making and information flow throughout the CLS-HASI governance structure and within the partner organisations
- Consider targets for lived experience workers and share approaches to role definitions and professional progression

- Exchange good practice to develop and maintain family involvement
- Consider strategies to increase engagement with other local service providers who are not CLS-HASI partners but support the same consumers
- Consider structures for CLS-HASI staff to share practice between partners and other providers, such as joint training and resources.

5. Action on social inclusion and social determinants of health, mental health and wellbeing

The fieldwork findings indicate that CLS-HASI supported social inclusion of consumers through social activities, group activities and outings. There was some evidence that CLS-HASI workers helped challenge the mental health stigma from community members and promoted positive attitudes among the consumers about themselves. There was little evidence of systemic advocacy and partnerships between the CLS-HASI partners and local communities.

‘Action on social determinants’ means addressing poor and unequal living circumstances that adversely impact personal recovery, for example housing, transport, education or employment. There was not enough evidence in the interviews to suggest that the programs acted in a systemic way on social determinants. Action did occur on an individual level, which is detailed more in other reports from this evaluation (e.g. Social inclusion focus report, Summary report).

Discussion points for CLS-HASI:

- Exchange good practice examples among CMOs about social inclusion
- Share strategies and resources to increase partnerships and referrals to other services and groups in the community
- Consider how to incorporate systemic advocacy and community development within CLS-HASI roles.

1 Introduction

The Community Living Supports (CLS) and Housing and Accommodation Support Initiative (HASI) are NSW Government programs that offer support to people who have a severe mental illness so that they can live and participate in the community the way they want to. The programs help people to work towards their own, unique recovery goals. The types of support that people receive depend on their individual needs and what they want to achieve.

Support available to program consumers includes help with daily living activities like shopping, meeting people in the community, learning new skills, maintaining their accommodation and tenancies, and accessing other services such as clinical mental health services. Many HASI consumers are also supported to apply for and access secure housing. The programs are partnerships between Local Health Districts (LHDs) and Community Managed Organisations (CMOs). The programs also have a strong partnership with the NSW Department of Communities and Justice (DCJ) and community housing providers for social housing.

CLS-HASI has a recovery focus, where each person receiving support sets their own recovery goals. Recovery is different for each person and can generally be defined as ‘being able to create and live a meaningful and contributing life in a community of choice with or without the presence of mental health issues’ (Australian Health Ministers' Advisory Council 2013). The NSW Government has committed to a recovery focus for CLS-HASI, through various policy commitments e.g. NSW Mental Health Reform and the Fifth National Mental Health and Suicide Prevention Plan, and directly through the service model, which requires CLS-HASI providers to offer supports that are recovery focused.

This report is part of the evaluation of CLS-HASI. The evaluation is conducted by the Social Policy Research Centre (SPRC) at UNSW Sydney for NSW Health, which administers CLS-HASI. Among the evaluation outputs are four focus reports, which present detailed evaluation findings about particular topics central to the implementation of CLS-HASI. This is one of the focus reports. It examines how the recovery focus is applied in CLS-HASI. The purpose of this focus report is to raise questions that can be explored further with CLS-HASI stakeholders to inform program implementation into the future.

2 Methods

This focus report is based on interviews from the first round of qualitative data collection for the evaluation in 2018. SPRC conducted 40 interviews with CLS-HASI consumers in three fieldwork sites in rural, regional and metropolitan locations; and 24 interviews with CMOs and LHDs in the fieldwork sites and with statewide stakeholders (Table 1). Interviews involved open-ended questions and informal discussions, and they explored themes covering the evaluation questions, as outlined in the Evaluation Plan (Giuntoli et al 2018). Data were analysed against the National Recovery Framework discussed in the next section. More detail about the evaluation design and methods for data collection are in the first annual report for the evaluation (Purcal et al 2018).

Table 1 Interviews for first annual report and recovery report

Group of participants	Participant number
CLS-HASI consumers	40
CMOs	15
LHDs	4
Stakeholders	5
Total	64

Notes: 'CMOs' refers to any staff in the community-managed organisations which provide HASI or CLS, whether managers or frontline staff; 'LHDs' refers to any staff members in local health district fieldwork sites; ‘stakeholders' refers to state government and other state-level stakeholders.

3 Analysis framework

A focus on recovery for people with mental illness is recognised and supported internationally (Slade 2010; Deegan 2005; Jacob et al 2015). In 2013 the Australian Health Ministers' Advisory Council (AHMAC) endorsed and formally launched *A national framework for recovery-oriented mental health services: guide for practitioners and providers* (the National Framework) (Australian Health Ministers' Advisory Council 2013).

Based on extensive research and consultation with people with lived experience and service providers, the National Framework is recognised as the benchmark for recovery-oriented service provision in Australia. It provides guidance on what recovery-oriented services should look like, by describing five key areas of practice (domains) and 17 associated capabilities that service providers need to effectively support people with mental health issues.

This focus report uses the National Framework domains and capabilities to analyse the recovery orientation in CLS-HASI. The findings are structured according to the five practice domains and associated capabilities in the National Framework. The practice domains are briefly described here to give an overview of the structure (see also Attachment: National Framework capabilities):

1. Promoting a culture and language of hope and optimism

The National Framework considers the first domain as overarching and fundamental to the other domains. The domain is achieved when a service has a culture and uses language that makes a person feel valued, important, welcome and safe, communicates positive expectations and promotes hope and optimism.

2. Person first and holistic

Putting people who experience mental health issues first, at the centre of practice and service delivery; and viewing a person’s life situation holistically. This domain means acknowledging the range of influences that affect a person’s mental health and wellbeing – including their culture, family, sexual orientation and other diversity – and providing a range of tailored supports.

3. Supporting personal recovery

The third domain requires providers to put recovery as defined by the person at the heart of their practice and have that recovery led by the person. This approach can be achieved by promoting the person’s autonomy and self-determination, and by focusing on their strengths and personal responsibility.

4. Organisational commitment and workforce development

Providers need to create a work environment and an organisational culture that are conducive to recovery – for example by learning from people’s lived experience and from families and communities – and to build a workforce that is appropriately skilled, equipped, supported and resourced for recovery-oriented practice.

5. Action on social inclusion and social determinants of health, mental health and wellbeing

The last domain requires services to uphold the human rights of people experiencing mental health issues, to challenge stigma and discrimination, and to advocate for addressing any living circumstances that adversely impact on recovery. This approach can be done, for example, through partnerships with communities.

4 Findings

The findings of this focus report are structured according to the five National Framework domains as outlined in the analysis framework. Each section below summarises consumer and other stakeholder experiences related to a domain before presenting the implications of the findings for CLS-HASI. Within each domain, findings in this section and the implications in the next section are structured according to the capabilities in the National Framework (Attachment: National Framework capabilities).

1. Promoting a culture and language of hope and optimism

In the National Framework, the first domain includes one capability.

Capability 1A Culture and language of a recovery-oriented mental health service communicates positive expectations, promotes hope and optimism and results in a person feeling valued, important, welcome and safe

In the interviews for the CLS-HASI evaluation, consumers and other stakeholders mostly described positive experiences of CLS-HASI. They spoke about the benefit and hope that CLS-HASI can generate for consumers:

> … it liberates the disabled… gives them freedom. (Consumer)

> … we shouldn’t lose sight in all of this that the overarching message is that these are great programs that are making a real difference. (stakeholder)

Some also spoke about holding hope for the programs themselves, including developing more strategic partnerships:

> … there is a real opportunity for us to think collectively about what we do. I’m quite hopeful, quite optimistic that we will improve in this area. (stakeholder)

An effective way to help consumers be more hopeful was to support them to consider what the future could hold for them through working with them to set and work towards personal goals:

> We are recovery-focused, so we do go through, every three months, with our consumers, what we call a care plan. In that care plan, consumers identify what goals they have and then we work out with them a plan of how they can

> achieve those goals. (CMO)

Some consumers talked about the service’s support to set goals and how they could now see what they could achieve in the future:

> I actually want to do a peer worker course in mental health and be a peer worker, and the mental health team are going to help me do that, so that I should be good to do. (Consumer)

Examples of good practice working with long term consumers demonstrated the benefit of perseverance and a recognition that goal achievement was not linear. This approach had helped consumers to continue to look to the future with hope:

> We had a list, but I got my temper and I threw it all out, which she done a big chart up for me, we marked it off when I done it. Like [the CMO worker] got me to a point where I used to walk my dog around the block and all that sort of stuff, but some days, some weeks, I go into a shell, like I have been the last couple of weeks. (Consumer)

There was also evidence of how staff with an optimistic outlook helped consumers to be more optimistic:

> I think positive a lot more than I used to, [CMO worker] has got me thinking positive. If something’s negative, I get out the back, cut a tree. Get out, run around with your dog. Get that thought out of your head. And I do that one out of three times now, as before I’d never do it. (Consumer)

To help maintain an optimistic outlook, many staff and consumers celebrated the small gains, engendering hope and optimism for change:

> … everything’s got to do with recovery, teaching people to shop and all that sort of stuff. (LHD)

The interviews with consumers and staff in the fieldwork sites indicate that both consumers and other stakeholders saw some challenges to promoting hope and optimism in the programs. It seems that program implementation had a strong focus on the day to day provision of practical support and this appeared to make it difficult for many consumers and staff to see beyond the immediate needs of the consumer. Many of the consumer recovery goals the interviewees spoke about seemed to be more service-driven (financial and staffing) than consumer-driven, such as participating in group activities.

Some consumers said they did not have any goals or they had not worked with staff on setting goals. Long-term consumers in particular reported doing the same activities as they had for several years and receiving the same types of supports, even when the service provider had changed. Staff also spoke about how goal setting could be more difficult with consumers who had been supported for a long time.

2. Person first and holistic

In the National Framework, the second domain includes six capabilities (Attachment: National Framework capabilities). The evaluation interviews had sufficient qualitative data about the first three capabilities, which are explored in this section.

Capability 2A Holistic and person-centred treatment, care, rehabilitation and psychosocial and other recovery support

According to the National Framework, a **holistic** view of individual health would consider a range of aspects that affect people's wellbeing including personal beliefs, cultural background, social and family contexts, physical health, housing, education and work. CLS-HASI services in the fieldwork sites mostly concentrated on one aspect, namely physical health. There appeared to be a strong emphasis on supporting lifestyle changes that could improve the consumers' physical wellbeing as part of improving their mental health.

CLS-HASI service provision included supported walking groups, weight loss programs, healthy eating cooking groups, taking consumers to the gym and negotiating affordable gym memberships. These programs encouraged other lifestyle changes that promoted good health.

> … we got a gym membership, got shoes... Yeah, and you go to the gym, and you do like the walking machine, the bicycle machine, they've got a heated pool there, and they bought us a six months gym membership. So, I thought that was a nice way of saying, get healthy, you know, without sort of putting anything in your face. (Consumer)
>
> We do lots of walks; specific walks, like the heritage walk, where you walk around, and you sightsee. We have a walking group, so it's good for them. (CMO)
>
> .. they're very encouraging, like when I say I've got to try and lose weight and things like that, they're very encouraging. (Consumer)

Person-centred practice was expressed as flexible provision of individual support and the individualised way most staff worked with consumers on goal setting:

> I find that with [CMO staff] she will, if I do have a particular interest, she is the type of person who will look into it, whether it be craft related, or – I feel if it was anything to do with skills as well, she would very eagerly look into it and get back to me with information. (Consumer)
>
> … how we were able to provide support to customers is first through establishing an individual support plan, because it is about creating the goals first, and working in accordance with those goals … It's never a prescribed thing where it's like you're ordering a customer to do all this stuff. (CMO)

At the same time, both consumers and other stakeholders viewed flexibility in the allocation of support hours in CLS-HASI as a facilitating factor for person-centred practice:

> So, the benefit of the CLS program and the new HASI program as well is that as opposed to allocating predetermined hours of support for someone, we can actually look at building a support package around that person's particular needs … (CMO)
>
> But [the hours] should go up and down too, because the simple fact is people under Mental Health, like myself and others, we do have good days where we don't need you to come around. (Consumer)
>
> So, there is a flexibility there in terms of what you can explore with a customer. I think it doesn't work in terms of recovery if it is a rigid prescriptive process. (CMO)

Some people also indicated that the increased flexibility allows for more consumer choice:

> If they have said, "I only want to be contacted Tuesday and Thursday," then we respect that, and we only contact them Tuesday and Thursday. (CMO)
>
> … I love HASI. HASI … allows spontaneity, and a bit of, "Oh, you know, I really don't feel like going to the movies today; can we go for a drive up to the bay? I'm just throwing things out there." So with HASI, it'd be like, "Oh, well, we've got time; let's do that." (CMO)

Some interview participants mentioned challenges to implementing holistic and person-centred, flexible services. For example, a few workers spoke about only supporting activity that staff considered beneficial for consumers' mental health. As an example, when a consumer wanted support to go to a weight loss clinic, one worker's response was:

> And if that is going to help her mental health, then yes, we can do that. But we're not just going to drive her to the clinic and do that because it's too far for her to drive. And that's something people have to understand when they do come in … It all depends on their mental health needs. And if it's mental health and it's recovery orientated. (CMO)

Group activities were a common practice across services, and CMOs in all fieldwork sites appeared to rely on groups as the keystone of support. Many consumers and other stakeholders commented on group activities, and the practice sometimes seemed to conflict with person-centred approaches.

Many consumers found group activities meaningful and that they helped with social engagement (further discussed in the National Framework Domain 4 – Action on Social Inclusion). Some consumers feared being in a group:

> I don't like crowds, so just one on one is good. Sometimes there's two of them, which I don't mind. But I can't handle crowds with more than three or four people. (Consumer)

Many consumers also reported that the activities offered in the groups were not always of interest to them. Staff in most services did not appear to be able to point to a structure that ensured the activities offered were selected by the consumers:

> …they weren't doing anything—like we would just sit down and listen to the little radio and colour in some printed out meditation prints and just have a cup of coffee or two and that. It wasn't going anywhere. ... it just didn't seem to have any value in it. (Consumer)

The apparent emphasis on group activities also appeared to reduce individual support for some consumers:

> They don't really ever call me to see how I'm going. They only call me to ask me if I want to attend art and craft group or if I want to go to the lunch or anything like that. (Consumer)

Good practice included running smaller groups to accommodate more diverse needs and participants who find larger groups difficult. Phasing participants into groups - starting with one on one and then adding others or keeping group membership consistent - were effective strategies:

> Sometimes they'll have different programs running which is really good because me and a few other ones, we actually don't get out a lot so just having those little groups … makes it so much easier. (Consumer)
>
> Like, each week, we kind of became sort of friendlier. … it was good that it was the same people the whole eight weeks, rather than swapping and changing and not knowing who you're going to be with and stuff like that. I thought it worked quite well. (Consumer)

Flexibility of program approaches and procedures - beyond the hours - was varied. Consumers and other stakeholders shared numerous examples of innovative, flexible solutions, including lots of practical support or extra effort to cater for individual need:

> I'm very lucky that [name of service] helped me with the skip bin which would have cost a couple of hundred bucks. Because I think they realise that with my OCD having clutter in boxes, it really gets me down. (Consumer)
>
> So it was actually [name of service] that got me into housing and into accommodation. So, without their support and help I think I would have been homeless for a very long time. (Consumer)
>
> No, just sometimes I don't want to be outside until they get there park the car. I'm a bit nervous of being in public by meself. But usually or normally they ring me from the house, from the flats and I almost come straight out. (Consumer)
>
> We had one [consumer] who wanted to go to Melbourne and see the Lion King stage production when it was on, and we were looking at being able to facilitate that. So, we never sort of say no, we just work out the logistics of it all. (CMO)

There were a few individual examples where program approaches did not suit consumers or even appeared to distress them, and the occasional difficulty working out how to support atypical consumers.

> Then the stress of the introduction wasn't good. The first part was - they want to come in my dark hot room and just stand there and introduce themselves and I said, "Well, I can't cope with all of that" and they said, "We'll meet you up

> at the park" but I don't drive a car. … I rang again and said, "I can't get to the park". [I was told] "I think they might have just left" and then all of that turned into a complete stressful mess. (Consumer)

Some consumers and other stakeholders linked increased flexibility with reduced accountability and/or inadequate structure; with concern that some consumers might not get the support they want or need. Some consumers, for example, were concerned that they were not getting the hours they required or that they risked losing the hours or the support placement if they did not use their hours:

> I was allocated [number] hours, and we don't always use those [number] hours … But recently I was told that there's a chance that I could lose those [number] hours because we're not using them, and so I've been asked, if I would like to get involved in crafts. And I thought I'd try it, but it's a long afternoon for me. (Consumer)

Some other stakeholders expressed concern that increased flexibility and the voluntary nature of the programs might lead to more complex consumers not being appropriately supported:

> That's one of the big problems … because it is a voluntary program, they won't - if they get to the client's house, and the client says, "I don't want help today," they won't give them help. (LHD)

On the other hand, a few other stakeholders expressed concern that flexibility in the allocation of hours could result in a few highly complex consumers using the bulk of the hours at the expense of other consumers. Some thought that both could be true:

> For me there seem to be tensions is where people have risk … that it becomes really, really hard for … the CMO, yeah … the funding could be gobbled up by one person. (stakeholder)

> I think some people are probably over serviced and some people are under serviced. (LHD)

Possibly to maintain flexibility without compromising structure and equity, some CMOs appeared to be moving towards more structured or predicted approaches to the allocation of hours. Some frontline staff were concerned that this might limit consumer-centred support and consumer choice:

> You are under a bit of pressure in terms of making sure that your services do

> act in blocks. So, we've been regularly prompted to do a lot of like pre-rostering, so you're actually trying to put supports in place before checking in with the customer. (CMO)

Capability 2B Responsive to Aboriginal and Torres Strait Islander people, families and communities

CMOs in the fieldwork sites responded to the needs of Aboriginal consumers mainly through employing Aboriginal workers and supporting Aboriginal consumers to connect with Aboriginal culture, community, support and local Aboriginal services. How this is implemented is described below. In CLS-HASI, some consumers and other stakeholders noted that there was less consumer contact with **Aboriginal workers** immediately after the separate Aboriginal HASI program ceased in 2017. At the time, they thought that there was a need to improve cultural capability for non-Aboriginal workers. When SPRC conducted the fieldwork for this evaluation, most CMOs in the fieldwork sites employed at least one Aboriginal worker. Many consumers and other stakeholders mentioned the positives in having Aboriginal people on staff:

> They [Aboriginal staff] understand our background, big families, support and they help. (Consumer)

> Well, they do employ also Aboriginal workers, too, which is really good. So, you do have the option if you want an Aboriginal case worker. (Consumer)

The numbers of Aboriginal workers in CLS-HASI services did not necessarily correspond to the number of Aboriginal consumers who required support. There was also variation in the role of Aboriginal staff, with some being available for Aboriginal consumers and others supporting a non-targeted caseload – supporting an allocation of Aboriginal and non-Aboriginal consumers by chance rather than design.

Some consumers who identified as Aboriginal reported that there were fewer Aboriginal workers and less opportunity for exposure and support from Aboriginal people in the HASI service that supported them. This level of Aboriginal staffing contrasted with their previous Aboriginal HASI service:

> There's been a bit of a change. Yeah, because there's less Aboriginal workers …. I thought it was really good when there were, there was a couple of trainees, you know, I think were under some Aboriginal program, they were learning, I thought that was really good, and I think a lot of that's cut back. (Consumer)

Overall, Aboriginal consumers thought that the employment of Aboriginal workers was a good first step and hoped there would be more Aboriginal workers in the future with links to the community. They also suggested that non-Aboriginal workers should be trained in cultural competency by Aboriginal workers and people in the local community:[1]

> I've actually said to my Aboriginal manager at the, at Housing, I said that you need to educate some of these workers a little bit more. (Consumer)

Consumers emphasised the need for cultural competence of all staff. One participant who identified as Aboriginal gave an example of good practice, where non-Aboriginal staff had local and cultural knowledge:

> My case worker, she's non-Aboriginal but she went to school here in [local area] so she grew up with the Aboriginal community so that makes things so much easier and she knows a bit of the slang or broken English that we use, so I don't have to explain myself to her and she knows what I'm talking about. (Consumer)

In some services Aboriginal workers had a role advising or educating non-Aboriginal staff on how to be more culturally aware and competent:

> Well I had a word to my [Aboriginal] case worker and he actually went and sat down with that other case worker … and he explained to her [why her actions were distressing to me as an Aboriginal person] and he came back and he said "she understood and she's sorry." (Consumer)

> We have Aboriginal workers that can provide supervision, support and mentoring in that space, particularly cultural supervision in understanding those kind of kinship structures and networks. (CMO)

An Aboriginal worker reported that staff were becoming more culturally aware and were more likely to ask for advice compared to when they first arrived:

> They're more aware of the culture, [this] helps. That helps a lot, I find. Because, I find myself, I mean I suppose I educate a few of them … like one case worker, she asked me, "Is it rude to do certain things." (Consumer)

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[1] The MoH provided Aboriginal Competency training in 2019. It is two part training, with online in 2019 and internal CMO work in 2020 rolled out to all CMO staff.

When consumers identified as Aboriginal, many services offered them support to connect to **local Aboriginal services**:

> I’ve been linked with services like the Aboriginal Medical Service. (Consumer)
>
> We actually have aligned a lot of our casework practice towards cultural competency, so we use a tool such as cultural mapping, which is wellness maps designed to identify Aboriginal people’s recovery and identify their recovery network. (CMO)

Most services also offered support to help people reconnect with **family, community and culture**. Most felt that this support was better when it came from an Aboriginal person, such as Aboriginal staff in conjunction with local elders:

> It’s important to note that particularly Aboriginal people are heavily involved with family and social networks, arguably more so than non-Aboriginal people so that our service models encompass the importance of family and encourage the importance of family in those care planning strategies. (stakeholder)
>
> I've had a few Aboriginal workers that have worked on [helping me learn more about my culture], and they've assisted me. (Consumer)
>
> We recently had, a couple of weekends ago, there was an event out [location] way, where we supported I think one or two consumers to go up there, it was an Aboriginal cultural day … the day was also around learning of one’s heritage. (CMO)
>
> [CMO support worker] helped me find out about the … Aboriginal men's group. (Consumer)
>
> … you’ve got to go through the elders to see what’s – that’s how the Indigenous community is. If you’re looking for, it might be just a men’s talk group or a sisters’ group, you just go and see a community member, an elder. (CMO)

Some Aboriginal staff had also helped to facilitate collaboration with Aboriginal community leaders and other Aboriginal services:

> We try and get our Aboriginal clients to go to the Aboriginal medical centres and sometimes I'll take a colleague who is Aboriginal sometimes just to break the ice a little bit. That seems to be helpful. (LHD)

Some CMOs partnered with Aboriginal services to support consumers to be involved in Aboriginal community events. Consumers and other stakeholders reported that this involvement increased cultural connections and engendered a sense of pride for Aboriginal consumers and increased the understanding and cultural competence of non-Aboriginal consumers and staff:

> We're also currently getting involved with NAIDOC week, which is coming up. Something that we're looking at trying to get involved in and also hoping to start having conversations and getting our consumers involved in participating. (CMO)

> And not only that, have our Caucasian participants come in and join in and show them a bit about our culture and maybe they might relate to us. (CMO)

Consumer contact with workers from their own culture engendered hope and provided a role model for consumers who identified as Aboriginal. This was particularly salient in one service where an Aboriginal person was in a senior role.

Not all consumers who identified as Aboriginal sought culturally specific services. They gave several reasons why people might choose mainstream rather than culturally specific services. These included: concerns about trust and confidentiality in small, close-knit communities; fear of discrimination or 'outing'; relocation to an area that had less cultural relevance; and that some people who identified as Aboriginal did not have a strong cultural identity. Consistent with person-centred recovery approaches, most services saw whether Aboriginal people embraced their culture as individual choice:

> Obviously we try and link the Aboriginal guys in with, particularly Aboriginal groups, particularly Aboriginal organisations. But some of them are very happy just to attend mainstream groups. (LHD)

Some people expressed concern about the loss of responsiveness to Aboriginal consumers' needs now that Aboriginal HASI was absorbed into CLS-HASI:

> It was better before. I got a lot more support, where now ... I do have support, but not as much as I did before. (Consumer)

> I thought that [Aboriginal HASI] was quite a useful program, because there are barriers that confront an Aboriginal client in terms of engaging with the mental health system. I think that program was particularly geared to help Indigenous customers with doing that navigation. I feel that there has been a severance with the … discontinuation of the program. (CMO)

Capability 2C Responsive to people from immigrant and refugee backgrounds, their families and communities

Some services in the fieldwork sites supported the preferences of culturally and linguistically diverse consumers. A few examples were evident:

> We do some groups, I've just recently started an arts and crafts group for my ladies. It was questioned why it was just for ladies, but we've got a few ladies from different cultures that don't like to be around men … and I just thought it would be nice, a safe place for the ladies to get together, to make friends. (CMO)

Consumers and other stakeholders talked about the importance of family in many cultures and how it was important for support workers to understand the family dynamics. Consumers gave examples when they felt well supported and others where they felt that their family needs were not given cultural consideration:

> Because I have a big family, when I first got started, they asked who was in our close circle and then they got to know my Mum. She was pretty important to me. They got to know my Nan. They know my family that's close to me. (Consumer)

There appeared to be limited endeavor in most CMOs to provide culturally specific services to meet individual needs. Consumers did not directly reflect on this source of this problem in the interviews, but stakeholders did. The stakeholders said that sometimes the problem seemed to be due to a lack of resources:

> So, the example that I offer there is that there's one customer that I used to do key work for, but they couldn't speak a word of English ... So there's communication barriers from the start.... We needed to rely upon interpreters. There's no brokerage or moneys available to fund an interpreter. That's necessary, I feel, because one of the things I tried to do was actually try to find if there was another support agency out there that provided workers that have – that spoke the customer's first language. There's nothing out there. So that's a gap that I see. (CMO)

Generally though, most other stakeholders appeared to see no need for different services or approaches to embrace cultural diversity of consumers.

> I don't think there's any difference in the day-to-day stuff. (LHD)

> Yeah, so we do have a small handful of consumers from different cultural and linguistic backgrounds, however, again, they haven't so much sought our support in terms of cultural and linguistic support. It's been just ongoing support, coming back to those daily living skills. (CMO)

> I mean they tend to need the same things. A roof over their head and to be able to feel safe. (LHD)

Some other stakeholders thought that if different services were offered to cater for cultural and ethnic diversity that this would perhaps be discriminatory. They appeared to be equating same services with equal services, rather than seeing individualised service provision as the core of equity in individual recovery:

> I treat them all the same so it's all the same to me. I don't care what colour they are. (LHD)

> No discrimination at all. … "I have no preference at all when it comes to your recovery. I have no discrimination whatsoever. It's your recovery. You're trying to reach that goal". (CMO)

> So, everybody's different, and I don't think it matters what background they come from, I think it's just personal preference. (CMO)

> I really view people just as an individual … I think because I do come from a recovery like kind of framework as well as I've got a very kind of holistic approach to viewing people. (CMO)

3. Supporting personal recovery

The fieldwork findings are presented below for each of the three capabilities (Attachment: National Framework capabilities) associated with this National Framework domain.

Capability 3A Promoting autonomy and self-determination

Consumers and other stakeholders gave many examples of how support was individually defined and led:

> It's very much based on my needs and based on what I'm going to get the most out of. (Consumer)

> So we look at what their needs are, so we always sit down and do an initial needs assessment. Then we'll work and that will guide us to what their needs are. (CMO)

Limitations seemed to be operational, such as how the planning was done; and practical, such as how to manage balancing between individual choice and developing autonomy. Some staff reported that they began the needs assessment process without the consumer. In some organisations, Individual Support Plans (sometimes called 'care plans' by other stakeholders) were drafted before the first meeting with the consumer:

> That would just be my ISP, my Individual Support Plan. So, I will go off—right now I am doing one. I go off the referral and the intake—or the assessment that I do. Then I will do a rough copy and I think—because generally at the end of the assessment the client will say what they want to get out of being with us, because they know what we are going to do anyway. I will put that into their Individual Support Plan, then I go over it with them and if they agree to it, then that is what we go ahead with, or we add things that they want to do. (CMO)

In the quote above, the other stakeholder calls the ISP 'my ISP', which raises questions about the level of consumer ownership.

There appeared to be limitations (real or perceived) on what services or support consumers could choose. Some consumers spoke of choices becoming restricted and many of them thought CMOs had experienced 'cuts to funding' that limited their choices.

> They pick me up, but there's a limit to what they, their services can do for you. So, there's a limit to that. There has been a big change since the funding has been cut. (Consumer)

> They can't do the cleaning. They are not allowed to. I don't like that. (Consumer)

> Where the program before, they used to take me shopping and do stuff like that. If me and another client would want to go out for a coffee every fortnight, they'd actually pick us up ... the worker [would] come in and have a coffee with us and pay for it. (Consumer)

> Yeah because that's what I mean, because they don't pay for anything for us, so they don't buy the ingredients like [name of previous service] did so we can do cooking group. (Consumer)

Asking consumers to pay for activities that were once free may have prevented them from participating. Their inability to choose to participate in activities due to lack of finances caused stress to some consumers:

> Also, I find that with not just me, but a lot of people under mental health can struggle a lot more financially, with the cost of things, basically, I suppose, finance stops us from doing a lot. (Consumer)

> It’s very stressful. Because I have [name of CMO] workers saying to me that I need to engage more, and asking me to come to the lunch, but I’m only on the pension, and they have the lunch like at the end of my fortnight pay … so I don’t have the money to go. (Consumer)

Some of these apparent changes seemed to be a result of the service approach to promote autonomy and independence, which are important recovery goals:

> … we’re putting their responsibility back on them. So, … like helping them scheduling, helping them budget, lots of different things like that, which then they can manage in their own time, as well as us supporting them every now and again with it. (CMO)

Independence was a cornerstone of the recovery orientation in most services, with most staff focusing on ‘teaching’ consumers how to live independently and moving them out of the program. Without a nuanced balance, this could be limiting consumer choice and the ability of consumers to drive their own recovery.

> So we had a bit of a backlash when it came to the consumers wanting us to [drive them places] … It's like well no that's not what our service is for. That's not teaching you anything. (CMO)

> And this is what our aim is to do, is to ensure that they can do everything for themselves, and they don’t need us anymore, and then we have the next person come along, and we start again. (CMO)

It appears that in some instances perhaps consumers were not ready or able to do the task independently. At least one service required consumers to make appointments for support a week in advance. This had worked well for some consumers, who had become more organised as a result. Some others had found this system difficult and reported that they no longer fully participated as they forgot to pre-arrange. Any consumers that may have more completely disengaged from the service as a result of this scheduling approach would not have been available for the evaluation.

A few staff spoke about how they had worked to balance these tensions in a recovery-oriented way:

> So it's about checking in with the customer to see what they've got capacity to do, and then working with that. (CMO)

> We would love all of our guys to move into independence, but in the real world, that doesn't happen. We can't push them out the door, and it's not fair either … So, we encourage independence as much as we can … And then you see things start to change, and they are getting quite independent. So, you have that constant conversation of where you need to move to next, where we're going … And we chart it ... So, every 12-month period, there's at least four good conversations with the people we support about where they're going, and how they're going. (CMO)

Others spoke about how they had used strategies to reduce support at the consumers' pace:

> I wouldn't have been able to get started off without them you know. (Consumer)

> It could be assisting them with their shopping, some people get too anxious going out to do their shopping by themselves, or they just can't, so we will assist them to do that, and we will get them doing that more and more … so that eventually we can start stepping back, and they can do that by themselves. (CMO)

A frequent example of balancing between choice and autonomy was transport. Consumers and other stakeholders spoke about how transport was important in supporting consumers in practical matters and to take care of their mental health:

> The support, how they help me a lot, they're there for me, they take me to all my appointments, and I find it very helpful, me not having a car or being able to afford a car to get myself off to appointments, I have a lot of appointments. (Consumer)

> Just talking to them, when I feel down sometimes they make me feel happy. They also make me feel…I just ask for little drives now and again, just to go out for a little drive and that and go and have a cup of coffee and going shopping. (Consumer)

> They also used to pick me and my son up one afternoon a week to spend some time together… and they'd take my son back out of town to where he was living at the time. That meant a lot to me. (Consumer)

> I got to a point now where with [CMO support worker] we could walk into [supermarket] and she'd be beside me, so the anxiety, when I started panicking, I just look at [them], and [they] could see in my eyes or my body shakes, and [they] just starts talking about whatever. And before I knew it, we were at the checkout, we're back in the car. It's hard to describe, but that's the sort of stuff they do. (Consumer)

Many services limited the lifts provided to consumers with the goal to encourage independence. This caused anxiety for some consumers and damaged relationships with workers and services, particularly where walking or public transport was not feasible or affected their mental health:

> I have to hitch-hike home from the shops because the services refuse to transport me. This transport and this time they spend with me is what, you know, a couple of hours a week, you know, and I don't think it's going out of their way or, you know, bending their schedule to do this for me. (Consumer)

> I don't understand why I'm not getting transport. I was getting transport for about six weeks and then it all sort of stopped. The worker got in a lot of trouble from transporting me. (Consumer)

> I'm too frightened of puppy dogs, because I am scared of dogs, because sometimes people have aggressive breeds of dogs and I get really nervous, like yesterday even I thought that his puppy dog wanted to attack me. (Consumer)

There were examples of good practice in balancing tensions. Some staff regarded consumer preferences about support with transport or working towards autonomy as individual choices that they respected and that may change over time:

> But yeah, we're very much so coming from a recovery framework. Everything we do is working towards someone's goals. We don't just go in and do support for people, we do it alongside people, so. Yeah, so we do provide transport. However, wherever we can identify that that person has that goal where they'd like to, say, learn how to independently make their own way to places, we can either support them to learn bus routes, or, alternatively, we've also helped people get their license. (CMO)

Capability 3B Focusing on strengths and personal responsibility

Strengths-based practice was evident in most services. Many consumers spoke of encouragement and praise for effort, progress and achievement:

> They're very good at encouraging you to do things but making me feel what I am doing is a good thing and making me feel almost normal, I suppose. When I'm not feeling great, they're still very supportive and very encouraging, so they definitely do that well. (Consumer)
>
> They're making me start to believe that I've got a voice, that my voice is worthy of talking. (Consumer)

Some consumers relayed stories where they said they felt judged or belittled by workers:

> Oh, like I get onto drugs sometimes and that, and one day I had a box of sharps on me, and she was trying to say "What are you doing, you can't be doing this", sort of thing, and it was none of her business really, like I've got a problem, and it was really in my face, and more or less talking down to me (Consumer).
>
> They're treating me like I'm a dumb person because I've got schizoaffective disorder. (Consumer)
>
> Like, you know, they think they're above me because they're a worker, you know, who is educated. (Consumer)

Capability 3C Collaborative relationships and reflective practice

On the whole, the relationships between staff and consumers appeared to be collaborative, with consumers reporting that they felt respected and validated:

> She hasn't been open, but she's just said, "I know what you're going through." … in other words I've experienced similarities. (Consumer)
>
> That's one good thing though too is they do make you feel a part of the team, part of the community. (Consumer)
>
> Most of the workers would sit down and have lunch with us, whether they ate what we had or whether they'd just have their lunch. (Consumer)

> They're good there, they're very good. We have positive conversations, you know what I mean? (Consumer)

> She doesn’t look down on you. She doesn’t look down on me and she’s someone I can trust. (Consumer)

Some consumers reported that relationship building with workers was difficult. Some interview participants reported that they did not trust workers to respect their choices. One consumer had not told workers he had autism for fear of prejudice. Some consumers reported that they did not disclose to workers when they were unwell as they were worried about the worker’s reaction:

> It would be good if you could talk to them about things without them hitting the panic button because a lot of things you can’t talk to them about. (Consumer)

> I didn’t really get that involved with them about anything. They think that—how are you going—they would always ask me and I would say that I was doing alright, so I just left it at that. (Consumer)

A few participants spoke about the lack of reliability of support. One participant said that the unpredictability he experienced had worsened his mental health:

> They’d say, “Well, we’d like you to fill some papers in and we’re doing it on the Friday at 12” and you’d be waiting around for them to come over, they wouldn’t turn up. … then later on I’d ring them up, “Oh, no, we’re going to do that late in the afternoon”. Then … “No, we’re not going to do it today, it’s going to be Monday”. So, you wait around Monday … and then - then they just disappear totally and then suddenly pop again up and “We’ll do the papers now” (Consumer).

Staff turnover or a system where key support workers changed often appeared to stifle collaborative relationship building. Some consumers did not know the names of the staff at the service, which also highlights the importance of ensuring equitable access to information:

> There’s two new people I can’t remember their names … They’ve got name tags but I can’t read properly, I’m not a very good reader. (Consumer)

The recent tender process also challenged trusting relationship building. Not just between consumers and staff, but also between CMOs and between CMOs and the Ministry.

> … if you're a consumer and you're one week working with one lot of people, and then next week suddenly these people that have become almost like your mum and dad or your best friends, now you're working with a completely different lot of people. (stakeholder)

There was not a lot of evidence of reflective practice in the field. This may be due to a strong focus on the day-to-day activities, which appeared to be at the expense of planning and reflection. An exception common to most locations was good structures for clinical supervision:

> … we have a senior peer worker who provides clinical supervision to our peer workers and importantly also for that peer worker to participate in supervision for our non-peer workers. (CMO)

Many staff also reported that they required more support and training, which are discussed further in the next section. Some other stakeholders spoke about the need for more support:

> I think that there should be a little bit more—like even our support for staff members to gain a bit of mental relief through speaking about their experiences as well. I had a very intense experience the other day and I approached a manager to talk about it and she spoke to me about it, but then I was—yeah, I have kind of just had to deal with it myself … We experience a lot of different scenarios. I think there needs to be a little bit more support just asking everyone, "How was your day? Did anything happen that you need to talk about?" I think that needs to improve. (CMO)

4. Organisational commitment and workforce development

This National Framework domain has four associated capabilities (Attachment: National Framework capabilities). Findings for each of these capabilities are presented below.

Capability 4A Recovery vision, commitment and culture

There was a strong commitment to recovery practice voiced at all levels of CLS and HASI. There were some barriers to create a program or organisation-wide vision and culture, including top-down decision making and information flow. Some frontline workers felt that the re-tendering of CMO services in 2016/207 de-valued expertise within CMOs. They said it disrupted recovery practices that relied on social connections between consumers and workers that were built on trust and helped to adequately respond to the individual needs of consumers.

Capability 4B Acknowledging, valuing and learning from people's lived experience and from families, staff and communities

CMOs in the fieldwork sites showed this capability mainly through employing peer workers and less through contact with families and communities.

Learning from lived experience was evident in increased employment of **peer workers** in most services. There was evidence of a growing recognition of the value and expertise of people with lived experience and structures to support the growth of the peer workforce:

> We have peer support workers that use a lived experience to support people accessing the program, [and] role model hope and recovery. (CMO)
>
> So, we have people that identify as peer workers. Which means they have a lived experience. As well as mental health workers as well. So, and we're, I think we're working towards, … around 50% or slightly more of the work force having identified. (CMO)
>
> Our peer support work strategy has been a long-term project starting off with some research we did with the University of Newcastle looking at how we can be more responsive to embed peer workers in our organisation and embed peer workers … – to have a professional identity in our organisation. (CMO)
>
> Peer support worker is a brand new role in this hub, so it's been evolving throughout [CMO], but they are trying to recruit some new peer support workers … They need more in the organisation, but yeah, I am the only one here and I have been here for four months. (CMO).

Some organisations also had models of professional progression for people with lived experience to acknowledge and use their expertise. They noted the benefit of peer worker support networks:

> We've had some pathways developed for consumers in our program [who] worked through their recovery and have gone on to be a volunteer and have gone into paid employment within our organisation or paid employment within other peer organisations as well. (CMO)
>
> I have connected with a couple of other peer workers in [the wider]

> organisation and it's been wonderful to talk to them, that has been really great. They have reassured me. (CMO)

Some organisations appeared to under-utilise the specialised expertise of their peer workers and other lived experience roles. A lived experience worker in one organisation spoke about a ratio of one peer worker for 20 consumers. There was also evidence that many peer workers and other staff working with them were unclear as to how peer worker roles differed from other roles. They reported that devaluing and misunderstanding roles dissuaded other people with lived experience from disclosing in the workplace or taking on lived experience roles:

> So, my job is quite—like the same thing as a community support worker, but I am allowed to share my own personal experiences in regards to mental health … We did have a customer representative council that I sat in on, but my input wasn't—they didn't open up the space for me to talk a great deal ... I have noticed in this organisation, because, I guess, after that initial experience with the coordinator, he kind of made it a point to tell me that I was in the wrong role. I kind of felt reverse discrimination. (CMO)

As discussed in section 2, the lived expertise of staff who identified as Aboriginal also appeared to be under-recognised and under-used in services. Some staff who identified as Aboriginal shared case load with other workers with no apparent processes to target support to Aboriginal consumers or to undertake roles in advising other staff on how best to work with consumers who identify as Aboriginal:

> I would like to have more of an opportunity to [have a role in culture change]. … and I definitely believe that I have a lot more to be able to help evolve this organisation, when it comes to mental health and the experiences of getting myself and other people through it as well. (CMO)

The involvement of **family members and communities** of consumers appeared to be ad hoc as revealed in the interview discussions about recovery goals, contact and activities. Most contact was confined to working with individuals rather than involving families and communities in organisational planning or program governance. Some organisations had, or had had in the past, a family advisory group or committee or contact with an external group, but most service providers across the fieldwork sites said such groups were floundering due to lack of family attendance.

The main reason that involvement of families was a challenge seemed due to many CLS-HASI consumers having lost contact with their family. Family members who did have relationships with consumers often had other commitments, including their caring role for the consumer. It meant that their participation with service activities for families was difficult.

In one area the contact with families appeared stronger than in others due to less mobility of people in and out of the area. This service had an active Carer Advisory Group and involved families in activities in the service, with the consumer's permission:

> Our HASI guys have really good family involvement, which is … I don't know, it just happens to seem to work out that there's always a family member involved, and it's good, we encourage … If it's healthy for the person, we encourage it; but we have a lot of great families that are involved. (CMO)

Capability 4C Recovery-promoting service partnerships

This capability was expressed in CLS-HASI through collaboration between CLS-HASI program partners, with some other local service providers and to some extent at the statewide program governance level.

There was a strong recognition of importance of, and commitment to, good **collaboration between local LHDs and CMOs** in all areas:

> We work very closely with Community Mental Health and other mental health support services. So, we have a lot of meetings with Community Mental Health, which is great, so we're having that wraparound service provision. (CMO)
>
> We have collaborative meetings so we know where our clients are and what's happening on both sides so we don't double up. We do a lot of joint sessions as well. We often sort of get … in the same car and go and see our clients together or go and collect them and take them somewhere. (LHD)
>
> I sit on our larger HASI LHD meeting that we have monthly, you know, where we discuss new referrals, issues with HASI, get updates from all the services, and all that sort of thing. (LHD)
>
> I feel that you get good outcomes when you're working collaboratively with services rather than working siloed. (CMO)

Stakeholders reported that the program partnerships had advantages for all concerned, including enabling holistic support for consumers, rationalising between services, service planning, communication about consumers and resolving problems:

> I’ve also been … liaising with other managers from the CMO organisations, regular meetings with them, regular catch-ups, you know, resolving many issues with them, and developing really good partnerships, networks with those people, which I think has been invaluable … having that communication. (LHD)

> But you know a participant might not be always happy with Community Mental Health just coming to see them. Whereas if [staff from our organisation] come around we're a lot different, and they're quite happy to see us, or coming together. I think it’s breaking down that little barrier for them as well. (CMO)

Some other stakeholders reported that clearer communication and more collaboration may have promoted more autonomy among service providers. Other stakeholders reported that high levels of autonomy could make collaboration difficult:

> With good communication and good level of support with them, I think [CMOs] feel now that they can make more decisions on their own (LHD)

> Some NGOs like to be very autonomous, they prefer to run their own race and to work to their own philosophies and do what they will. Others like to be more involved, and to use [CMO] as an example, I suppose we found them to be very removed. They were quite isolative in terms of they like to do their own thing in their own way to their own philosophy. (LHD)

Another stakeholder spoke about the advantage of CLS-HASI funding facilitating good collaboration, in contrast to other programs, especially NDIS, that had less or no dedicated funding for collaboration:

> The benefit of the types of CLS support say compared to NDIS support is the ability to work in concert with the clinical mental health team and the ability to provide those case management-based services for consumers that might not necessarily get that level of support from the NDIS or may even be ineligible for NDIS packages. (CMO)

There was some evidence of collaboration **between CLS-HASI and other support providers** at the local level:

> We do a lot of stepped care in partnership with the Justice and Forensic Health Network Services, so looking at supporting conditional releases and

> people who are spending a couple of days in the community before returning to the unit. (CMO)
>
> I have quite a close relationship with the property manager here with public housing and she'll let me know if there's any issues, and I will let her know if there's any issues. So we can get on top of it straight away and try and sort it out. (CMO)

Some local communication structures seemed weak, for example local housing and Aboriginal services seemed not to be routinely informed about changes of CLS-HASI providers or staff:

> I'm sure that a number of providers [in this area] are engaged in the HASI program but they don't feel very engaged by Health in that they don't feel that they're consulted about any changes. (stakeholder)

Some of the difficulties were due to the way some local service provider organisations operated, such as having high staff turnover, without strategies to communicate their constraints:

> Some organisations it's every time you see the client you deal with a different staff member. And you say "so how's [name] been going?" "Oh, look I don't normally work with [name]" you know and yeah whereas with say [a different CMO name] you're more likely to get someone who knows the client, who's got a history with the client, can actually provide you with some valid feedback. (LHD)

To improve collaboration, some other stakeholders said it was important to have shared vision and be able to understand the motives and challenges of partners. Some expressed their hope for the future:

> So, I think what has been a gradual thing to address is a lack of understanding about what each of us do. (CMO)
>
> It is about shared understanding. I mean, always the best partnerships are the ones where people really understand the constraints on the other party and can go: I get that, I get that that's something you have to do and how do we work with that, what can we do. So, I do think there are real possibilities there. (stakeholder)

Collaboration at statewide **governance** levels of CLS-HASI appeared to have limitations. At these levels, other stakeholders felt that there should be more formal partnerships and collaborative strategies beyond the CLS-HASI Stakeholder Forum:

> I think the only interface is through that advisory group or steering committee … which I think feels a little bit sad really. I quite like that group and I think it's a very open group and tries to really engage but it just feels like there is a lot more that we could be doing in partnership with Health around the issues that providers see all the time with people with mental health conditions. (stakeholder)

> We in [partner organisation] have been trying probably over the last year for me in particular, trying to build stronger relationship, working relationship with Health New South Wales and particularly with the team who run the CLS and HASI programs to try and basically increase the number of referrals directly from [us] to those programs. [This is going] slowly, as it usually does with a lot of government agencies. (stakeholder)

Some other stakeholders reported that the focus on NSW Health led to attributing the successes of the program to the role of Health, without acknowledging the significant resources contributed by other programs and departments, especially Housing:

> I think that's great for Health but it should also be seen as Housing, as the housing that has also provided some of the benefits so that the kind of savings around health outcomes and costs actually should be seen as some things that are being driven as well by the Housing part of the partnership … I think it probably is understood but I don't think it's made any difference to how the program is funded or structured. (stakeholder)

Capability 4D Workforce development and planning

Within the limitations of interview data, the workforce experience and qualifications of frontline support workers seemed to vary within and between services – with some workers having little or no training or experience and other workers having relevant tertiary qualifications and equivalent experience. Most other stakeholders and some consumers spoke about a range of training needs that were not consistently met, including:

- recovery orientation, especially supported decision making
- lived experience roles for peer workers and other staff

- suicide prevention
- hoarding
- basic mental illness diagnosis and symptoms
- basic information about common psychiatric medication.

NSW Health advised that after the fieldwork finished the Ministry put additional grant programs in place for CMOs to train staff, which will be further analysed in the final summary report. One was funding TAFE certificates to increase the number of people available as support workers for HASI and CLS. Others were an Aboriginal cultural awareness training program and training about cultural and linguistical diversity.

Some other stakeholders noted that the flexibility of CLS-HASI funding allowed resources for training and workforce development. They contrasted this with the NDIS funding structure.

Some other stakeholders spoke about the importance of workforce development and training of both CLS-HASI staff and those in other local services working with CLS-HASI consumers towards recovery. Some other stakeholders spoke about how this cross-service training could occur in partnership among local providers, with each training the others to get a better sense of the others' roles:

> Not just for CMOs, but for public health, and not just around recovery, but specifically around supported decision making, self-advocacy, self-management, having help to build capacity for people, to undertake those activities themselves. (stakeholder)
>
> People probably don't know what the right process is for referrals and so I would say it's probably a communication thing, so clarifying what the referral process is and then for us internally ensuring that there's communication around what that process is for a referral. (stakeholder)
>
> Many people working to support people don't actually understand how the tenancy works, what the responsibilities are, what the options are for a housing provider … I think improving the awareness of support providers about what it means for somebody to enter into a tenancy would be really helpful. (stakeholder)
>
> So, it's not about doing each other's jobs. It's just about understanding what

> they are … I think that would be an exciting area to try and work with (stakeholder)

5. Action on social inclusion

This National Framework domain has three associated capabilities (Attachment: National Framework capabilities). Findings for each of these capabilities are presented below.

Capability 5A Supporting social inclusion and advocacy on social determinants

Interviews indicate that CLS-HASI supported social inclusion of consumers through social activities in the community, through group activities at the service provider locations, and through group outings, as described below. ‘Advocacy on social determinants’ means advocacy to address poor and unequal living circumstances that adversely impact personal recovery, in areas such as housing, transport, education, employment, income security and health care. There was not enough evidence in the interviews to suggest that the programs advocated in a consistent or discernible way on social determinants.

Many consumers spoke about how their **social activity** and social networks had increased with CLS-HASI support. Some gave examples about how they were supported to make connections in the local community:

> I go shopping with them. Go to a little restaurant now and again on the weekend. Go for walks. Like today, I went to the restaurant and then we stopped and had a cup of coffee and then went out to the Aborigine thing out at [town] … and that was real good … it’s been a really good day. (Consumer)
>
> They have got me in with—other organisations within mental health like [local ‘Hearing Voices Group’] and other things like that which I find was pretty good because no one has ever done that before. Those fellas have put me in that direction to do that, which I appreciate. … if I wasn’t here, I never would have done that. I would still be how I was, standoffish to them all. (Consumer)
>
> Yeah, she helped me find out about the men's group. (Consumer)

Some support staff described the importance of social integration beyond the immediate CMO service organisation:

> I'm looking at as the whole of integrating into society is getting people back into that level of – I can do what the general population would most likely be able to do, feeling comfortable with it, not feeling stressed, not feeling anything like that. (CMO)

> The groups don't have to be run by us. There's groups that are outside. So if a person wants to go and engage in a group which is specifically for elderly, over 65s, that's something that we can work with as well, and we can take them to that group and introduce them and get them working. If they want to go to church, we can take them to church and introduce them to church groups, if that's what they identify as their need. (CMO)

An innovative strategy for increasing community connections was to bring the community into the service:

> A lot of our programs go on Meetup and so, the outer community come. …which is good, because when they come along it gives our customers extra people to interact with as well and create new friendships. (CMO)

Not all services had the facilities to be able to do this. Also, the location of the venue was important in promoting social interaction. Consumers supported by services that were located outside of the town centre reported that they had less connection with the local community and that they were much more likely to require support to visit the service:

> There's nothing else out there they would normally go to, whereas … when it was based [in town] a client could kind of do a couple, a few things together. "While I'm in the main street, I'm going to go see my bank, and I'm going to go see Centrelink, and I'm going to go and do this." (LHD)

A large proportion of the social inclusion support offered was through **group activities**. CLS-HASI service providers saw group activities as an important facilitator of social engagement and inclusion:

> Social inclusion, I mean that's the fun part of the job, I think. … So we look at seeing what they do like, engaging them in the community, we have them up for social - I like to call it social group - but it could be a bit of craft, it could be a bit of colouring in, it could be a bit of painting, it could be some games, you know, good for their cognitive functioning. (CMO)

> Lot of them just want that social connection and interaction. We do have quite

> a lot that don't have any family at all. They really, really thrive … coming to these craft groups because that is really the only interaction that they get with other people. (CMO)
>
> Social inclusion has been a particularly large focus for CLS in this region, particularly working with people who are from isolated and stigmatised communities. We do quite a lot of social activity programs through CLS and have regular attendance of the 15 consumers a few times a week. (CMO)

Some stakeholders described these in-service activities as a transition towards greater social inclusion, while other stakeholders voiced concerns that consumers' social engagement was only service-specific and that consumers might make connections in the service, but not beyond the service:

> Yeah, an example would be a person comes into a HASI or CLS program, and … the services and supports that the program provides, not necessarily supporting the person to be involved and included in their community. … I think it comes back to that skill set around supported decision making, self-advocacy, self-management, teaching people the skills they need for life, rather than replacing or becoming a substitute skill set for them in that space. (stakeholder)
>
> So people get comfortable in the service, they make friends in the service and they just kind of keep getting supported in the service. (CMO)

When consumers were asked whether they had further social contact with people they had met at CLS-HASI services, they gave varying responses:

> I've met some other guys there, I've seen them around a lot of times, they just always yell out. (Consumer)
>
> There was some people that, you know, are a bit harder to get along with than others. But yeah, I made a few friends in those groups that I'm still friends with now. (Consumer)
>
> I don't think I would necessarily catch up with them outside of [the service] or anything like that. (Consumer)

For some consumers, social contact within services might be the first step towards greater social inclusion, for others it seemed better than no social contact at all:

> Me and my partner, we suffer from like our social skills. We don't get out much

> and [CLS-HASI Service Provider] come around and they talk to us and they take us out to groups and yeah, just get us out and talk to us. (Consumer)

> So, I might start coming to art and craft just for a social experience rather than actually doing art and craft. (Consumer)

> So, we’ve got one lady that really loves doing crafts and things, and she’s very, very good at it, and people like that just come in and they make friends quite easily which is nice, and yet there’s other people that have never done that before or have never been in a group setting before. So, it’s just nice to get them involved. (CMO)

For some consumers, making social connections was not a priority at the time:

> Oh, look, I’m really not well enough to be doing that at the moment. Like I have my family, and I’m quite close to them, but as far as making new relationships or making new friendships, it’s really not on my agenda at the moment. (Consumer)

> So, there are consumers who do not feel well enough to participate in, say, our walking group, so we’ll walk one-on-one with them at another time that is suitable for them. (CMO)

Most CMOs also offered **group outings**. While excursions might assist people to be in the community, the consumers were contained within the group with support. Without transition strategies to generate social inclusion beyond the service, there is a risk that the service-led group activities might make developing broader social connections difficult:

> We have an outing every Wednesday and that’s sort of catered around some suggestions consumers have given us on things that they want to do. A popular one, actually, is ten-pin bowling. (CMO)

> So now I'm pretty more independent, which kind of worries me, because I'm thinking if I'm pretty independent, maybe they'll stop taking me out on a Thursday or Saturday because I don't need their help, you know what I mean? But, I don't want to lose that bit. I know I'm looking after myself and what I need in my life, but I still like getting out and about with them. (Consumer)

Capability 5B Actively challenging stigmatising attitudes and discrimination, and promoting positive understandings

Some staff relayed stories where they had **challenged stigma and discrimination** when supporting a consumer in the community or at other service providers:

> I have a real strong dislike for doctors that go “dah dah dah”, and the person’s there. “Can you please talk to them? Because this is who needs your help.” So, educating the general GPs and stuff is part of our job, that this person is a human being, and you need to talk to that person. (CMO).

Staff also reported that they were careful not to draw attention to the person needing support when in the community:

> Because I don't want them to feel like we're walking around with a support worker. I just want them to feel like they're walking around with someone... If someone was walking past on the street. I want them to think that we're just two friends hanging out, not I'm in formal attire therefore I'm definitely a support worker. We have to wear a badge but I wear mine around my waist rather than around my neck because it's not as obvious. It's not as in your face. People in society aren't going to see it so the people that we're working with aren't feeling as judged. (CMO)

There did not appear to be evidence of approaches to address discrimination more widely. This could be because of the strong focus of service provision on the immediate needs of consumers (section 1).

Promoting positive understanding seemed to happen mostly through the in-service group activities, which in most cases appeared to provide a safe, non-discriminating space where consumers could feel accepted and could develop positive perceptions of themselves. In other words, the groups may have assisted in alleviating consumers' exposure to discrimination and in changing negative perceptions of themselves and their mental health challenges – often referred to as ‘self-discrimination’ or ‘self-stigma’:

> I found [participating in groups] good for my mental health, like being around other people that knew what it was like, and like doing – having a common interest in something with people that you know understand. (Consumer)

> I find like when I do the groups, like there's other people that are... like consumers that are in the same boat... You've got something in common with some of the other consumers with you, when you do the group activities.

> Yeah. (Consumer)
>
> I just like the idea that I can go out somewhere and there's people who just won't judge me. (Consumer)

On the other hand, a few consumers felt that group activities perpetuated their self-stigma:

> I went to a few groups … but the people that they are involved with them, they all seem a bit impaired, and a bit not the full quid, and when I get around them I think that I'm inadequate, and it makes me feel down on myself, to be classed as the sort of category as them … so I don't like coming to the groups much no more. (Consumer)

Apart from group activities, most consumers reported that they were generally being treated respectfully by CLS-HASI staff, and that this had helped them feel better about themselves.

> They're very good at … making me feel almost normal, I suppose. When I'm not feeling great, they're still very supportive and very encouraging, so they definitely do that well. (Consumer)
>
> Just talk to me normally, like I'm either a friend or a colleague or – yeah, I definitely don't get looked down on. (Consumer)

Capability 5C Partnerships with communities

As discussed above (section 2), while there were some good examples of local partnerships with communities there seemed opportunity for much more – especially in assisting consumers to reintegrate with community.

5 Facilitators of good practice in recovery-oriented support

The interviews revealed how CLS-HASI supported consumer recovery. The findings also demonstrated trade-offs and practices that compromised the recovery-oriented approach to some extent. There were gaps in program implementation, where some National Framework capabilities appeared to be addressed only to some extent or not at all.

The existing evidence of good practice and the elements that facilitated good practice in recovery-oriented support could be used for continuous improvement of CLS-HASI. Facilitators of good practice could be discussed and actioned among the program partners, both at a central level and locally. The facilitators of good practice in recovery-oriented support in CLS-HASI below relate to the five key practice domains in the National Framework (Australian Health Ministers' Advisory Council 2013):

1. Promoting a culture and language of hope and optimism

The findings indicate that CLS-HASI could further improve their service practice and capabilities by supporting CMO and LHD staff to keep their focus on incremental steps to achieve longer term recovery goals with the consumer, in addition to supporting consumers with practical, day-to-day activities.

2. Person first and holistic

Capability 2A Holistic and person-centred treatment, care, rehabilitation and psychosocial and other recovery support

- Examine the role of group activities in reaching individual recovery goals
- Explore program funding structures to give providers incentives for individual support rather than group support, when required
- Explore the possible effects of NDIS funding on the operation of CLS-HASI services in organisations that offer both to leverage new opportunities
- Consider staff training and resources about holistic recovery, the objectives of CLS-HASI and psychosocial support so that all staff fully embrace the approach.

Capability 2B Responsive to Aboriginal and Torres Strait Islander people, families and communities

- Create opportunities for all consumers who identify as Aboriginal to access a local Aboriginal support worker when they choose to
- Consider Aboriginal support worker roles to incorporate cultural competency, community liaison and partnership building
- Build on links with local Aboriginal communities, such as Aboriginal services, Elders, community leaders and Aboriginal workers with local connections
- Build cultural competency of all staff, for example training and advice from local community leaders and Aboriginal staff
- Consider ways to replicate the strengths of the past specialist Aboriginal HASI to inform community collaborations.

Capability 2C Responsive to people from immigrant and refugee backgrounds, their families and communities

- Exchange good practice about responding to consumers’ cultural group identity with a personal recovery approach
- Consider staff training and resources to support staff to recognise and address consumers’ cultural needs
- Build on links with communities and organisations that identify with and support people from diverse backgrounds.

3. Supporting personal recovery

- Exchange good practice about negotiating balances between promoting autonomy and individual choice and need

- Consider training and resources for staff and service providers on strengths-focused practice and language

- Prioritise reliability of service provision, for example turning up on time, and communicating with consumers if scheduling needs to change

- Exchange good practice about how to develop and support a culture of reflective practice with staff and consumers.

4. Organisational commitment and workforce development

- Consider strategies for inclusive, collaborative decision making and information flow throughout the CLS-HASI governance structure and within the partner organisations
- Consider targets for lived experience workers and share approaches to role definitions and professional progression
- Exchange good practice to develop and maintain family involvement
- Consider strategies to increase engagement with other local service providers who are not CLS-HASI partners but support the same consumers
- Consider structures for CLS-HASI staff to share practice between partners and other providers, such as joint training and resources.

5. Action on social inclusion and social determinants of health, mental health and wellbeing

- Exchange good practice examples among CMOs about social inclusion
- Share strategies and resources to increase partnerships and referrals to other services and groups in the community
- Consider how to incorporate systemic advocacy and community development within CLS-HASI roles.

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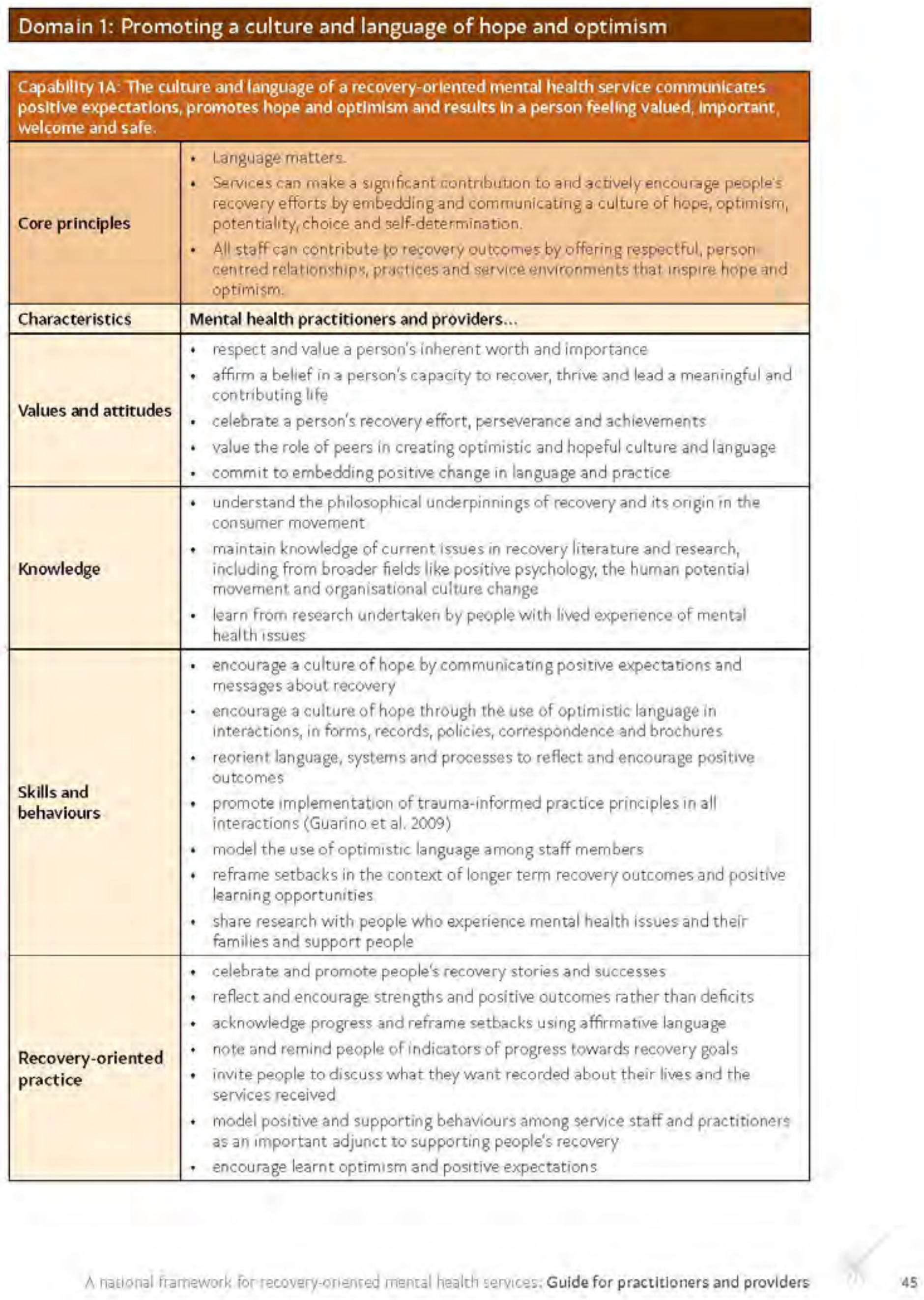
Attachment: National Framework capabilities

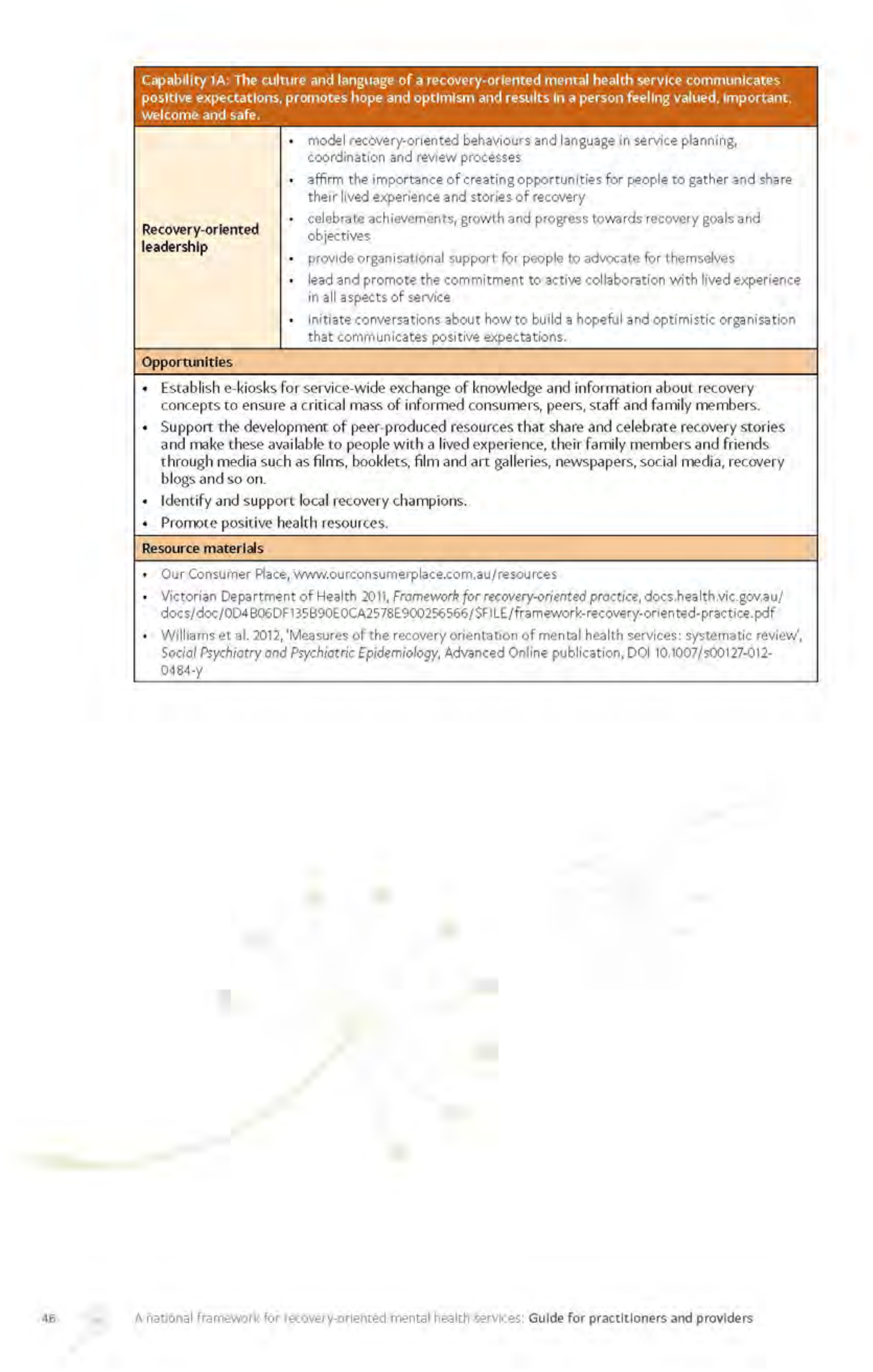


Domain 1: Promoting a culture and language of hope and optimism

Capability 1A: The culture and language of a recovery-oriented mental health service communicates positive expectations, promotes hope and optimism and results in a person feeling valued, important, welcome and safe.

Core principles	• Language matters. • Services can make a significant contribution to and actively encourage people's recovery efforts by embedding and communicating a culture of hope, optimism, potentiality, choice and self-determination. • All staff can contribute to recovery outcomes by offering respectful, person-centred relationships, practices and service environments that inspire hope and optimism.
Characteristics	**Mental health practitioners and providers…**
Values and attitudes	• respect and value a person's inherent worth and importance • affirm a belief in a person's capacity to recover, thrive and lead a meaningful and contributing life • celebrate a person's recovery effort, perseverance and achievements • value the role of peers in creating optimistic and hopeful culture and language • commit to embedding positive change in language and practice
Knowledge	• understand the philosophical underpinnings of recovery and its origin in the consumer movement • maintain knowledge of current issues in recovery literature and research, including from broader fields like positive psychology, the human potential movement and organisational culture change • learn from research undertaken by people with lived experience of mental health issues
Skills and behaviours	• encourage a culture of hope by communicating positive expectations and messages about recovery • encourage a culture of hope through the use of optimistic language in interactions, in forms, records, policies, correspondence and brochures • reorient language, systems and processes to reflect and encourage positive outcomes • promote implementation of trauma-informed practice principles in all interactions (Guarino et al. 2009) • model the use of optimistic language among staff members • reframe setbacks in the context of longer term recovery outcomes and positive learning opportunities • share research with people who experience mental health issues and their families and support people
Recovery-oriented practice	• celebrate and promote people's recovery stories and successes • reflect and encourage strengths and positive outcomes rather than deficits • acknowledge progress and reframe setbacks using affirmative language • note and remind people of indicators of progress towards recovery goals • invite people to discuss what they want recorded about their lives and the services received • model positive and supporting behaviours among service staff and practitioners as an important adjunct to supporting people's recovery • encourage learnt optimism and positive expectations

A national framework for recovery-oriented mental health services: **Guide for practitioners and providers** 45



Capability 1A: The culture and language of a recovery-oriented mental health service communicates positive expectations, promotes hope and optimism and results in a person feeling valued, important, welcome and safe.	
Recovery-oriented leadership	• model recovery-oriented behaviours and language in service planning, coordination and review processes • affirm the importance of creating opportunities for people to gather and share their lived experience and stories of recovery • celebrate achievements, growth and progress towards recovery goals and objectives • provide organisational support for people to advocate for themselves • lead and promote the commitment to active collaboration with lived experience in all aspects of service • initiate conversations about how to build a hopeful and optimistic organisation that communicates positive expectations.
Opportunities	
• Establish e-kiosks for service-wide exchange of knowledge and information about recovery concepts to ensure a critical mass of informed consumers, peers, staff and family members. • Support the development of peer-produced resources that share and celebrate recovery stories and make these available to people with a lived experience, their family members and friends through media such as films, booklets, film and art galleries, newspapers, social media, recovery blogs and so on. • Identify and support local recovery champions. • Promote positive health resources.	
Resource materials	
• Our Consumer Place, www.ourconsumerplace.com.au/resources • Victorian Department of Health 2011, *Framework for recovery-oriented practice*, docs.health.vic.gov.au/docs/doc/0D4B06DF135B90E0CA2578E900256566/$FILE/framework-recovery-oriented-practice.pdf • Williams et al. 2012, 'Measures of the recovery orientation of mental health services: systematic review', *Social Psychiatry and Psychiatric Epidemiology*, Advanced Online publication, DOI 10.1007/s00127-012-0484-y	

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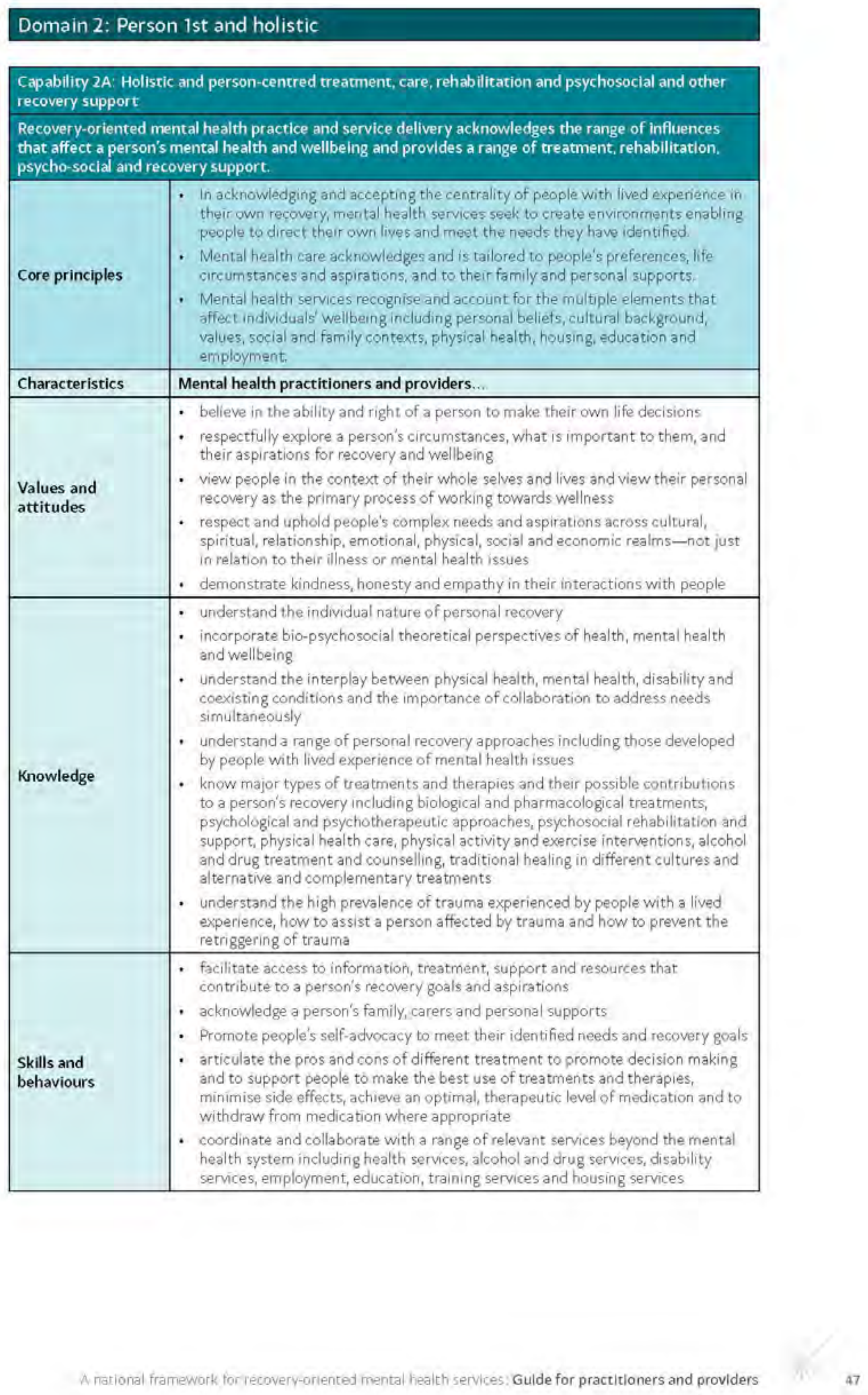
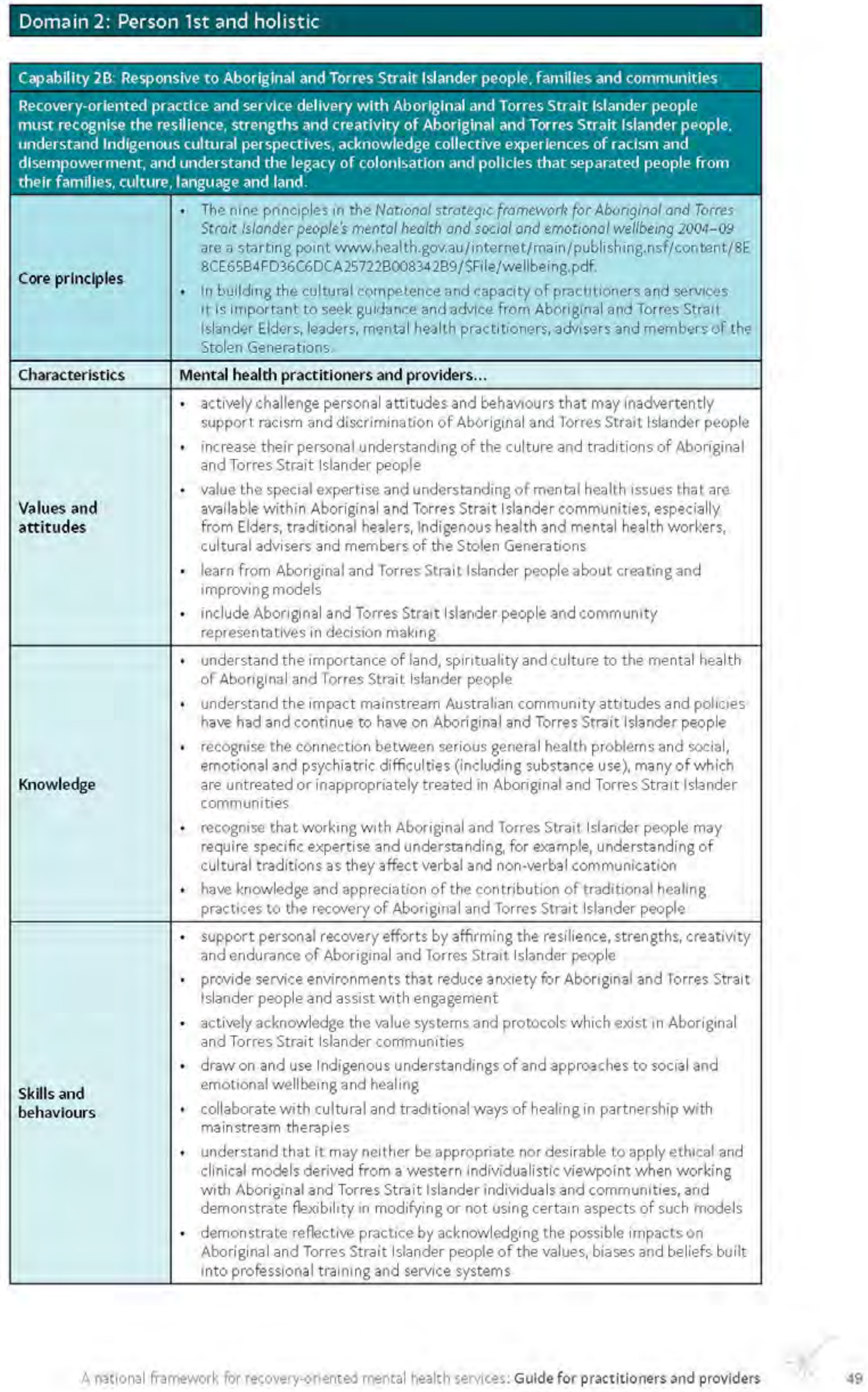


Domain 2: Person 1st and holistic

Capability 2A: Holistic and person-centred treatment, care, rehabilitation and psychosocial and other recovery support	
Recovery-oriented mental health practice and service delivery acknowledges the range of influences that affect a person's mental health and wellbeing and provides a range of treatment, rehabilitation, psycho-social and recovery support.	
Core principles	• In acknowledging and accepting the centrality of people with lived experience in their own recovery, mental health services seek to create environments enabling people to direct their own lives and meet the needs they have identified. • Mental health care acknowledges and is tailored to people's preferences, life circumstances and aspirations, and to their family and personal supports. • Mental health services recognise and account for the multiple elements that affect individuals' wellbeing including personal beliefs, cultural background, values, social and family contexts, physical health, housing, education and employment.
Characteristics	**Mental health practitioners and providers…**
Values and attitudes	• believe in the ability and right of a person to make their own life decisions • respectfully explore a person's circumstances, what is important to them, and their aspirations for recovery and wellbeing • view people in the context of their whole selves and lives and view their personal recovery as the primary process of working towards wellness • respect and uphold people's complex needs and aspirations across cultural, spiritual, relationship, emotional, physical, social and economic realms—not just in relation to their illness or mental health issues • demonstrate kindness, honesty and empathy in their interactions with people
Knowledge	• understand the individual nature of personal recovery • incorporate bio-psychosocial theoretical perspectives of health, mental health and wellbeing • understand the interplay between physical health, mental health, disability and coexisting conditions and the importance of collaboration to address needs simultaneously • understand a range of personal recovery approaches including those developed by people with lived experience of mental health issues • know major types of treatments and therapies and their possible contributions to a person's recovery including biological and pharmacological treatments, psychological and psychotherapeutic approaches, psychosocial rehabilitation and support, physical health care, physical activity and exercise interventions, alcohol and drug treatment and counselling, traditional healing in different cultures and alternative and complementary treatments • understand the high prevalence of trauma experienced by people with a lived experience, how to assist a person affected by trauma and how to prevent the retriggering of trauma
Skills and behaviours	• facilitate access to information, treatment, support and resources that contribute to a person's recovery goals and aspirations • acknowledge a person's family, carers and personal supports • Promote people's self-advocacy to meet their identified needs and recovery goals • articulate the pros and cons of different treatment to promote decision making and to support people to make the best use of treatments and therapies, minimise side effects, achieve an optimal, therapeutic level of medication and to withdraw from medication where appropriate • coordinate and collaborate with a range of relevant services beyond the mental health system including health services, alcohol and drug services, disability services, employment, education, training services and housing services

Capability 2A: Holistic and person-centred treatment, care, rehabilitation and psychosocial and other recovery support	
Recovery-oriented practice	• shape service responses to match people's aspirations, expectations, goals and needs • investigate the potential for alternative responses to those offered by the service • demonstrate trauma-informed practice • create opportunities for improvement in physical health, exercise, recreation, nutrition, expressions of spirituality, creative outlets and stress management • learn from and are informed by a person's understanding of what helps • maintain connections with referring agencies and explore new service partnerships
Recovery-oriented leadership	• encourage flexibility in supporting people's recovery goals • ensure holistic assessment processes that include reference to a person's home environment, personal goals, priorities and relationships • have clinical governance and professional development processes in place to ensure that the person is central to all that is done • review procedures and service environments to ensure that they are accessible (disability and age-appropriate, access and signage) • ensure that best-practice processes for coordination and collaboration are in place (referral pathways, service conferencing, shared care and joint discharge planning).
Opportunities	
• Ensure that staff, consumers and families have access to information and narratives about recovery in different formats and mediums.	
Resource materials	
• Glover, *Unpacking practices that support personal efforts of recovery: a resource book written for the workers and practitioners within the mental health sector* • Scottish Recovery Network, *Module 4: providing person-centred support*, Realising recovery, www.scottishrecovery.net/Realising-Recovery/realising-recovery.html • Kezelman & Stavropoulos 2012, *Practice guidelines for treatment of complex trauma and trauma informed care and service delivery*, Adults Surviving Child Abuse, Sydney • Queensland Health 2010, Dual diagnosis clinical guidelines and clinicians' toolkit, www.dualdiagnosis.org.au/home/index.php?option=com_contentandtask=viewandid=72andItemid=1	



Domain 2: Person 1st and holistic

Capability 2B: Responsive to Aboriginal and Torres Strait Islander people, families and communities

Recovery-oriented practice and service delivery with Aboriginal and Torres Strait Islander people must recognise the resilience, strengths and creativity of Aboriginal and Torres Strait Islander people, understand Indigenous cultural perspectives, acknowledge collective experiences of racism and disempowerment, and understand the legacy of colonisation and policies that separated people from their families, culture, language and land.

Core principles	• The nine principles in the *National strategic framework for Aboriginal and Torres Strait Islander people's mental health and social and emotional wellbeing 2004–09* are a starting point www.health.gov.au/internet/main/publishing.nsf/content/8E8CE65B4FD36C6DCA25722B008342B9/$File/wellbeing.pdf. • In building the cultural competence and capacity of practitioners and services it is important to seek guidance and advice from Aboriginal and Torres Strait Islander Elders, leaders, mental health practitioners, advisers and members of the Stolen Generations.
Characteristics	**Mental health practitioners and providers…**
Values and attitudes	• actively challenge personal attitudes and behaviours that may inadvertently support racism and discrimination of Aboriginal and Torres Strait Islander people • increase their personal understanding of the culture and traditions of Aboriginal and Torres Strait Islander people • value the special expertise and understanding of mental health issues that are available within Aboriginal and Torres Strait Islander communities, especially from Elders, traditional healers, Indigenous health and mental health workers, cultural advisers and members of the Stolen Generations • learn from Aboriginal and Torres Strait Islander people about creating and improving models • include Aboriginal and Torres Strait Islander people and community representatives in decision making
Knowledge	• understand the importance of land, spirituality and culture to the mental health of Aboriginal and Torres Strait Islander people • understand the impact mainstream Australian community attitudes and policies have had and continue to have on Aboriginal and Torres Strait Islander people • recognise the connection between serious general health problems and social, emotional and psychiatric difficulties (including substance use), many of which are untreated or inappropriately treated in Aboriginal and Torres Strait Islander communities • recognise that working with Aboriginal and Torres Strait Islander people may require specific expertise and understanding, for example, understanding of cultural traditions as they affect verbal and non-verbal communication • have knowledge and appreciation of the contribution of traditional healing practices to the recovery of Aboriginal and Torres Strait Islander people
Skills and behaviours	• support personal recovery efforts by affirming the resilience, strengths, creativity and endurance of Aboriginal and Torres Strait Islander people • provide service environments that reduce anxiety for Aboriginal and Torres Strait Islander people and assist with engagement • actively acknowledge the value systems and protocols which exist in Aboriginal and Torres Strait Islander communities • draw on and use Indigenous understandings of and approaches to social and emotional wellbeing and healing • collaborate with cultural and traditional ways of healing in partnership with mainstream therapies • understand that it may neither be appropriate nor desirable to apply ethical and clinical models derived from a western individualistic viewpoint when working with Aboriginal and Torres Strait Islander individuals and communities, and demonstrate flexibility in modifying or not using certain aspects of such models • demonstrate reflective practice by acknowledging the possible impacts on Aboriginal and Torres Strait Islander people of the values, biases and beliefs built into professional training and service systems

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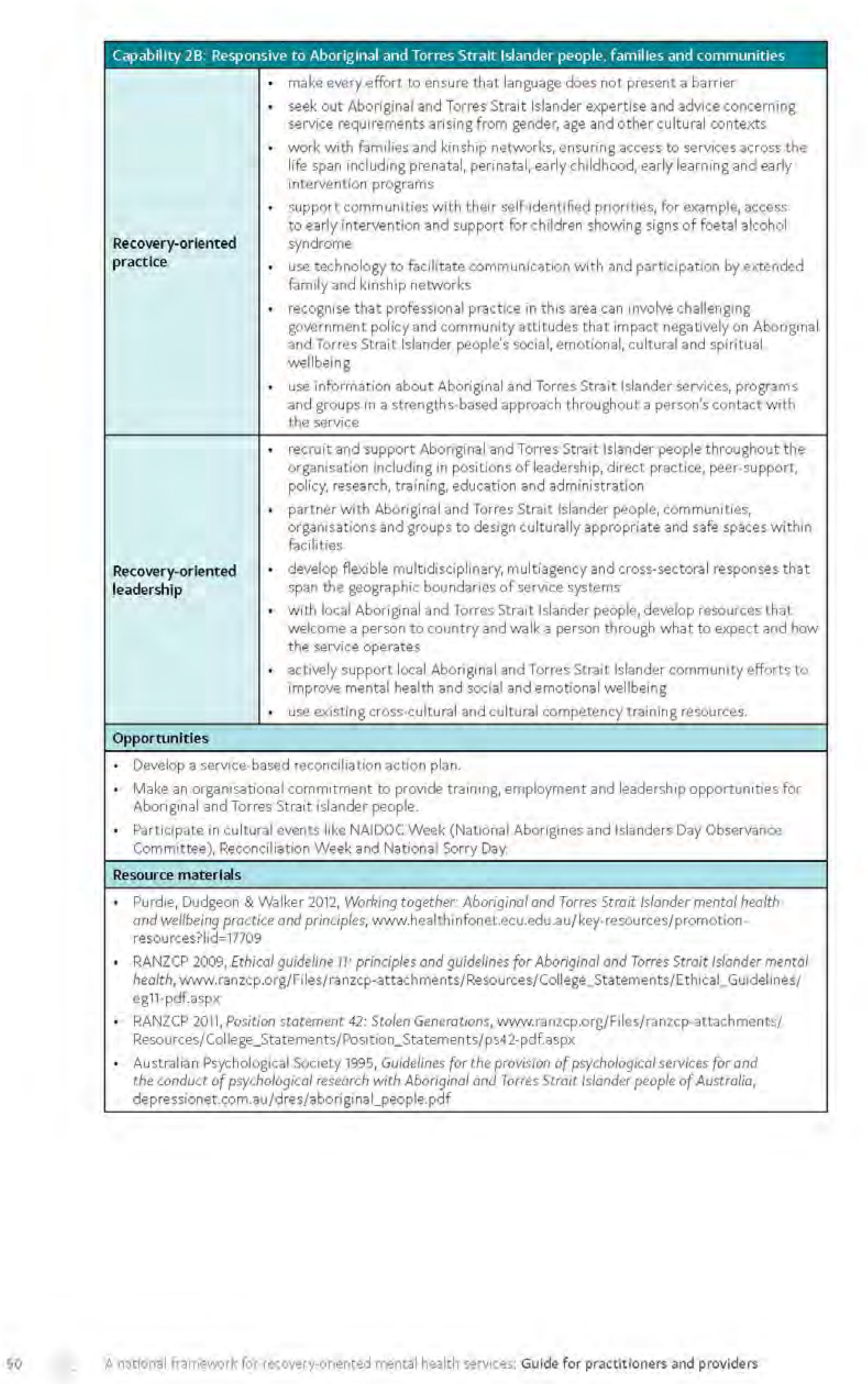


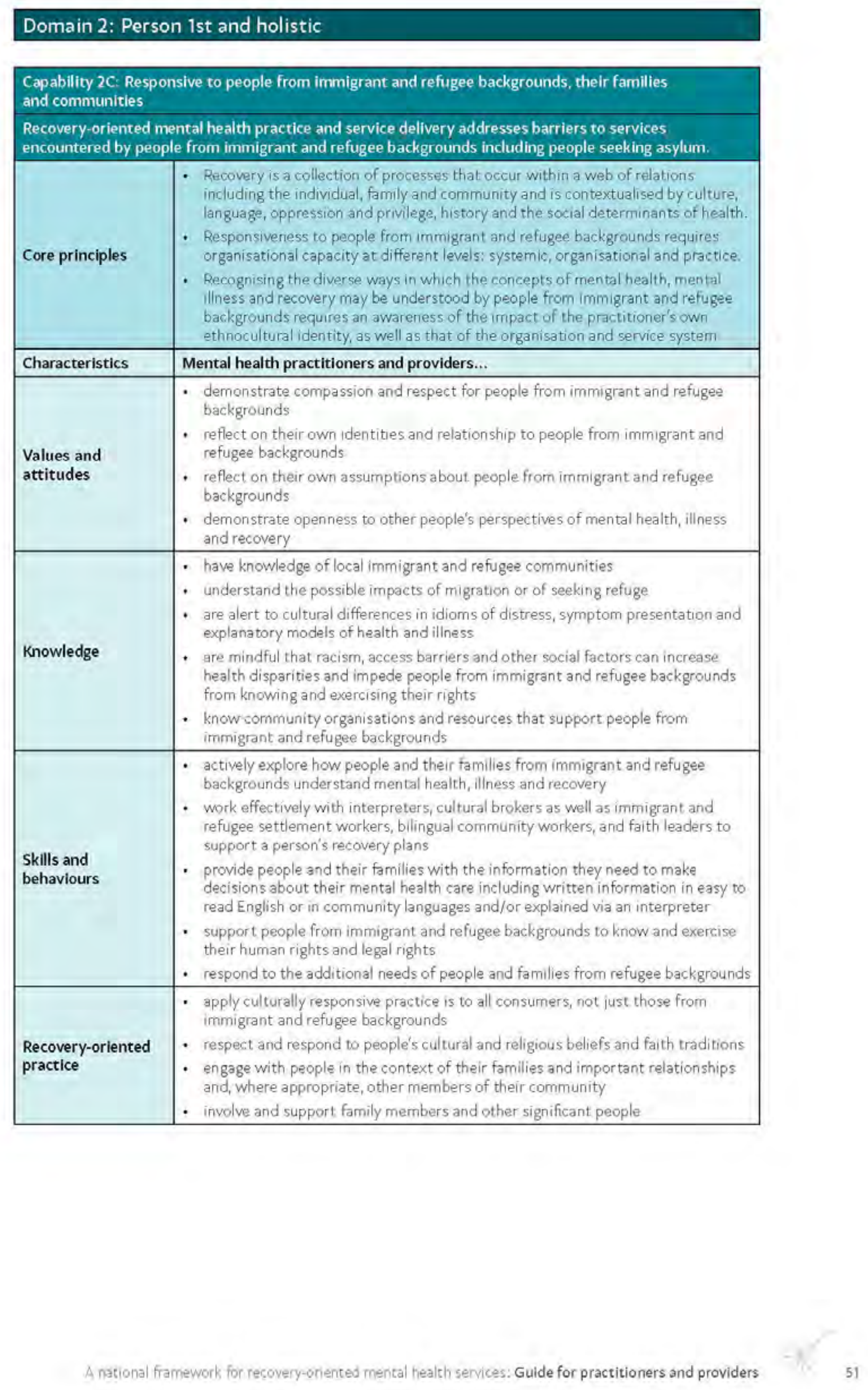
Capability 2B: Responsive to Aboriginal and Torres Strait Islander people, families and communities	
Recovery-oriented practice	• make every effort to ensure that language does not present a barrier • seek out Aboriginal and Torres Strait Islander expertise and advice concerning service requirements arising from gender, age and other cultural contexts • work with families and kinship networks, ensuring access to services across the life span including prenatal, perinatal, early childhood, early learning and early intervention programs • support communities with their self-identified priorities, for example, access to early intervention and support for children showing signs of foetal alcohol syndrome • use technology to facilitate communication with and participation by extended family and kinship networks • recognise that professional practice in this area can involve challenging government policy and community attitudes that impact negatively on Aboriginal and Torres Strait Islander people's social, emotional, cultural and spiritual wellbeing • use information about Aboriginal and Torres Strait Islander services, programs and groups in a strengths-based approach throughout a person's contact with the service
Recovery-oriented leadership	• recruit and support Aboriginal and Torres Strait Islander people throughout the organisation including in positions of leadership, direct practice, peer-support, policy, research, training, education and administration • partner with Aboriginal and Torres Strait Islander people, communities, organisations and groups to design culturally appropriate and safe spaces within facilities • develop flexible multidisciplinary, multiagency and cross-sectoral responses that span the geographic boundaries of service systems • with local Aboriginal and Torres Strait Islander people, develop resources that welcome a person to country and walk a person through what to expect and how the service operates • actively support local Aboriginal and Torres Strait Islander community efforts to improve mental health and social and emotional wellbeing • use existing cross-cultural and cultural competency training resources.

Opportunities

- Develop a service-based reconciliation action plan.
- Make an organisational commitment to provide training, employment and leadership opportunities for Aboriginal and Torres Strait islander people.
- Participate in cultural events like NAIDOC Week (National Aborigines and Islanders Day Observance Committee), Reconciliation Week and National Sorry Day.

Resource materials

- Purdie, Dudgeon & Walker 2012, *Working together: Aboriginal and Torres Strait Islander mental health and wellbeing practice and principles*, www.healthinfonet.ecu.edu.au/key-resources/promotion-resources?lid=17709
- RANZCP 2009, *Ethical guideline 11: principles and guidelines for Aboriginal and Torres Strait Islander mental health*, www.ranzcp.org/Files/ranzcp-attachments/Resources/College_Statements/Ethical_Guidelines/eg11-pdf.aspx
- RANZCP 2011, *Position statement 42: Stolen Generations*, www.ranzcp.org/Files/ranzcp-attachments/Resources/College_Statements/Position_Statements/ps42-pdf.aspx
- Australian Psychological Society 1995, *Guidelines for the provision of psychological services for and the conduct of psychological research with Aboriginal and Torres Strait Islander people of Australia*, depressionet.com.au/dres/aboriginal_people.pdf

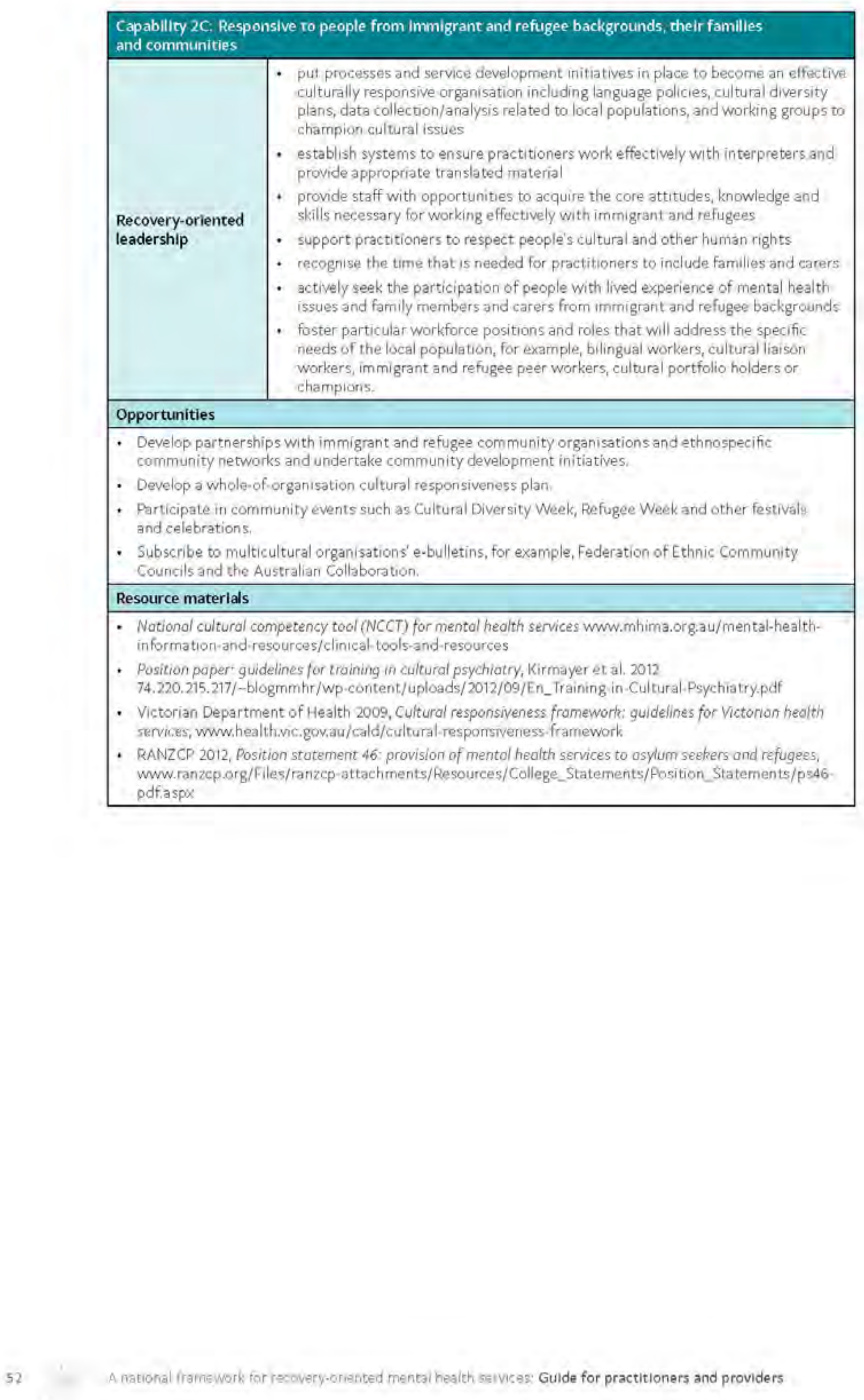


Domain 2: Person 1st and holistic

Capability 2C: Responsive to people from immigrant and refugee backgrounds, their families and communities

Recovery-oriented mental health practice and service delivery addresses barriers to services encountered by people from immigrant and refugee backgrounds including people seeking asylum.

Core principles	• Recovery is a collection of processes that occur within a web of relations including the individual, family and community and is contextualised by culture, language, oppression and privilege, history and the social determinants of health. • Responsiveness to people from immigrant and refugee backgrounds requires organisational capacity at different levels: systemic, organisational and practice. • Recognising the diverse ways in which the concepts of mental health, mental illness and recovery may be understood by people from immigrant and refugee backgrounds requires an awareness of the impact of the practitioner's own ethnocultural identity, as well as that of the organisation and service system
Characteristics	**Mental health practitioners and providers...**
Values and attitudes	• demonstrate compassion and respect for people from immigrant and refugee backgrounds • reflect on their own identities and relationship to people from immigrant and refugee backgrounds • reflect on their own assumptions about people from immigrant and refugee backgrounds • demonstrate openness to other people's perspectives of mental health, illness and recovery
Knowledge	• have knowledge of local immigrant and refugee communities • understand the possible impacts of migration or of seeking refuge • are alert to cultural differences in idioms of distress, symptom presentation and explanatory models of health and illness • are mindful that racism, access barriers and other social factors can increase health disparities and impede people from immigrant and refugee backgrounds from knowing and exercising their rights • know community organisations and resources that support people from immigrant and refugee backgrounds
Skills and behaviours	• actively explore how people and their families from immigrant and refugee backgrounds understand mental health, illness and recovery • work effectively with interpreters, cultural brokers as well as immigrant and refugee settlement workers, bilingual community workers, and faith leaders to support a person's recovery plans • provide people and their families with the information they need to make decisions about their mental health care including written information in easy to read English or in community languages and/or explained via an interpreter • support people from immigrant and refugee backgrounds to know and exercise their human rights and legal rights • respond to the additional needs of people and families from refugee backgrounds
Recovery-oriented practice	• apply culturally responsive practice is to all consumers, not just those from immigrant and refugee backgrounds • respect and respond to people's cultural and religious beliefs and faith traditions • engage with people in the context of their families and important relationships and, where appropriate, other members of their community • involve and support family members and other significant people



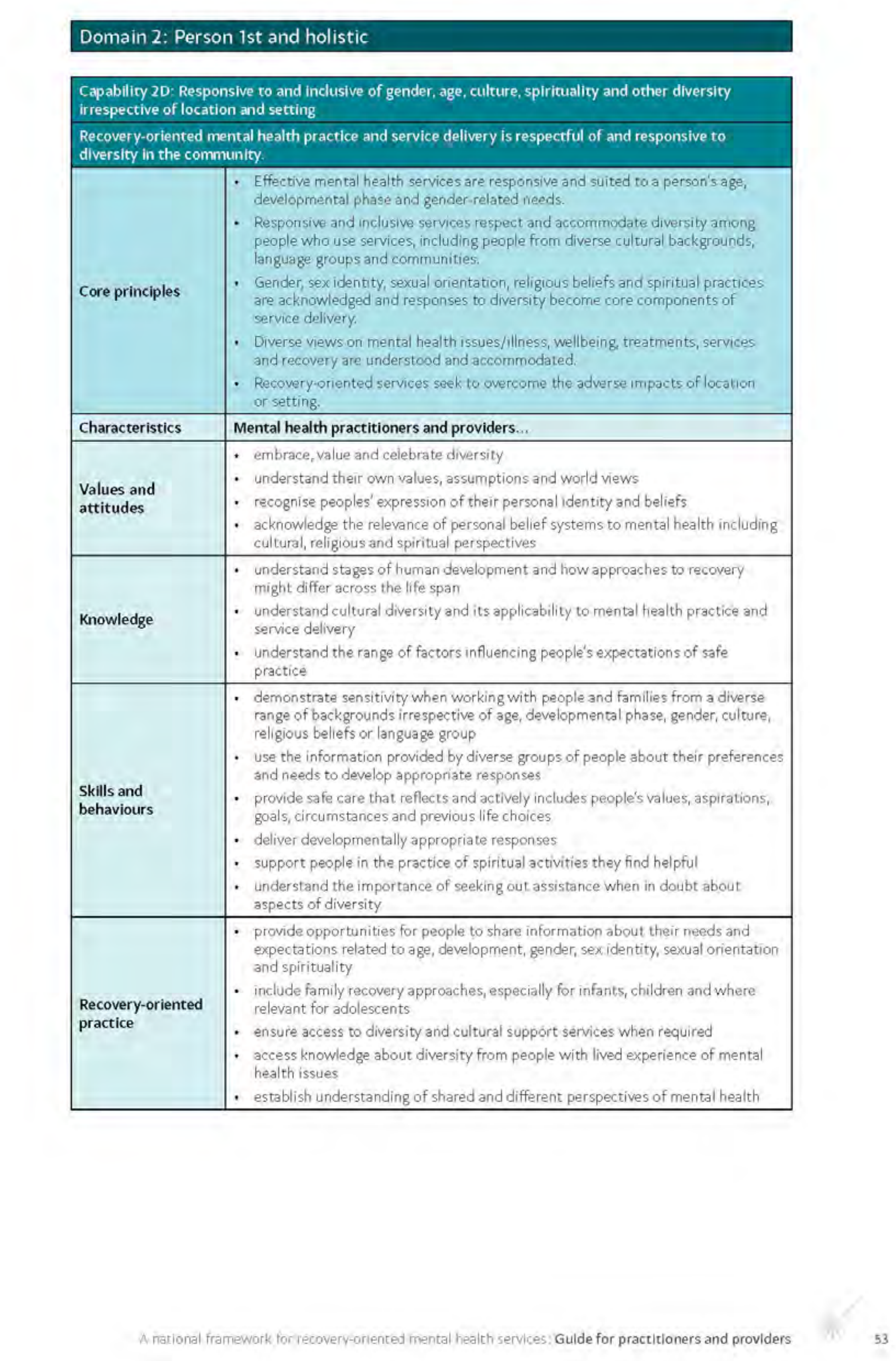
Capability 2C: Responsive to people from immigrant and refugee backgrounds, their families and communities	
Recovery-oriented leadership	• put processes and service development initiatives in place to become an effective culturally responsive organisation including language policies, cultural diversity plans, data collection/analysis related to local populations, and working groups to champion cultural issues • establish systems to ensure practitioners work effectively with interpreters and provide appropriate translated material • provide staff with opportunities to acquire the core attitudes, knowledge and skills necessary for working effectively with immigrant and refugees • support practitioners to respect people's cultural and other human rights • recognise the time that is needed for practitioners to include families and carers • actively seek the participation of people with lived experience of mental health issues and family members and carers from immigrant and refugee backgrounds • foster particular workforce positions and roles that will address the specific needs of the local population, for example, bilingual workers, cultural liaison workers, immigrant and refugee peer workers, cultural portfolio holders or champions.

Opportunities

- Develop partnerships with immigrant and refugee community organisations and ethnospecific community networks and undertake community development initiatives.
- Develop a whole-of-organisation cultural responsiveness plan.
- Participate in community events such as Cultural Diversity Week, Refugee Week and other festivals and celebrations.
- Subscribe to multicultural organisations' e-bulletins, for example, Federation of Ethnic Community Councils and the Australian Collaboration.

Resource materials

- *National cultural competency tool (NCCT) for mental health services* www.mhima.org.au/mental-health-information-and-resources/clinical-tools-and-resources
- *Position paper: guidelines for training in cultural psychiatry*, Kirmayer et al. 2012 74.220.215.217/~blogmmhr/wp-content/uploads/2012/09/En_Training-in-Cultural-Psychiatry.pdf
- Victorian Department of Health 2009, *Cultural responsiveness framework: guidelines for Victorian health services*, www.health.vic.gov.au/cald/cultural-responsiveness-framework
- RANZCP 2012, *Position statement 46: provision of mental health services to asylum seekers and refugees*, www.ranzcp.org/Files/ranzcp-attachments/Resources/College_Statements/Position_Statements/ps46-pdf.aspx



Domain 2: Person 1st and holistic

Capability 2D: Responsive to and inclusive of gender, age, culture, spirituality and other diversity irrespective of location and setting	
Recovery-oriented mental health practice and service delivery is respectful of and responsive to diversity in the community.	
Core principles	• Effective mental health services are responsive and suited to a person's age, developmental phase and gender-related needs. • Responsive and inclusive services respect and accommodate diversity among people who use services, including people from diverse cultural backgrounds, language groups and communities. • Gender, sex identity, sexual orientation, religious beliefs and spiritual practices are acknowledged and responses to diversity become core components of service delivery. • Diverse views on mental health issues/illness, wellbeing, treatments, services and recovery are understood and accommodated. • Recovery-oriented services seek to overcome the adverse impacts of location or setting.
Characteristics	**Mental health practitioners and providers...**
Values and attitudes	• embrace, value and celebrate diversity • understand their own values, assumptions and world views • recognise peoples' expression of their personal identity and beliefs • acknowledge the relevance of personal belief systems to mental health including cultural, religious and spiritual perspectives
Knowledge	• understand stages of human development and how approaches to recovery might differ across the life span • understand cultural diversity and its applicability to mental health practice and service delivery • understand the range of factors influencing people's expectations of safe practice
Skills and behaviours	• demonstrate sensitivity when working with people and families from a diverse range of backgrounds irrespective of age, developmental phase, gender, culture, religious beliefs or language group • use the information provided by diverse groups of people about their preferences and needs to develop appropriate responses • provide safe care that reflects and actively includes people's values, aspirations, goals, circumstances and previous life choices • deliver developmentally appropriate responses • support people in the practice of spiritual activities they find helpful • understand the importance of seeking out assistance when in doubt about aspects of diversity
Recovery-oriented practice	• provide opportunities for people to share information about their needs and expectations related to age, development, gender, sex identity, sexual orientation and spirituality • include family recovery approaches, especially for infants, children and where relevant for adolescents • ensure access to diversity and cultural support services when required • access knowledge about diversity from people with lived experience of mental health issues • establish understanding of shared and different perspectives of mental health

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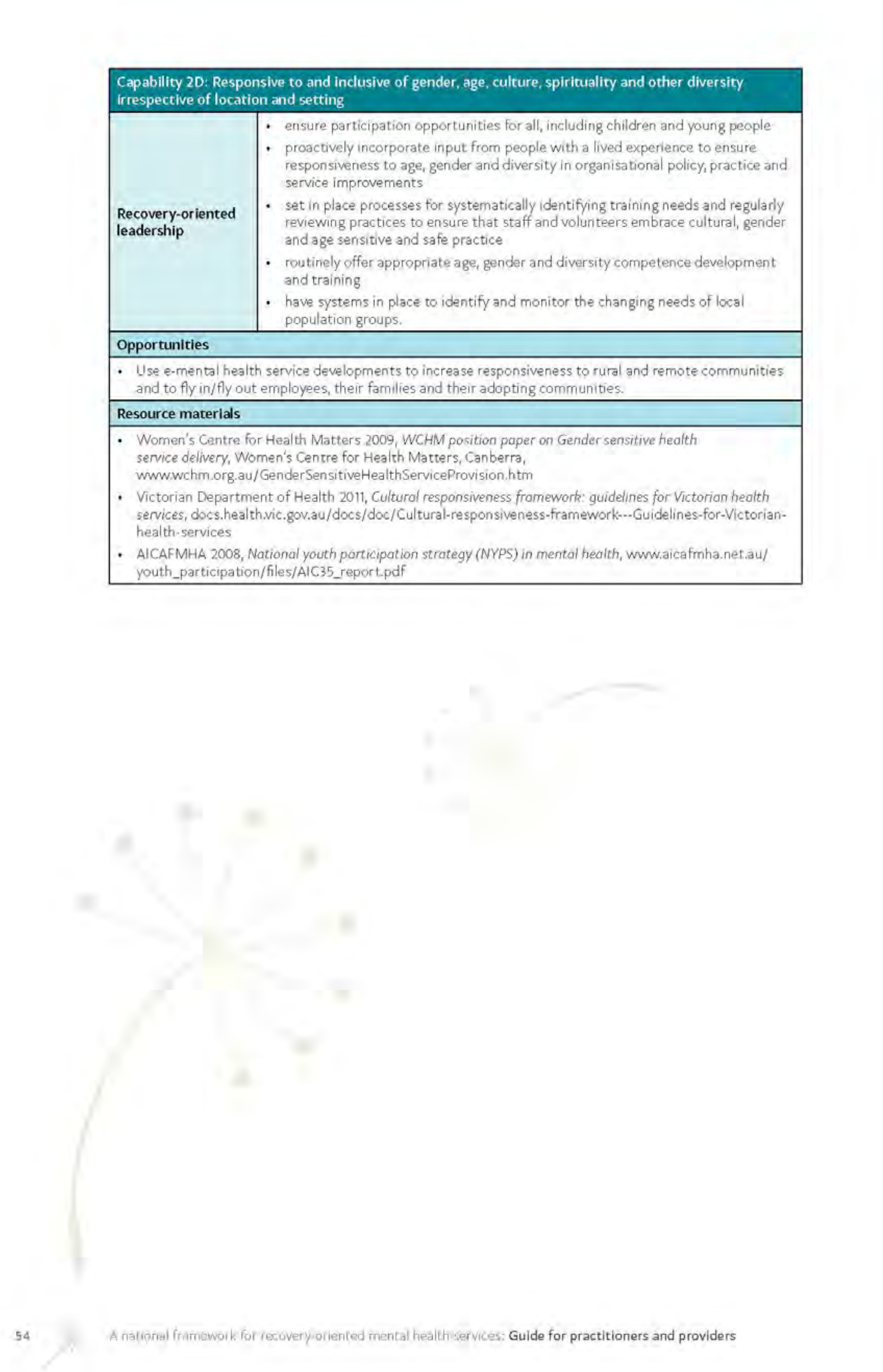

Capability 2D: Responsive to and inclusive of gender, age, culture, spirituality and other diversity irrespective of location and setting	
Recovery-oriented leadership	• ensure participation opportunities for all, including children and young people • proactively incorporate input from people with a lived experience to ensure responsiveness to age, gender and diversity in organisational policy, practice and service improvements • set in place processes for systematically identifying training needs and regularly reviewing practices to ensure that staff and volunteers embrace cultural, gender and age sensitive and safe practice • routinely offer appropriate age, gender and diversity competence development and training • have systems in place to identify and monitor the changing needs of local population groups.
Opportunities	
• Use e-mental health service developments to increase responsiveness to rural and remote communities and to fly in/fly out employees, their families and their adopting communities.	
Resource materials	
• Women's Centre for Health Matters 2009, *WCHM position paper on Gender sensitive health service delivery*, Women's Centre for Health Matters, Canberra, www.wchm.org.au/GenderSensitiveHealthServiceProvision.htm • Victorian Department of Health 2011, *Cultural responsiveness framework: guidelines for Victorian health services*, docs.health.vic.gov.au/docs/doc/Cultural-responsiveness-framework---Guidelines-for-Victorian-health-services • AICAFMHA 2008, *National youth participation strategy (NYPS) in mental health*, www.aicafmha.net.au/youth_participation/files/AIC35_report.pdf	

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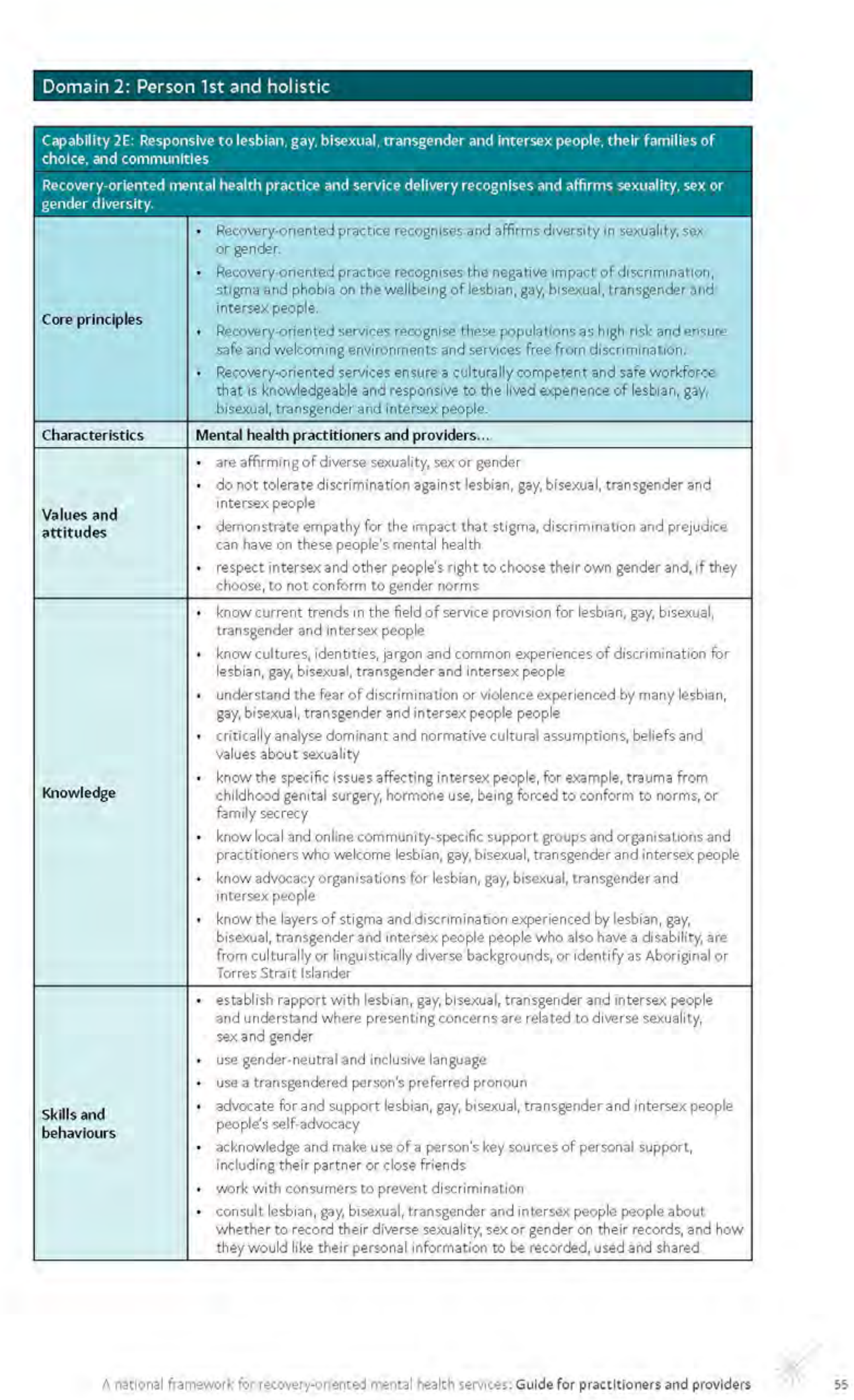

Domain 2: Person 1st and holistic

Capability 2E: Responsive to lesbian, gay, bisexual, transgender and intersex people, their families of choice, and communities	
Recovery-oriented mental health practice and service delivery recognises and affirms sexuality, sex or gender diversity.	
Core principles	• Recovery-oriented practice recognises and affirms diversity in sexuality, sex or gender. • Recovery-oriented practice recognises the negative impact of discrimination, stigma and phobia on the wellbeing of lesbian, gay, bisexual, transgender and intersex people. • Recovery-oriented services recognise these populations as high risk and ensure safe and welcoming environments and services free from discrimination. • Recovery-oriented services ensure a culturally competent and safe workforce that is knowledgeable and responsive to the lived experience of lesbian, gay, bisexual, transgender and intersex people.
Characteristics	**Mental health practitioners and providers…**
Values and attitudes	• are affirming of diverse sexuality, sex or gender • do not tolerate discrimination against lesbian, gay, bisexual, transgender and intersex people • demonstrate empathy for the impact that stigma, discrimination and prejudice can have on these people's mental health • respect intersex and other people's right to choose their own gender and, if they choose, to not conform to gender norms
Knowledge	• know current trends in the field of service provision for lesbian, gay, bisexual, transgender and intersex people • know cultures, identities, jargon and common experiences of discrimination for lesbian, gay, bisexual, transgender and intersex people • understand the fear of discrimination or violence experienced by many lesbian, gay, bisexual, transgender and intersex people people • critically analyse dominant and normative cultural assumptions, beliefs and values about sexuality • know the specific issues affecting intersex people, for example, trauma from childhood genital surgery, hormone use, being forced to conform to norms, or family secrecy • know local and online community-specific support groups and organisations and practitioners who welcome lesbian, gay, bisexual, transgender and intersex people • know advocacy organisations for lesbian, gay, bisexual, transgender and intersex people • know the layers of stigma and discrimination experienced by lesbian, gay, bisexual, transgender and intersex people people who also have a disability, are from culturally or linguistically diverse backgrounds, or identify as Aboriginal or Torres Strait Islander
Skills and behaviours	• establish rapport with lesbian, gay, bisexual, transgender and intersex people and understand where presenting concerns are related to diverse sexuality, sex and gender • use gender-neutral and inclusive language • use a transgendered person's preferred pronoun • advocate for and support lesbian, gay, bisexual, transgender and intersex people people's self-advocacy • acknowledge and make use of a person's key sources of personal support, including their partner or close friends • work with consumers to prevent discrimination • consult lesbian, gay, bisexual, transgender and intersex people people about whether to record their diverse sexuality, sex or gender on their records, and how they would like their personal information to be recorded, used and shared

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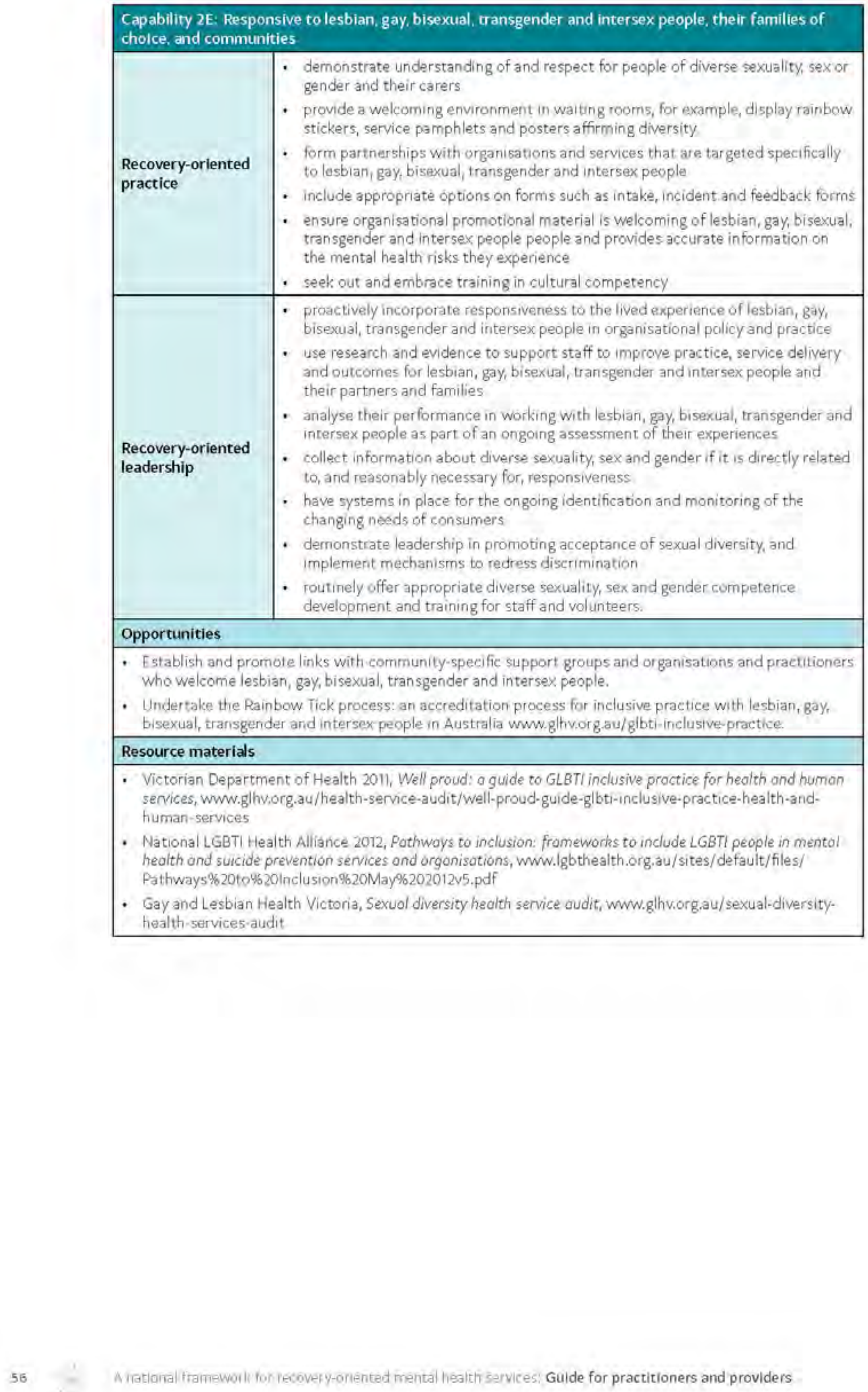

Capability 2E: Responsive to lesbian, gay, bisexual, transgender and intersex people, their families of choice, and communities	
Recovery-oriented practice	• demonstrate understanding of and respect for people of diverse sexuality, sex or gender and their carers • provide a welcoming environment in waiting rooms, for example, display rainbow stickers, service pamphlets and posters affirming diversity • form partnerships with organisations and services that are targeted specifically to lesbian, gay, bisexual, transgender and intersex people • include appropriate options on forms such as intake, incident and feedback forms • ensure organisational promotional material is welcoming of lesbian, gay, bisexual, transgender and intersex people people and provides accurate information on the mental health risks they experience • seek out and embrace training in cultural competency
Recovery-oriented leadership	• proactively incorporate responsiveness to the lived experience of lesbian, gay, bisexual, transgender and intersex people in organisational policy and practice • use research and evidence to support staff to improve practice, service delivery and outcomes for lesbian, gay, bisexual, transgender and intersex people and their partners and families • analyse their performance in working with lesbian, gay, bisexual, transgender and intersex people as part of an ongoing assessment of their experiences • collect information about diverse sexuality, sex and gender if it is directly related to, and reasonably necessary for, responsiveness • have systems in place for the ongoing identification and monitoring of the changing needs of consumers • demonstrate leadership in promoting acceptance of sexual diversity, and implement mechanisms to redress discrimination • routinely offer appropriate diverse sexuality, sex and gender competence development and training for staff and volunteers.

Opportunities

- Establish and promote links with community-specific support groups and organisations and practitioners who welcome lesbian, gay, bisexual, transgender and intersex people.
- Undertake the Rainbow Tick process: an accreditation process for inclusive practice with lesbian, gay, bisexual, transgender and intersex people in Australia www.glhv.org.au/glbti-inclusive-practice.

Resource materials

- Victorian Department of Health 2011, *Well proud: a guide to GLBTI inclusive practice for health and human services*, www.glhv.org.au/health-service-audit/well-proud-guide-glbti-inclusive-practice-health-and-human-services
- National LGBTI Health Alliance 2012, *Pathways to inclusion: frameworks to include LGBTI people in mental health and suicide prevention services and organisations*, www.lgbthealth.org.au/sites/default/files/Pathways%20to%20Inclusion%20May%202012v5.pdf
- Gay and Lesbian Health Victoria, *Sexual diversity health service audit*, www.glhv.org.au/sexual-diversity-health-services-audit

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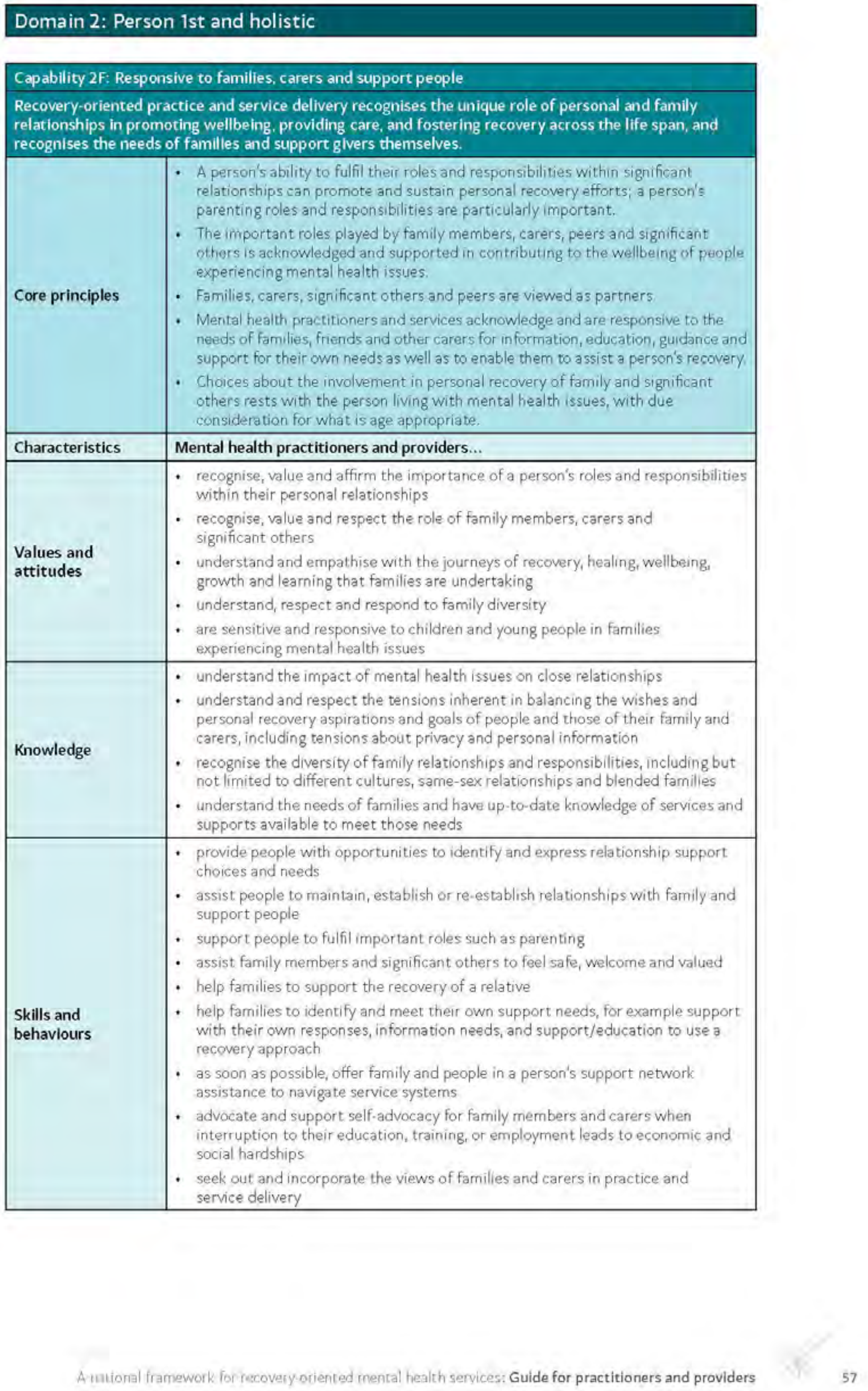

Domain 2: Person 1st and holistic

Capability 2F: Responsive to families, carers and support people	
Recovery-oriented practice and service delivery recognises the unique role of personal and family relationships in promoting wellbeing, providing care, and fostering recovery across the life span, and recognises the needs of families and support givers themselves.	
Core principles	• A person's ability to fulfil their roles and responsibilities within significant relationships can promote and sustain personal recovery efforts; a person's parenting roles and responsibilities are particularly important. • The important roles played by family members, carers, peers and significant others is acknowledged and supported in contributing to the wellbeing of people experiencing mental health issues. • Families, carers, significant others and peers are viewed as partners. • Mental health practitioners and services acknowledge and are responsive to the needs of families, friends and other carers for information, education, guidance and support for their own needs as well as to enable them to assist a person's recovery. • Choices about the involvement in personal recovery of family and significant others rests with the person living with mental health issues, with due consideration for what is age appropriate.
Characteristics	**Mental health practitioners and providers…**
Values and attitudes	• recognise, value and affirm the importance of a person's roles and responsibilities within their personal relationships • recognise, value and respect the role of family members, carers and significant others • understand and empathise with the journeys of recovery, healing, wellbeing, growth and learning that families are undertaking • understand, respect and respond to family diversity • are sensitive and responsive to children and young people in families experiencing mental health issues
Knowledge	• understand the impact of mental health issues on close relationships • understand and respect the tensions inherent in balancing the wishes and personal recovery aspirations and goals of people and those of their family and carers, including tensions about privacy and personal information • recognise the diversity of family relationships and responsibilities, including but not limited to different cultures, same-sex relationships and blended families • understand the needs of families and have up-to-date knowledge of services and supports available to meet those needs
Skills and behaviours	• provide people with opportunities to identify and express relationship support choices and needs • assist people to maintain, establish or re-establish relationships with family and support people • support people to fulfil important roles such as parenting • assist family members and significant others to feel safe, welcome and valued • help families to support the recovery of a relative • help families to identify and meet their own support needs, for example support with their own responses, information needs, and support/education to use a recovery approach • as soon as possible, offer family and people in a person's support network assistance to navigate service systems • advocate and support self-advocacy for family members and carers when interruption to their education, training, or employment leads to economic and social hardships • seek out and incorporate the views of families and carers in practice and service delivery

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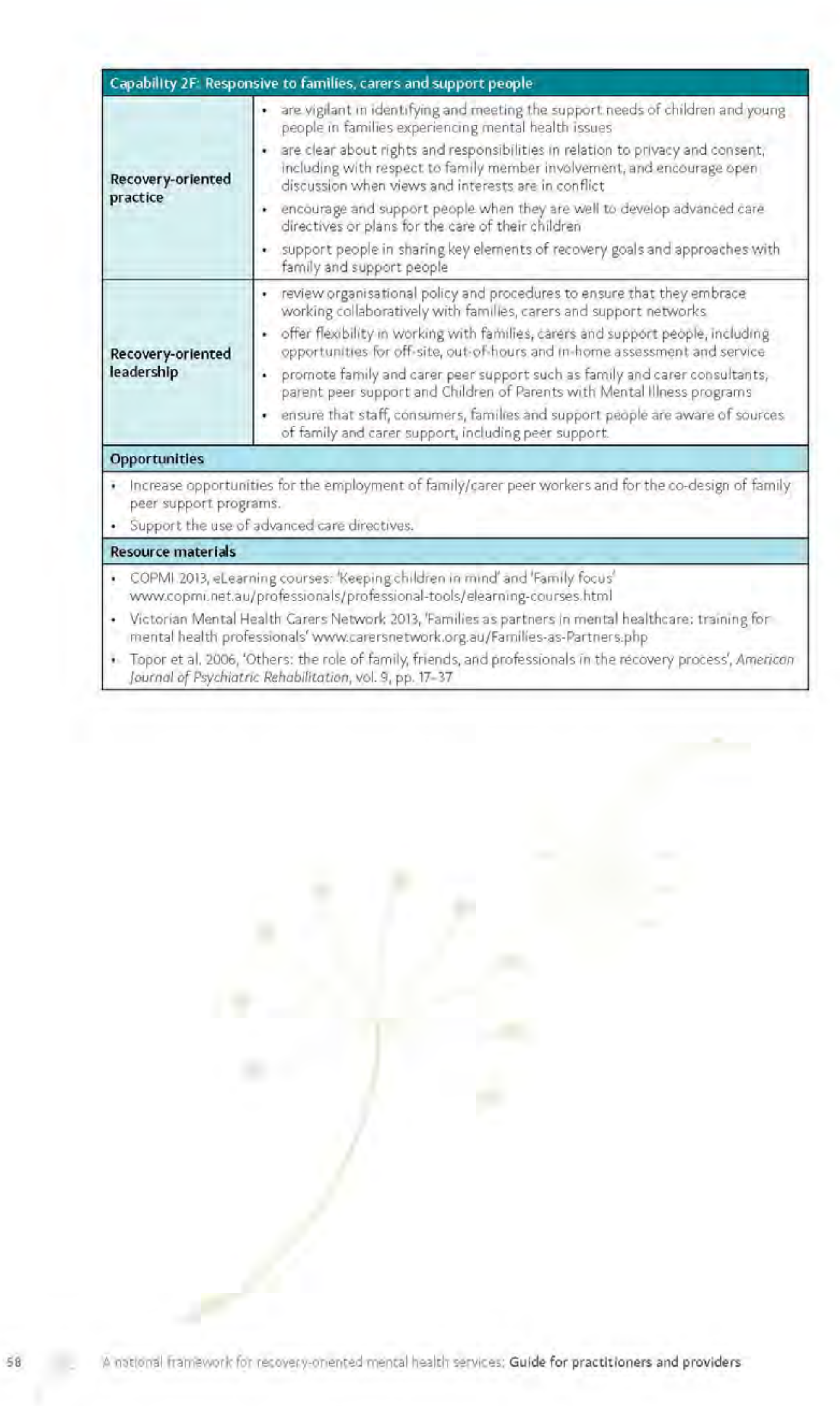
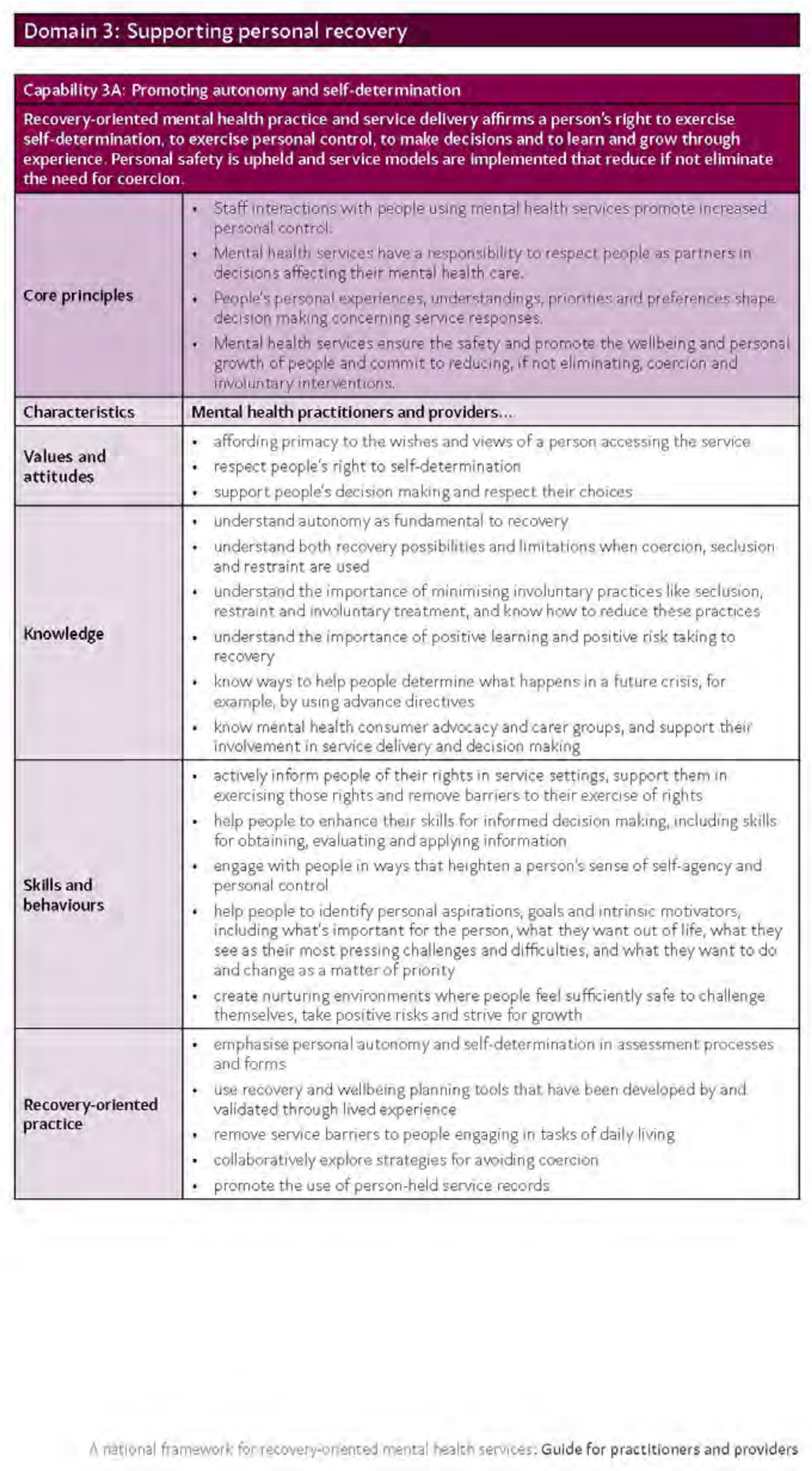


Capability 2F: Responsive to families, carers and support people	
Recovery-oriented practice	- are vigilant in identifying and meeting the support needs of children and young people in families experiencing mental health issues - are clear about rights and responsibilities in relation to privacy and consent, including with respect to family member involvement, and encourage open discussion when views and interests are in conflict - encourage and support people when they are well to develop advanced care directives or plans for the care of their children - support people in sharing key elements of recovery goals and approaches with family and support people
Recovery-oriented leadership	- review organisational policy and procedures to ensure that they embrace working collaboratively with families, carers and support networks - offer flexibility in working with families, carers and support people, including opportunities for off-site, out-of-hours and in-home assessment and service - promote family and carer peer support such as family and carer consultants, parent peer support and Children of Parents with Mental Illness programs - ensure that staff, consumers, families and support people are aware of sources of family and carer support, including peer support.
Opportunities	
- Increase opportunities for the employment of family/carer peer workers and for the co-design of family peer support programs. - Support the use of advanced care directives.	
Resource materials	
- COPMI 2013, eLearning courses: 'Keeping children in mind' and 'Family focus' www.copmi.net.au/professionals/professional-tools/elearning-courses.html - Victorian Mental Health Carers Network 2013, 'Families as partners in mental healthcare: training for mental health professionals' www.carersnetwork.org.au/Families-as-Partners.php - Topor et al. 2006, 'Others: the role of family, friends, and professionals in the recovery process', *American Journal of Psychiatric Rehabilitation*, vol. 9, pp. 17–37	

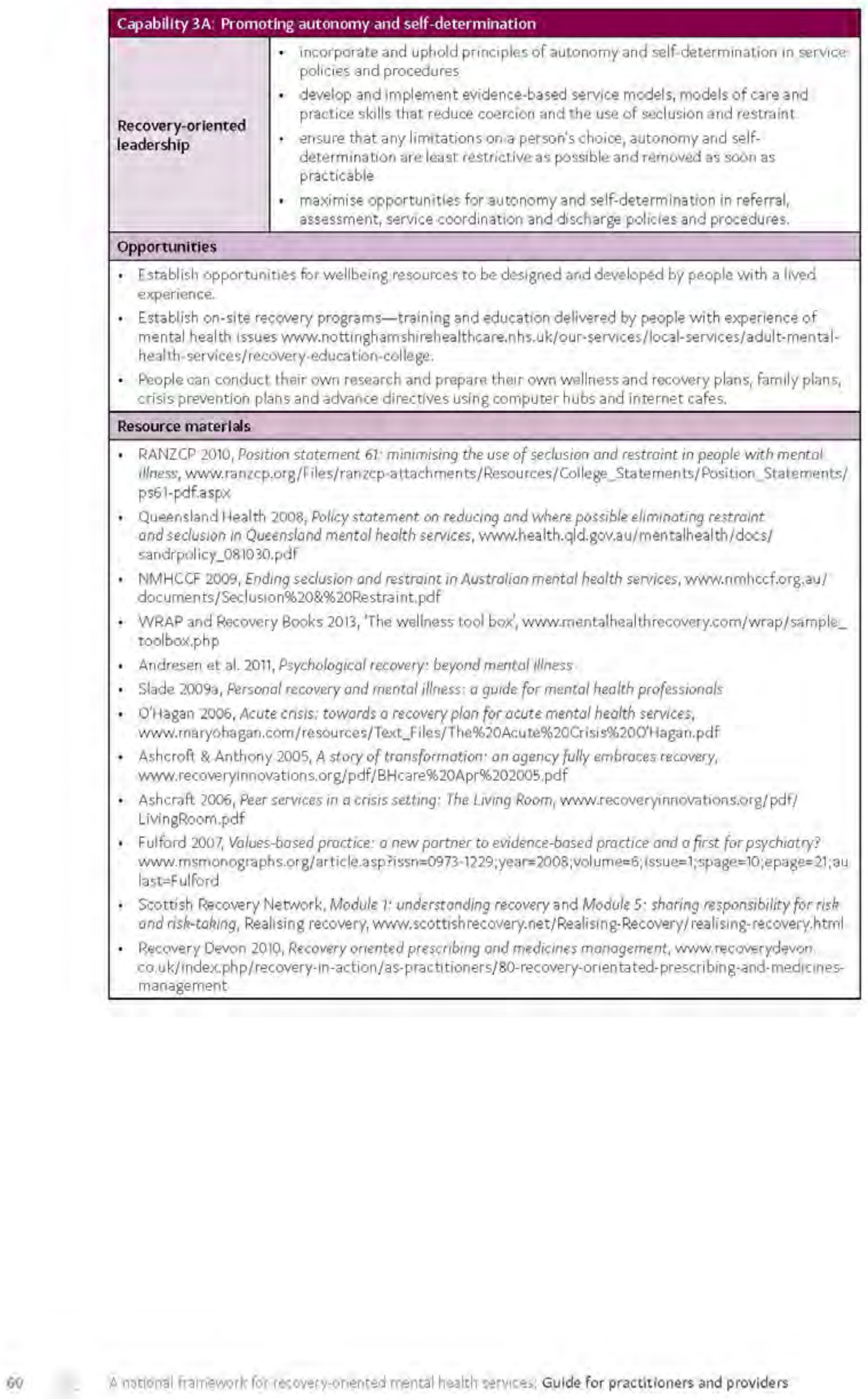


Domain 3: Supporting personal recovery

Capability 3A: Promoting autonomy and self-determination

Recovery-oriented mental health practice and service delivery affirms a person's right to exercise self-determination, to exercise personal control, to make decisions and to learn and grow through experience. Personal safety is upheld and service models are implemented that reduce if not eliminate the need for coercion.

Core principles	• Staff interactions with people using mental health services promote increased personal control. • Mental health services have a responsibility to respect people as partners in decisions affecting their mental health care. • People's personal experiences, understandings, priorities and preferences shape decision making concerning service responses. • Mental health services ensure the safety and promote the wellbeing and personal growth of people and commit to reducing, if not eliminating, coercion and involuntary interventions.
Characteristics	**Mental health practitioners and providers...**
Values and attitudes	• affording primacy to the wishes and views of a person accessing the service • respect people's right to self-determination • support people's decision making and respect their choices
Knowledge	• understand autonomy as fundamental to recovery • understand both recovery possibilities and limitations when coercion, seclusion and restraint are used • understand the importance of minimising involuntary practices like seclusion, restraint and involuntary treatment, and know how to reduce these practices • understand the importance of positive learning and positive risk taking to recovery • know ways to help people determine what happens in a future crisis, for example, by using advance directives • know mental health consumer advocacy and carer groups, and support their involvement in service delivery and decision making
Skills and behaviours	• actively inform people of their rights in service settings, support them in exercising those rights and remove barriers to their exercise of rights • help people to enhance their skills for informed decision making, including skills for obtaining, evaluating and applying information • engage with people in ways that heighten a person's sense of self-agency and personal control • help people to identify personal aspirations, goals and intrinsic motivators, including what's important for the person, what they want out of life, what they see as their most pressing challenges and difficulties, and what they want to do and change as a matter of priority • create nurturing environments where people feel sufficiently safe to challenge themselves, take positive risks and strive for growth
Recovery-oriented practice	• emphasise personal autonomy and self-determination in assessment processes and forms • use recovery and wellbeing planning tools that have been developed by and validated through lived experience • remove service barriers to people engaging in tasks of daily living • collaboratively explore strategies for avoiding coercion • promote the use of person-held service records



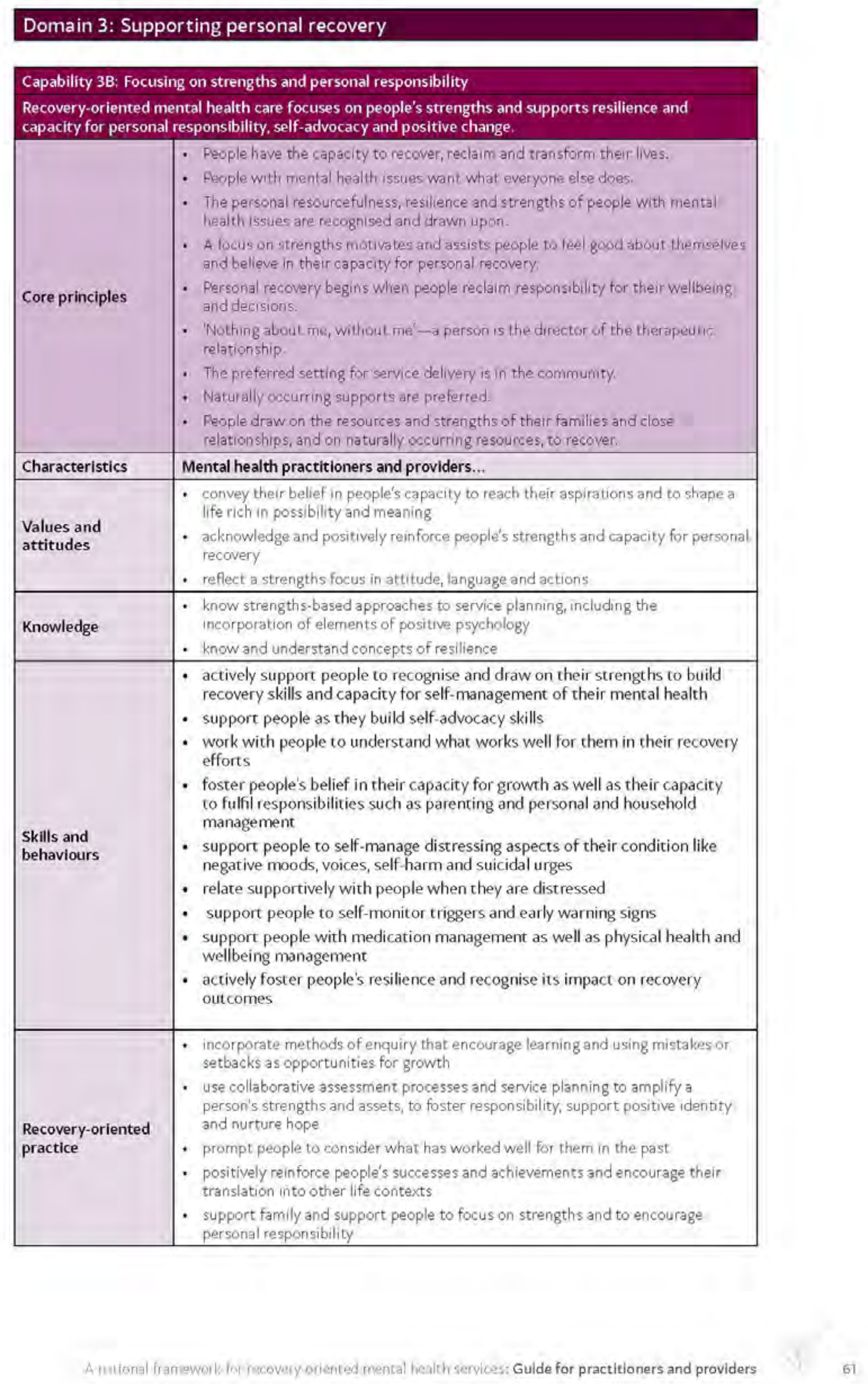
Capability 3A: Promoting autonomy and self-determination	
Recovery-oriented leadership	• incorporate and uphold principles of autonomy and self-determination in service policies and procedures • develop and implement evidence-based service models, models of care and practice skills that reduce coercion and the use of seclusion and restraint • ensure that any limitations on a person's choice, autonomy and self-determination are least restrictive as possible and removed as soon as practicable • maximise opportunities for autonomy and self-determination in referral, assessment, service coordination and discharge policies and procedures.

Opportunities

- Establish opportunities for wellbeing resources to be designed and developed by people with a lived experience.
- Establish on-site recovery programs—training and education delivered by people with experience of mental health issues www.nottinghamshirehealthcare.nhs.uk/our-services/local-services/adult-mental-health-services/recovery-education-college.
- People can conduct their own research and prepare their own wellness and recovery plans, family plans, crisis prevention plans and advance directives using computer hubs and internet cafes.

Resource materials

- RANZCP 2010, *Position statement 61: minimising the use of seclusion and restraint in people with mental illness*, www.ranzcp.org/Files/ranzcp-attachments/Resources/College_Statements/Position_Statements/ps61-pdf.aspx
- Queensland Health 2008, *Policy statement on reducing and where possible eliminating restraint and seclusion in Queensland mental health services*, www.health.qld.gov.au/mentalhealth/docs/sandrpolicy_081030.pdf
- NMHCCF 2009, *Ending seclusion and restraint in Australian mental health services*, www.nmhccf.org.au/documents/Seclusion%20&%20Restraint.pdf
- WRAP and Recovery Books 2013, 'The wellness tool box', www.mentalhealthrecovery.com/wrap/sample_toolbox.php
- Andresen et al. 2011, *Psychological recovery: beyond mental illness*
- Slade 2009a, *Personal recovery and mental illness: a guide for mental health professionals*
- O'Hagan 2006, *Acute crisis: towards a recovery plan for acute mental health services*, www.maryohagan.com/resources/Text_Files/The%20Acute%20Crisis%20O'Hagan.pdf
- Ashcroft & Anthony 2005, *A story of transformation: an agency fully embraces recovery*, www.recoveryinnovations.org/pdf/BHcare%20Apr%202005.pdf
- Ashcraft 2006, *Peer services in a crisis setting: The Living Room*, www.recoveryinnovations.org/pdf/LivingRoom.pdf
- Fulford 2007, *Values-based practice: a new partner to evidence-based practice and a first for psychiatry?* www.msmonographs.org/article.asp?issn=0973-1229;year=2008;volume=6;issue=1;spage=10;epage=21;aulast=Fulford
- Scottish Recovery Network, *Module 1: understanding recovery* and *Module 5: sharing responsibility for risk and risk-taking*, Realising recovery, www.scottishrecovery.net/Realising-Recovery/realising-recovery.html
- Recovery Devon 2010, *Recovery oriented prescribing and medicines management*, www.recoverydevon.co.uk/index.php/recovery-in-action/as-practitioners/80-recovery-orientated-prescribing-and-medicines-management



Domain 3: Supporting personal recovery

Capability 3B: Focusing on strengths and personal responsibility

Recovery-oriented mental health care focuses on people's strengths and supports resilience and capacity for personal responsibility, self-advocacy and positive change.

Core principles	• People have the capacity to recover, reclaim and transform their lives. • People with mental health issues want what everyone else does. • The personal resourcefulness, resilience and strengths of people with mental health issues are recognised and drawn upon. • A focus on strengths motivates and assists people to feel good about themselves and believe in their capacity for personal recovery. • Personal recovery begins when people reclaim responsibility for their wellbeing and decisions. • 'Nothing about me, without me'—a person is the director of the therapeutic relationship. • The preferred setting for service delivery is in the community. • Naturally occurring supports are preferred. • People draw on the resources and strengths of their families and close relationships, and on naturally occurring resources, to recover.
Characteristics	**Mental health practitioners and providers...**
Values and attitudes	• convey their belief in people's capacity to reach their aspirations and to shape a life rich in possibility and meaning • acknowledge and positively reinforce people's strengths and capacity for personal recovery • reflect a strengths focus in attitude, language and actions
Knowledge	• know strengths-based approaches to service planning, including the incorporation of elements of positive psychology • know and understand concepts of resilience
Skills and behaviours	• actively support people to recognise and draw on their strengths to build recovery skills and capacity for self-management of their mental health • support people as they build self-advocacy skills • work with people to understand what works well for them in their recovery efforts • foster people's belief in their capacity for growth as well as their capacity to fulfil responsibilities such as parenting and personal and household management • support people to self-manage distressing aspects of their condition like negative moods, voices, self-harm and suicidal urges • relate supportively with people when they are distressed • support people to self-monitor triggers and early warning signs • support people with medication management as well as physical health and wellbeing management • actively foster people's resilience and recognise its impact on recovery outcomes
Recovery-oriented practice	• incorporate methods of enquiry that encourage learning and using mistakes or setbacks as opportunities for growth • use collaborative assessment processes and service planning to amplify a person's strengths and assets, to foster responsibility, support positive identity and nurture hope • prompt people to consider what has worked well for them in the past • positively reinforce people's successes and achievements and encourage their translation into other life contexts • support family and support people to focus on strengths and to encourage personal responsibility

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Capability 3B: Focusing on strengths and personal responsibility	
Recovery-oriented leadership	• foster opportunities within and beyond the service setting for people to apply and build on identified strengths • draw on lived expertise when incorporating strengths-based approaches into policies and procedures • use language in assessment processes, forms and tools and data collection that emphasises strengths and personal roles and relationships • encourage the co-design of new strength-based approaches and solutions with people who have a lived experience • model strengths-based approaches with staff and highlight the strengths of staff.
Opportunities	
• Use self-stigma reduction resources. • Adopt a strengths-based model of practice. • Develop information resources that promote positive messages and emphasise strengths.	
Resource materials	
• Rapp & Goscha 2011, *Strengths model: a recovery-oriented approach to mental health services*, www.mindshare.org.au • Scottish Recovery Network, 'Multimedia', www.scottishrecovery.net/Multimedia/multimedia.html • Scottish Recovery Network, *Module 3: enabling self-direction*, Realising recovery, www.scottishrecovery.net/Realising-Recovery/realising-recovery.html • Bird et al. 2012, 'Assessing the strengths of mental health consumers: a systematic review', *Psychological Assessment*, Advance online publication, doi: 10.1037/a0028983 • Leamy et al. 2011, 'Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis', *British Journal of Psychiatry*, vol. 199, pp. 445–452	

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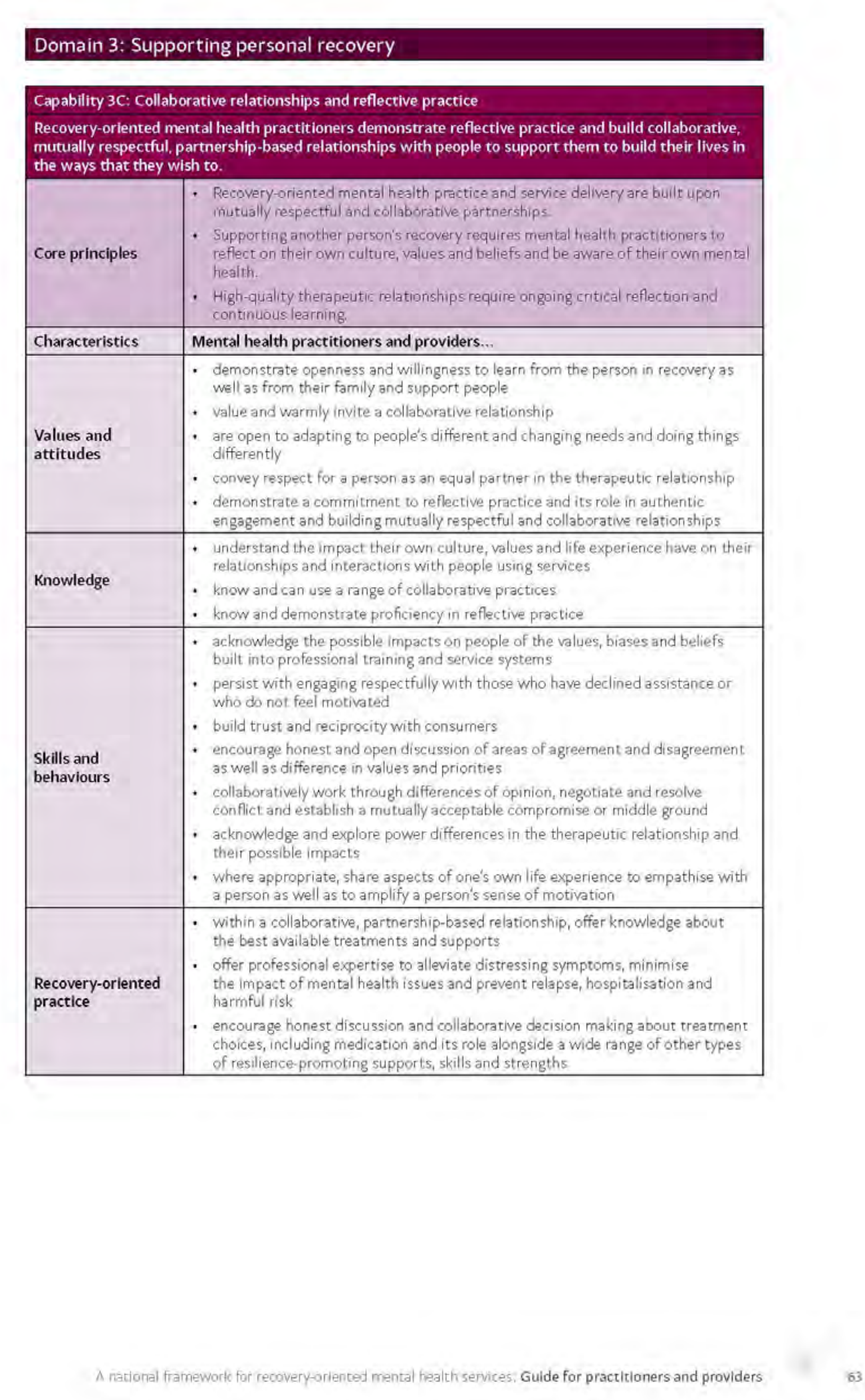

Domain 3: Supporting personal recovery

Capability 3C: Collaborative relationships and reflective practice	
Recovery-oriented mental health practitioners demonstrate reflective practice and build collaborative, mutually respectful, partnership-based relationships with people to support them to build their lives in the ways that they wish to.	
Core principles	• Recovery-oriented mental health practice and service delivery are built upon mutually respectful and collaborative partnerships. • Supporting another person's recovery requires mental health practitioners to reflect on their own culture, values and beliefs and be aware of their own mental health. • High-quality therapeutic relationships require ongoing critical reflection and continuous learning.
Characteristics	**Mental health practitioners and providers…**
Values and attitudes	• demonstrate openness and willingness to learn from the person in recovery as well as from their family and support people • value and warmly invite a collaborative relationship • are open to adapting to people's different and changing needs and doing things differently • convey respect for a person as an equal partner in the therapeutic relationship • demonstrate a commitment to reflective practice and its role in authentic engagement and building mutually respectful and collaborative relationships
Knowledge	• understand the impact their own culture, values and life experience have on their relationships and interactions with people using services • know and can use a range of collaborative practices • know and demonstrate proficiency in reflective practice
Skills and behaviours	• acknowledge the possible impacts on people of the values, biases and beliefs built into professional training and service systems • persist with engaging respectfully with those who have declined assistance or who do not feel motivated • build trust and reciprocity with consumers • encourage honest and open discussion of areas of agreement and disagreement as well as difference in values and priorities • collaboratively work through differences of opinion, negotiate and resolve conflict and establish a mutually acceptable compromise or middle ground • acknowledge and explore power differences in the therapeutic relationship and their possible impacts • where appropriate, share aspects of one's own life experience to empathise with a person as well as to amplify a person's sense of motivation
Recovery-oriented practice	• within a collaborative, partnership-based relationship, offer knowledge about the best available treatments and supports • offer professional expertise to alleviate distressing symptoms, minimise the impact of mental health issues and prevent relapse, hospitalisation and harmful risk • encourage honest discussion and collaborative decision making about treatment choices, including medication and its role alongside a wide range of other types of resilience-promoting supports, skills and strengths

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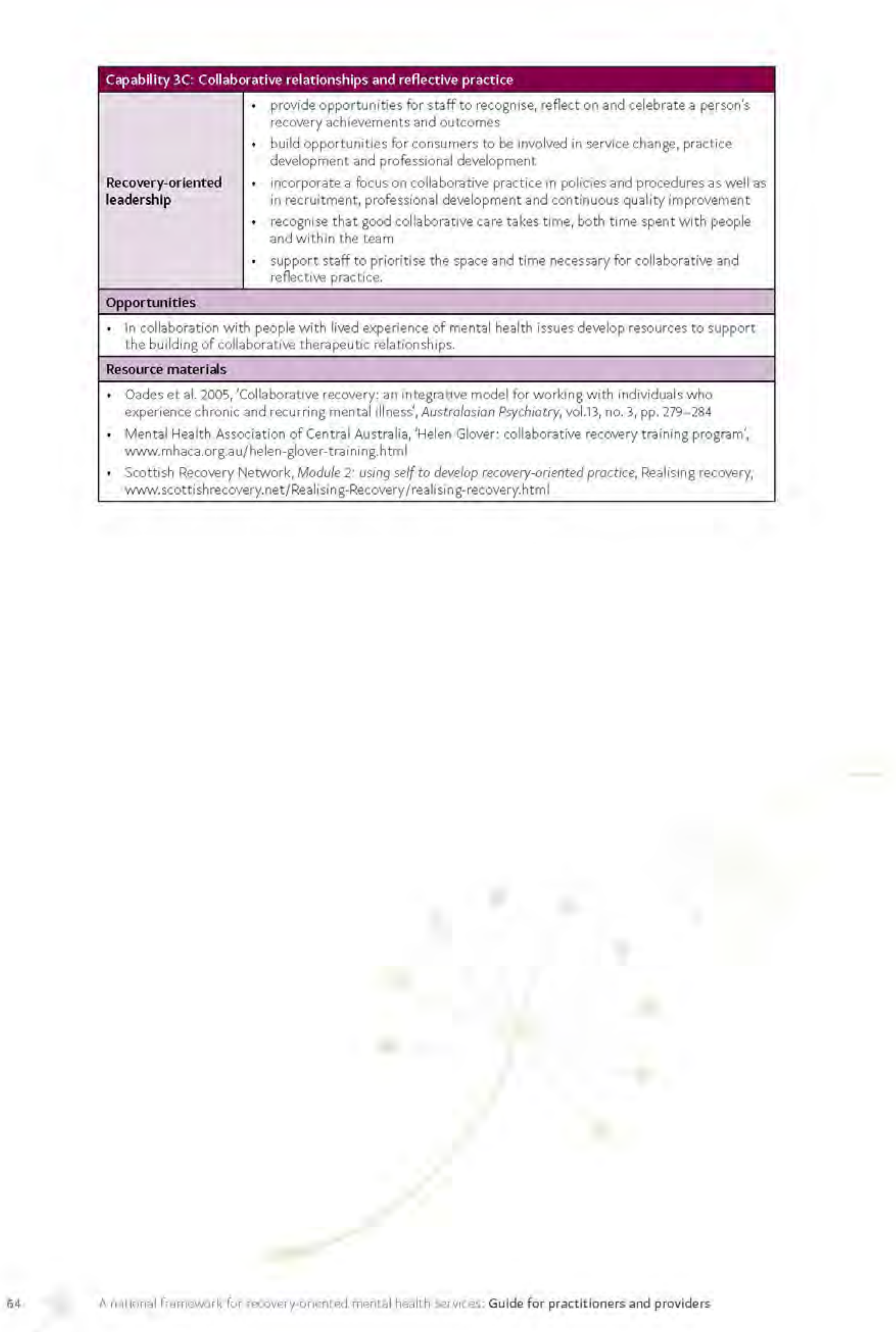

Capability 3C: Collaborative relationships and reflective practice	
Recovery-oriented leadership	• provide opportunities for staff to recognise, reflect on and celebrate a person's recovery achievements and outcomes • build opportunities for consumers to be involved in service change, practice development and professional development • incorporate a focus on collaborative practice in policies and procedures as well as in recruitment, professional development and continuous quality improvement • recognise that good collaborative care takes time, both time spent with people and within the team • support staff to prioritise the space and time necessary for collaborative and reflective practice.
Opportunities	
• In collaboration with people with lived experience of mental health issues develop resources to support the building of collaborative therapeutic relationships.	
Resource materials	
• Oades et al. 2005, 'Collaborative recovery: an integrative model for working with individuals who experience chronic and recurring mental illness', *Australasian Psychiatry*, vol.13, no. 3, pp. 279–284 • Mental Health Association of Central Australia, 'Helen Glover: collaborative recovery training program', www.mhaca.org.au/helen-glover-training.html • Scottish Recovery Network, *Module 2: using self to develop recovery-oriented practice*, Realising recovery, www.scottishrecovery.net/Realising-Recovery/realising-recovery.html	

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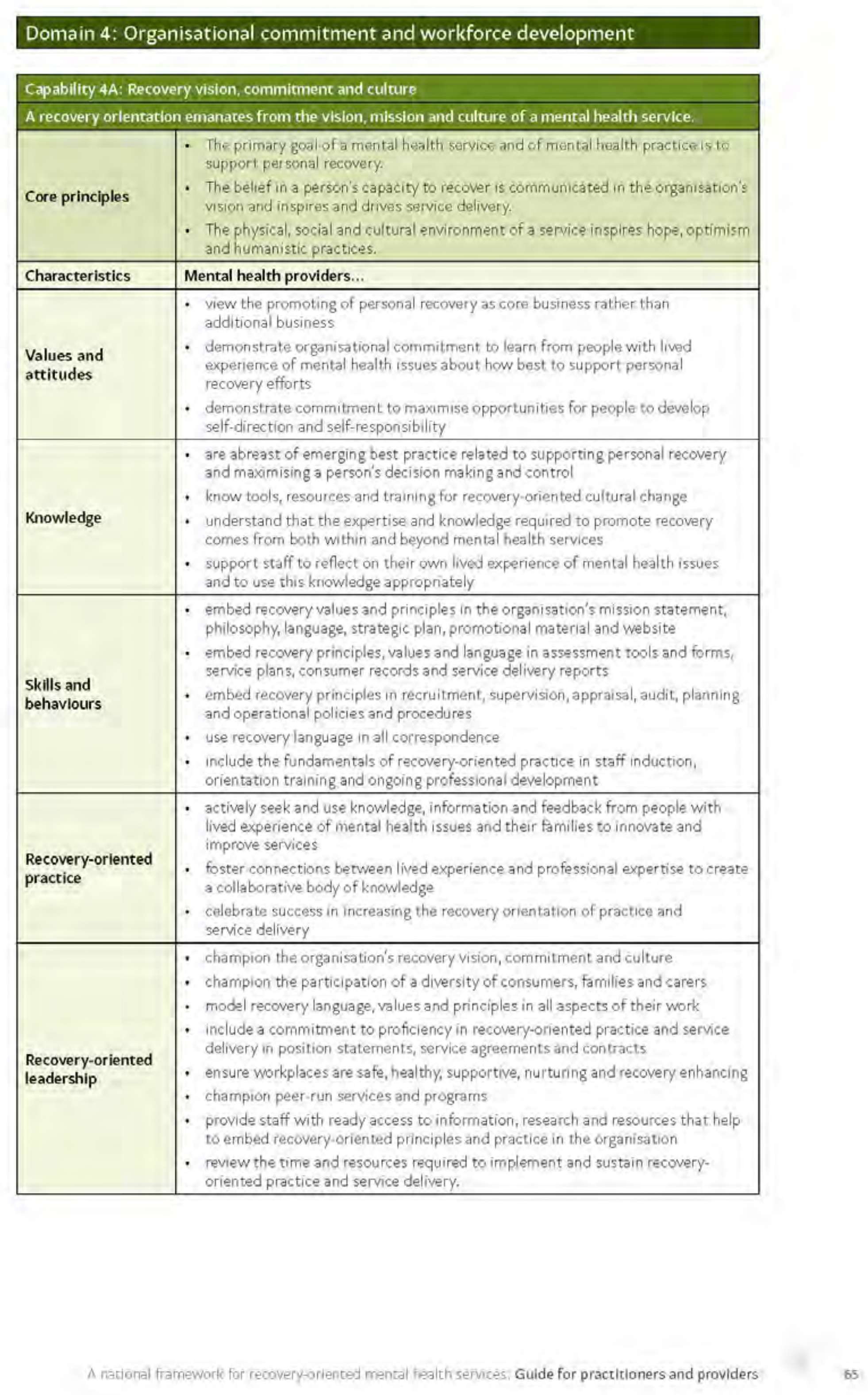

Domain 4: Organisational commitment and workforce development

Capability 4A: Recovery vision, commitment and culture

A recovery orientation emanates from the vision, mission and culture of a mental health service.

Core principles	• The primary goal of a mental health service and of mental health practice is to support personal recovery. • The belief in a person's capacity to recover is communicated in the organisation's vision and inspires and drives service delivery. • The physical, social and cultural environment of a service inspires hope, optimism and humanistic practices.
Characteristics	**Mental health providers...**
Values and attitudes	• view the promoting of personal recovery as core business rather than additional business • demonstrate organisational commitment to learn from people with lived experience of mental health issues about how best to support personal recovery efforts • demonstrate commitment to maximise opportunities for people to develop self-direction and self-responsibility
Knowledge	• are abreast of emerging best practice related to supporting personal recovery and maximising a person's decision making and control • know tools, resources and training for recovery-oriented cultural change • understand that the expertise and knowledge required to promote recovery comes from both within and beyond mental health services • support staff to reflect on their own lived experience of mental health issues and to use this knowledge appropriately
Skills and behaviours	• embed recovery values and principles in the organisation's mission statement, philosophy, language, strategic plan, promotional material and website • embed recovery principles, values and language in assessment tools and forms, service plans, consumer records and service delivery reports • embed recovery principles in recruitment, supervision, appraisal, audit, planning and operational policies and procedures • use recovery language in all correspondence • include the fundamentals of recovery-oriented practice in staff induction, orientation training and ongoing professional development
Recovery-oriented practice	• actively seek and use knowledge, information and feedback from people with lived experience of mental health issues and their families to innovate and improve services • foster connections between lived experience and professional expertise to create a collaborative body of knowledge • celebrate success in increasing the recovery orientation of practice and service delivery
Recovery-oriented leadership	• champion the organisation's recovery vision, commitment and culture • champion the participation of a diversity of consumers, families and carers • model recovery language, values and principles in all aspects of their work • include a commitment to proficiency in recovery-oriented practice and service delivery in position statements, service agreements and contracts • ensure workplaces are safe, healthy, supportive, nurturing and recovery enhancing • champion peer-run services and programs • provide staff with ready access to information, research and resources that help to embed recovery-oriented principles and practice in the organisation • review the time and resources required to implement and sustain recovery-oriented practice and service delivery.

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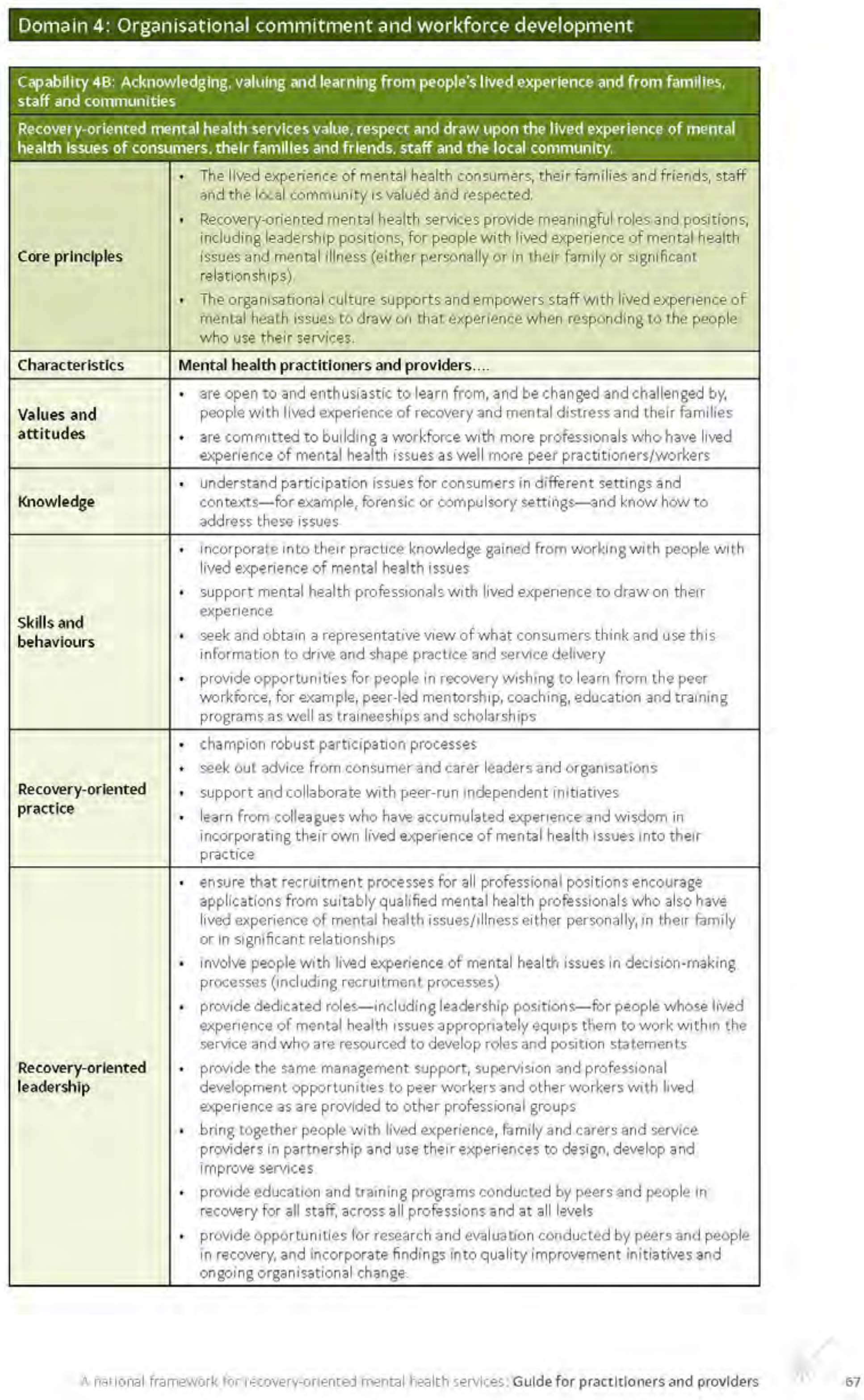
Capability 4A: Recovery vision, commitment and culture
Opportunities
• Bring together people with lived experience, their families and carers and practitioners to discuss how to increase the recovery orientation of practice and services www.trialogue.co.
Resource materials
• RANZCP 2010, *Position statement 62: consumer and carer engagement*, www.ranzcp.org/Files/ranzcp-attachments/Resources/College_Statements/Position_Statements/ps62-pdf.aspx • Sainsbury Centre for Mental Health 2010, *Implementing recovery: a methodology for organisational change*, www.centreformentalhealth.org.uk/pdfs/implementing_recovery_methodology.pdf • Sainsbury Centre for Mental Health 2009, *Implementing recovery: a new framework for organisational change*, www.centreformentalhealth.org.uk/pdfs/implementing_recovery_paper.pdf • NHS Education for Scotland/Scottish Recovery Network 2007, *Realising recovery: a national framework for learning and training in recovery focused practice*, www.nes.scot.nhs.uk/education-and-training/by-theme-initiative/mental-health-and-learning-disabilities/publications-and-resources.aspx • Williams et al. 2012, 'Measures of the recovery orientation of mental health services: systematic review', *Social Psychiatry and Psychiatric Epidemiology*, Advanced Online publication, DOI 10.1007/s00127-012-0484-y



Domain 4: Organisational commitment and workforce development

Capability 4B: Acknowledging, valuing and learning from people's lived experience and from families, staff and communities	
Recovery-oriented mental health services value, respect and draw upon the lived experience of mental health issues of consumers, their families and friends, staff and the local community.	
Core principles	• The lived experience of mental health consumers, their families and friends, staff and the local community is valued and respected. • Recovery-oriented mental health services provide meaningful roles and positions, including leadership positions, for people with lived experience of mental health issues and mental illness (either personally or in their family or significant relationships). • The organisational culture supports and empowers staff with lived experience of mental heath issues to draw on that experience when responding to the people who use their services.
Characteristics	**Mental health practitioners and providers....**
Values and attitudes	• are open to and enthusiastic to learn from, and be changed and challenged by, people with lived experience of recovery and mental distress and their families • are committed to building a workforce with more professionals who have lived experience of mental health issues as well more peer practitioners/workers
Knowledge	• understand participation issues for consumers in different settings and contexts—for example, forensic or compulsory settings—and know how to address these issues
Skills and behaviours	• incorporate into their practice knowledge gained from working with people with lived experience of mental health issues • support mental health professionals with lived experience to draw on their experience • seek and obtain a representative view of what consumers think and use this information to drive and shape practice and service delivery • provide opportunities for people in recovery wishing to learn from the peer workforce, for example, peer-led mentorship, coaching, education and training programs as well as traineeships and scholarships
Recovery-oriented practice	• champion robust participation processes • seek out advice from consumer and carer leaders and organisations • support and collaborate with peer-run independent initiatives • learn from colleagues who have accumulated experience and wisdom in incorporating their own lived experience of mental health issues into their practice
Recovery-oriented leadership	• ensure that recruitment processes for all professional positions encourage applications from suitably qualified mental health professionals who also have lived experience of mental health issues/illness either personally, in their family or in significant relationships • involve people with lived experience of mental health issues in decision-making processes (including recruitment processes) • provide dedicated roles—including leadership positions—for people whose lived experience of mental health issues appropriately equips them to work within the service and who are resourced to develop roles and position statements • provide the same management support, supervision and professional development opportunities to peer workers and other workers with lived experience as are provided to other professional groups • bring together people with lived experience, family and carers and service providers in partnership and use their experiences to design, develop and improve services • provide education and training programs conducted by peers and people in recovery for all staff, across all professions and at all levels • provide opportunities for research and evaluation conducted by peers and people in recovery, and incorporate findings into quality improvement initiatives and ongoing organisational change

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Capability 4B: Acknowledging, valuing and learning from people's lived experience and from families, staff and communities

Opportunities

- Explore and develop new peer-run service models and programs, for example:
  - peer support in the community www.brookred.org.au
  - peer services in crisis and acute settings www.recoveryinnovations.org/pdf/LivingRoom.pdf
  - lived experience in clinical training and professional development
  - Hospital to Home canmentalhealth.org.au/resources/forms/hospital-to-home.html
  - peer support and hospital avoidance and discharge informahealthcare.com/doi/abs/10.1080/09638230701530242
  - warmlines (help and support telephone services) www.lifeline.org.nz/Warmline272.aspx
  - recovery colleges www.nottinghamshirehealthcare.nhs.uk/our-services/local-services/adult-mental-health-services/recovery-education-college/
  - peer support training.

Resource materials

- MH ECO: Experience Co-Design, www.mheco.org.au
- Scottish Recovery Network 2012, *Experts by experience: implementation guidelines*, www.scottishrecovery.net/View-document-details/328-Experts-by-Experience-Form-view.html
- Centre for Excellence in Peer Support Victoria, www.peersupportvic.org
- Daniels et al. 2010, *Pillars of peer support: transforming mental health systems of care through peer support services*, www.pillarsofpeersupport.org/final%20%20PillarsofPeerSupportService%20Report.pdf

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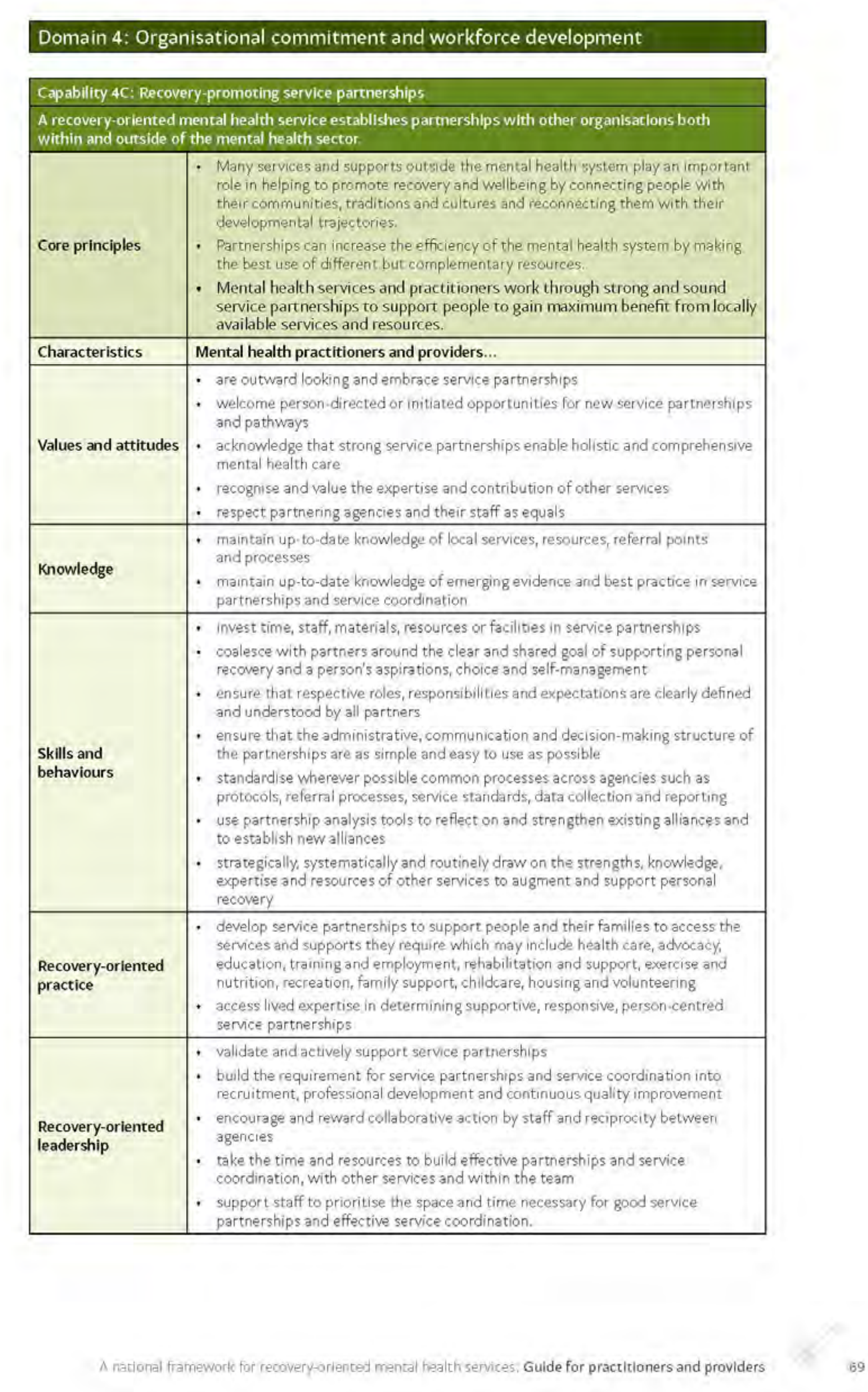

Domain 4: Organisational commitment and workforce development

Capability 4C: Recovery-promoting service partnerships	
A recovery-oriented mental health service establishes partnerships with other organisations both within and outside of the mental health sector.	
Core principles	• Many services and supports outside the mental health system play an important role in helping to promote recovery and wellbeing by connecting people with their communities, traditions and cultures and reconnecting them with their developmental trajectories. • Partnerships can increase the efficiency of the mental health system by making the best use of different but complementary resources. • Mental health services and practitioners work through strong and sound service partnerships to support people to gain maximum benefit from locally available services and resources.
Characteristics	**Mental health practitioners and providers…**
Values and attitudes	• are outward looking and embrace service partnerships • welcome person-directed or initiated opportunities for new service partnerships and pathways • acknowledge that strong service partnerships enable holistic and comprehensive mental health care • recognise and value the expertise and contribution of other services • respect partnering agencies and their staff as equals
Knowledge	• maintain up-to-date knowledge of local services, resources, referral points and processes • maintain up-to-date knowledge of emerging evidence and best practice in service partnerships and service coordination
Skills and behaviours	• invest time, staff, materials, resources or facilities in service partnerships • coalesce with partners around the clear and shared goal of supporting personal recovery and a person's aspirations, choice and self-management • ensure that respective roles, responsibilities and expectations are clearly defined and understood by all partners • ensure that the administrative, communication and decision-making structure of the partnerships are as simple and easy to use as possible • standardise wherever possible common processes across agencies such as protocols, referral processes, service standards, data collection and reporting • use partnership analysis tools to reflect on and strengthen existing alliances and to establish new alliances • strategically, systematically and routinely draw on the strengths, knowledge, expertise and resources of other services to augment and support personal recovery
Recovery-oriented practice	• develop service partnerships to support people and their families to access the services and supports they require which may include health care, advocacy, education, training and employment, rehabilitation and support, exercise and nutrition, recreation, family support, childcare, housing and volunteering • access lived expertise in determining supportive, responsive, person-centred service partnerships
Recovery-oriented leadership	• validate and actively support service partnerships • build the requirement for service partnerships and service coordination into recruitment, professional development and continuous quality improvement • encourage and reward collaborative action by staff and reciprocity between agencies • take the time and resources to build effective partnerships and service coordination, with other services and within the team • support staff to prioritise the space and time necessary for good service partnerships and effective service coordination.

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Capability 4C: Recovery-promoting service partnerships
Opportunities
• Establish local recovery communities of practice. • Subscribe to and circulate the e-newsletters of community organisations.
Resource materials
• VIC Health 2011, *The partnership analysis tool: a resource for establishing, developing and maintaining partnerships for health promotion*, www.vichealth.vic.gov.au/Publications/VicHealth-General-Publications/Partnerships-Analysis-Tool.aspx • Scottish Recovery Network, *Putting a network together* and *Sustaining a network*, www.scottishrecovery.net/Local-Recovery-Networks/supporting-resources.html

Domain 4: Organisational commitment and workforce development

Capability 4D: Workforce development and planning	
Recovery-oriented mental health services prioritise building a workforce that is knowledgeable, compassionate, collaborative, skilled, diverse and committed to supporting personal recovery first and foremost.	
Core principles	• The vision for recovery-oriented organisations incorporates a workforce that is knowledgeable, compassionate, collaborative, skilled and diverse. • Ongoing learning, skill development and reflection for recovery-based practice is built into an organisation's professional development processes and continuous quality improvement.
Characteristics	**Mental health providers...**
Values and attitudes	• are open to changing, developing and embracing new work practices • commit to being a learning organisation and to continuous quality improvement • welcome lived expertise as a tool for strengthening organisational commitment to compassionate, person-centred ways of working • are generous and share resources and knowledge through partnerships and collaboration to contribute to the development of a skilled workforce
Knowledge	• know and understand the evidence base embracing new work practices required for an increased recovery orientation • understand relevant legislation and its requirements regarding safety and rationale for coercive intervention • seek knowledge in a wide range of fields to support recovery-oriented workforce development
Skills and behaviours	• are proficient in using measures to assess the recovery orientation of the organisation • collaborate with people with lived experience when formulating plans for organisational and workforce development • build teams that are skilled and equipped to strengthen the recovery orientation of their practice and service delivery • have a plan and infrastructure for supporting the personal and professional development of staff • contribute to service innovation at all levels of the organisation
Recovery-oriented practice	• have open and shared knowledge management • recruit staff with the appropriate values, attitudes and knowledge to support recovery processes • retain staff through a supportive, healthy and nurturing workplace • recruit people with lived experience to applied lived experience positions and peer worker positions as well as people with lived experience who also have professional training and experience • views applied lived experience as a discipline that contributes skills and expertise to mental health services • builds a culturally competent and diverse workforce • provide staff with opportunities to increase and enhance knowledge, engage in reflective practice and make progress in their careers • provide equal opportunities for staff in supervision, mentoring and coaching so they can explore, critically reflect and learn directly from the wisdom and experience of others • have effective performance management systems to assess workers' progress with supporting recovery and providing recovery-oriented services with indicators that are validated as well as relevant and meaningful to consumers and families

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Capability 4D: Workforce development and planning	
Recovery-oriented leadership	• reward strong, committed, inspiring and forward-thinking leadership enables, resources and supports staff to apply recovery-oriented principles and values to their practice • work together and in partnership with consumers and their families to move the organisation forwards in recovery-oriented framework • enable staff to perform at their highest potential in their roles of supporting personal recovery.
Opportunities	
• Establish learning circles and communities of practice for applying recovery in life and work.	
Resource materials	
• Mental Health Coordinating Council 2008, *Mental health recovery philosophy into practice: a workforce development guide* www.mhcc.org.au/documents/Staff%20Development%20Guide/Introduction-revised.pdf	

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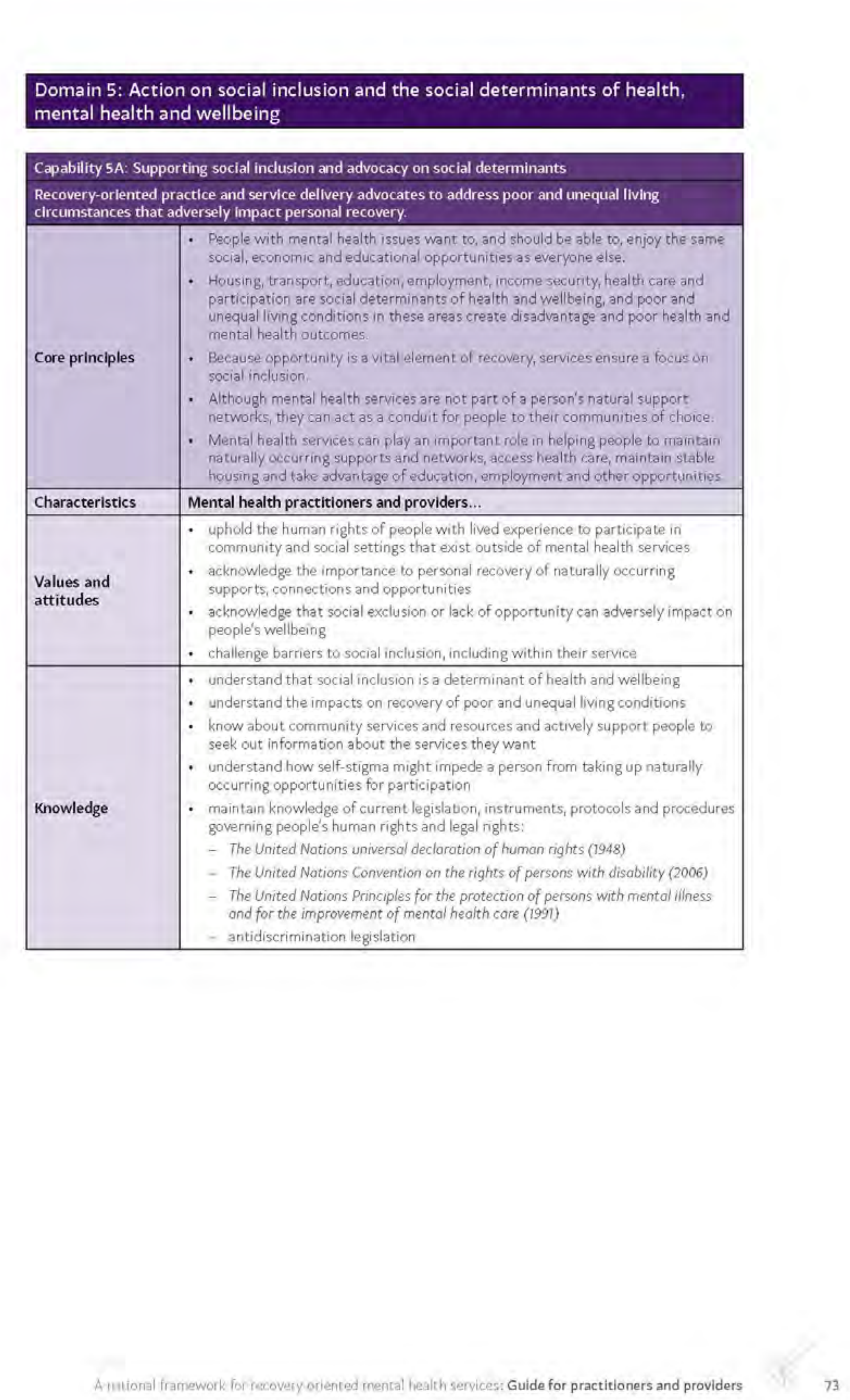

Domain 5: Action on social inclusion and the social determinants of health, mental health and wellbeing

Capability 5A: Supporting social inclusion and advocacy on social determinants	
Recovery-oriented practice and service delivery advocates to address poor and unequal living circumstances that adversely impact personal recovery.	
Core principles	• People with mental health issues want to, and should be able to, enjoy the same social, economic and educational opportunities as everyone else. • Housing, transport, education, employment, income security, health care and participation are social determinants of health and wellbeing, and poor and unequal living conditions in these areas create disadvantage and poor health and mental health outcomes. • Because opportunity is a vital element of recovery, services ensure a focus on social inclusion. • Although mental health services are not part of a person's natural support networks, they can act as a conduit for people to their communities of choice. • Mental health services can play an important role in helping people to maintain naturally occurring supports and networks, access health care, maintain stable housing and take advantage of education, employment and other opportunities.
Characteristics	**Mental health practitioners and providers...**
Values and attitudes	• uphold the human rights of people with lived experience to participate in community and social settings that exist outside of mental health services • acknowledge the importance to personal recovery of naturally occurring supports, connections and opportunities • acknowledge that social exclusion or lack of opportunity can adversely impact on people's wellbeing • challenge barriers to social inclusion, including within their service
Knowledge	• understand that social inclusion is a determinant of health and wellbeing • understand the impacts on recovery of poor and unequal living conditions • know about community services and resources and actively support people to seek out information about the services they want • understand how self-stigma might impede a person from taking up naturally occurring opportunities for participation • maintain knowledge of current legislation, instruments, protocols and procedures governing people's human rights and legal rights: – *The United Nations universal declaration of human rights (1948)* – *The United Nations Convention on the rights of persons with disability (2006)* – *The United Nations Principles for the protection of persons with mental illness and for the improvement of mental health care (1991)* – antidiscrimination legislation

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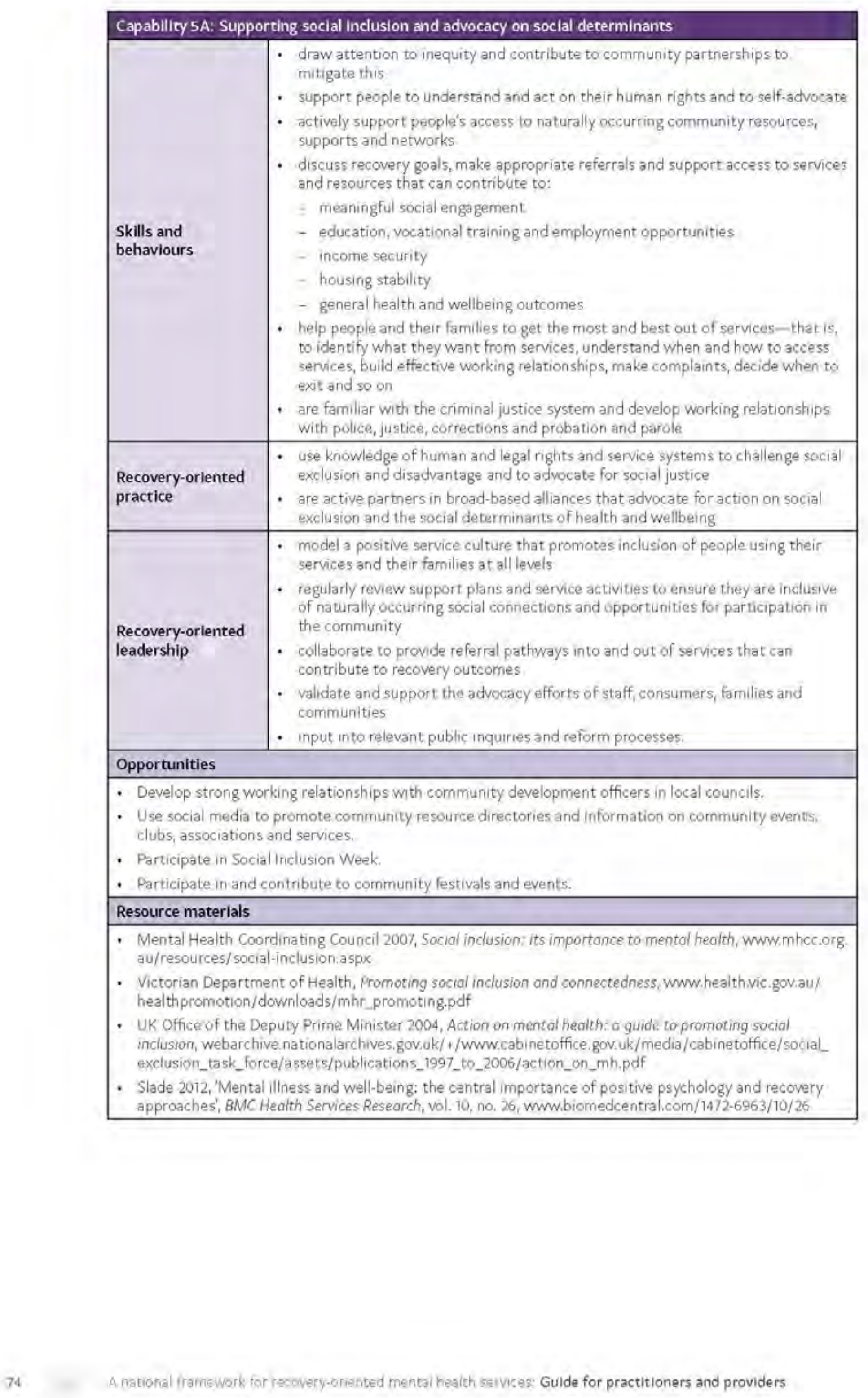

Capability 5A: Supporting social inclusion and advocacy on social determinants	
Skills and behaviours	• draw attention to inequity and contribute to community partnerships to mitigate this • support people to understand and act on their human rights and to self-advocate • actively support people's access to naturally occurring community resources, supports and networks • discuss recovery goals, make appropriate referrals and support access to services and resources that can contribute to: – meaningful social engagement – education, vocational training and employment opportunities – income security – housing stability – general health and wellbeing outcomes • help people and their families to get the most and best out of services—that is, to identify what they want from services, understand when and how to access services, build effective working relationships, make complaints, decide when to exit and so on • are familiar with the criminal justice system and develop working relationships with police, justice, corrections and probation and parole
Recovery-oriented practice	• use knowledge of human and legal rights and service systems to challenge social exclusion and disadvantage and to advocate for social justice • are active partners in broad-based alliances that advocate for action on social exclusion and the social determinants of health and wellbeing
Recovery-oriented leadership	• model a positive service culture that promotes inclusion of people using their services and their families at all levels • regularly review support plans and service activities to ensure they are inclusive of naturally occurring social connections and opportunities for participation in the community • collaborate to provide referral pathways into and out of services that can contribute to recovery outcomes • validate and support the advocacy efforts of staff, consumers, families and communities • input into relevant public inquiries and reform processes.

Opportunities

- Develop strong working relationships with community development officers in local councils.
- Use social media to promote community resource directories and information on community events, clubs, associations and services.
- Participate in Social Inclusion Week.
- Participate in and contribute to community festivals and events.

Resource materials

- Mental Health Coordinating Council 2007, *Social inclusion: its importance to mental health*, www.mhcc.org.au/resources/social-inclusion.aspx
- Victorian Department of Health, *Promoting social inclusion and connectedness*, www.health.vic.gov.au/healthpromotion/downloads/mhr_promoting.pdf
- UK Office of the Deputy Prime Minister 2004, *Action on mental health: a guide to promoting social inclusion*, webarchive.nationalarchives.gov.uk/+/www.cabinetoffice.gov.uk/media/cabinetoffice/social_exclusion_task_force/assets/publications_1997_to_2006/action_on_mh.pdf
- Slade 2012, 'Mental illness and well-being: the central importance of positive psychology and recovery approaches', *BMC Health Services Research*, vol. 10, no. 26, www.biomedcentral.com/1472-6963/10/26

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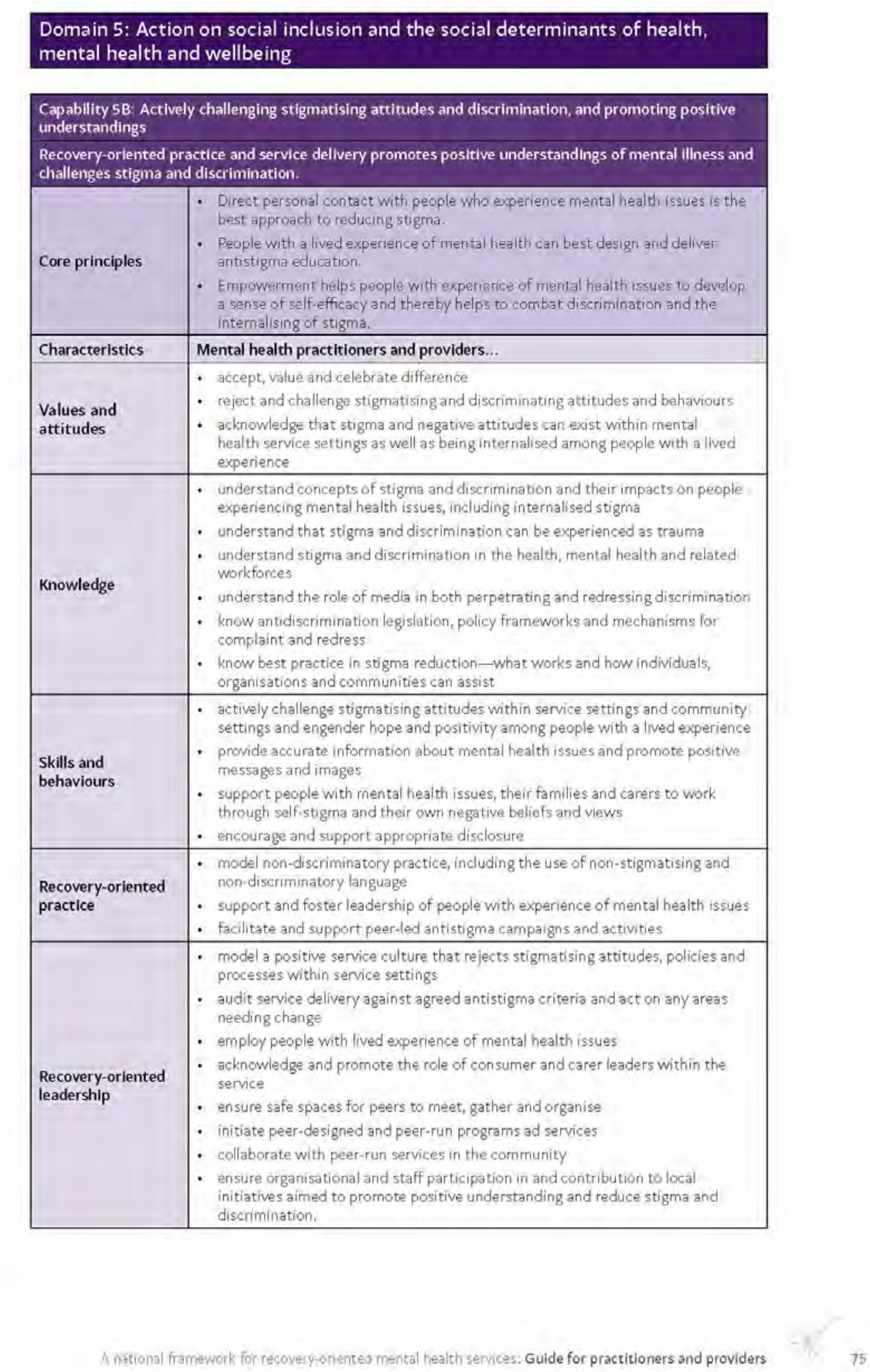

Domain 5: Action on social inclusion and the social determinants of health, mental health and wellbeing

Capability 5B: Actively challenging stigmatising attitudes and discrimination, and promoting positive understandings	
Recovery-oriented practice and service delivery promotes positive understandings of mental illness and challenges stigma and discrimination.	
Core principles	• Direct personal contact with people who experience mental health issues is the best approach to reducing stigma. • People with a lived experience of mental health can best design and deliver antistigma education. • Empowerment helps people with experience of mental health issues to develop a sense of self-efficacy and thereby helps to combat discrimination and the internalising of stigma.
Characteristics	**Mental health practitioners and providers…**
Values and attitudes	• accept, value and celebrate difference • reject and challenge stigmatising and discriminating attitudes and behaviours • acknowledge that stigma and negative attitudes can exist within mental health service settings as well as being internalised among people with a lived experience
Knowledge	• understand concepts of stigma and discrimination and their impacts on people experiencing mental health issues, including internalised stigma • understand that stigma and discrimination can be experienced as trauma • understand stigma and discrimination in the health, mental health and related workforces • understand the role of media in both perpetrating and redressing discrimination • know antidiscrimination legislation, policy frameworks and mechanisms for complaint and redress • know best practice in stigma reduction—what works and how individuals, organisations and communities can assist
Skills and behaviours	• actively challenge stigmatising attitudes within service settings and community settings and engender hope and positivity among people with a lived experience • provide accurate information about mental health issues and promote positive messages and images • support people with mental health issues, their families and carers to work through self-stigma and their own negative beliefs and views • encourage and support appropriate disclosure
Recovery-oriented practice	• model non-discriminatory practice, including the use of non-stigmatising and non-discriminatory language • support and foster leadership of people with experience of mental health issues • facilitate and support peer-led antistigma campaigns and activities
Recovery-oriented leadership	• model a positive service culture that rejects stigmatising attitudes, policies and processes within service settings • audit service delivery against agreed antistigma criteria and act on any areas needing change • employ people with lived experience of mental health issues • acknowledge and promote the role of consumer and carer leaders within the service • ensure safe spaces for peers to meet, gather and organise • initiate peer-designed and peer-run programs ad services • collaborate with peer-run services in the community • ensure organisational and staff participation in and contribution to local initiatives aimed to promote positive understanding and reduce stigma and discrimination.

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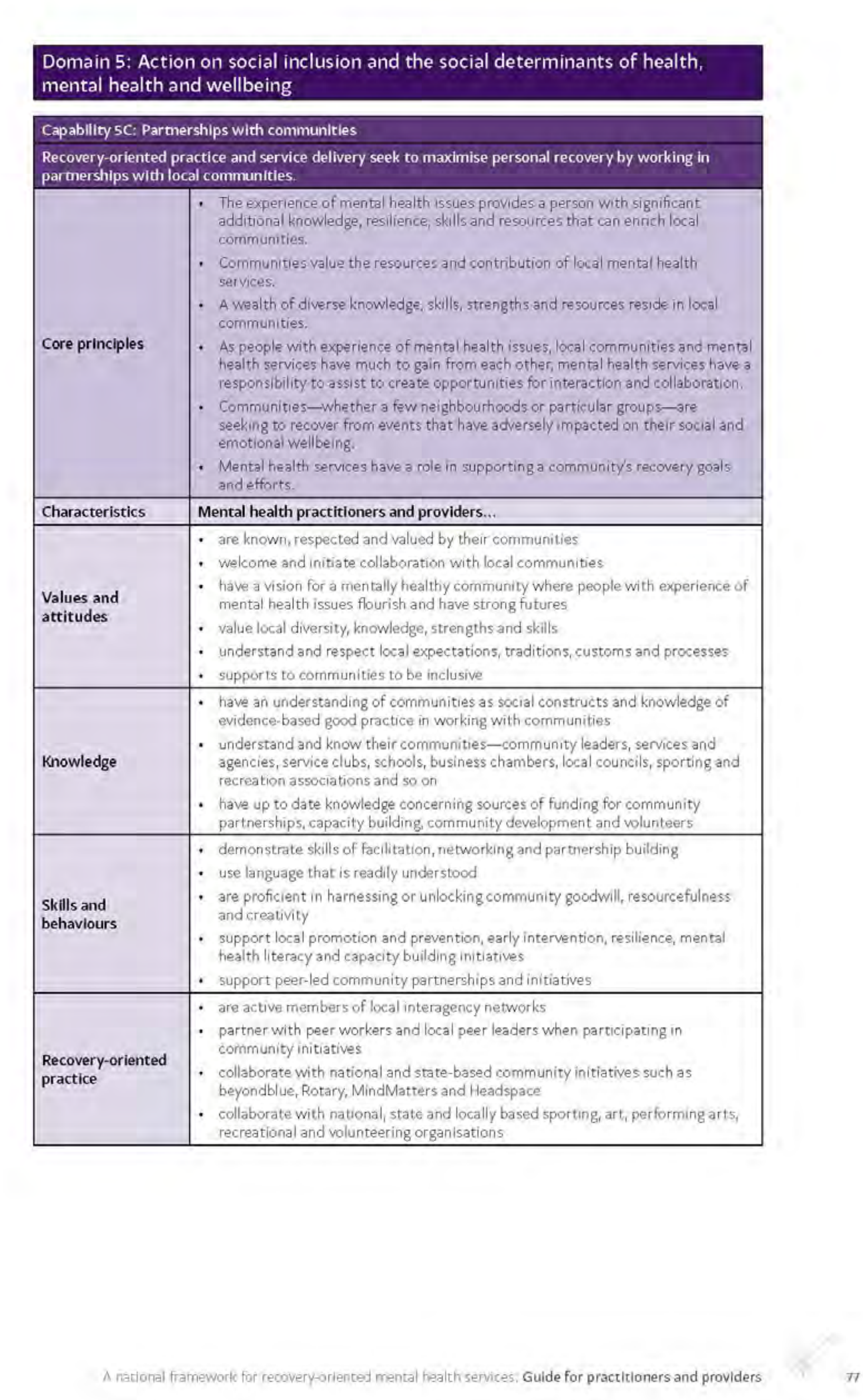
Capability 5B: Actively challenging stigmatising attitudes and discrimination, and promoting positive understandings

Opportunities

- Make an organisational commitment to challenge stigma and discrimination.
- Sponsor local awards and competitions that seek to address stigma by promoting positive messages.
- Link to existing advocacy groups and activities from non-health areas (for example, sporting associations, the arts and media).

Resource materials

- See me, Scotland's national campaign to end the stigma and discrimination of mental ill-health, www.seemescotland.org
- Like Minds, Like Mine, www.likeminds.org.nz/page/5-Home
- World Health Organisation, 'Ottawa charter for health promotion', www.who.int/healthpromotion/conferences/previous/ottawa/en
- VicHealth 2009, *The Melbourne charter for promoting mental health and preventing mental and behavioural disorders*, www.vichealth.vic.gov.au/Publications/Mental-health-promotion/Melbourne-Charter.aspx
- Mindframe National Media Initiative, www.mindframe-media.info



Domain 5: Action on social inclusion and the social determinants of health, mental health and wellbeing

Capability 5C: Partnerships with communities	
Recovery-oriented practice and service delivery seek to maximise personal recovery by working in partnerships with local communities.	
Core principles	• The experience of mental health issues provides a person with significant additional knowledge, resilience, skills and resources that can enrich local communities. • Communities value the resources and contribution of local mental health services. • A wealth of diverse knowledge, skills, strengths and resources reside in local communities. • As people with experience of mental health issues, local communities and mental health services have much to gain from each other, mental health services have a responsibility to assist to create opportunities for interaction and collaboration. • Communities—whether a few neighbourhoods or particular groups—are seeking to recover from events that have adversely impacted on their social and emotional wellbeing. • Mental health services have a role in supporting a community's recovery goals and efforts.
Characteristics	**Mental health practitioners and providers...**
Values and attitudes	• are known, respected and valued by their communities • welcome and initiate collaboration with local communities • have a vision for a mentally healthy community where people with experience of mental health issues flourish and have strong futures • value local diversity, knowledge, strengths and skills • understand and respect local expectations, traditions, customs and processes • supports to communities to be inclusive
Knowledge	• have an understanding of communities as social constructs and knowledge of evidence-based good practice in working with communities • understand and know their communities—community leaders, services and agencies, service clubs, schools, business chambers, local councils, sporting and recreation associations and so on • have up to date knowledge concerning sources of funding for community partnerships, capacity building, community development and volunteers
Skills and behaviours	• demonstrate skills of facilitation, networking and partnership building • use language that is readily understood • are proficient in harnessing or unlocking community goodwill, resourcefulness and creativity • support local promotion and prevention, early intervention, resilience, mental health literacy and capacity building initiatives • support peer-led community partnerships and initiatives
Recovery-oriented practice	• are active members of local interagency networks • partner with peer workers and local peer leaders when participating in community initiatives • collaborate with national and state-based community initiatives such as beyondblue, Rotary, MindMatters and Headspace • collaborate with national, state and locally based sporting, art, performing arts, recreational and volunteering organisations

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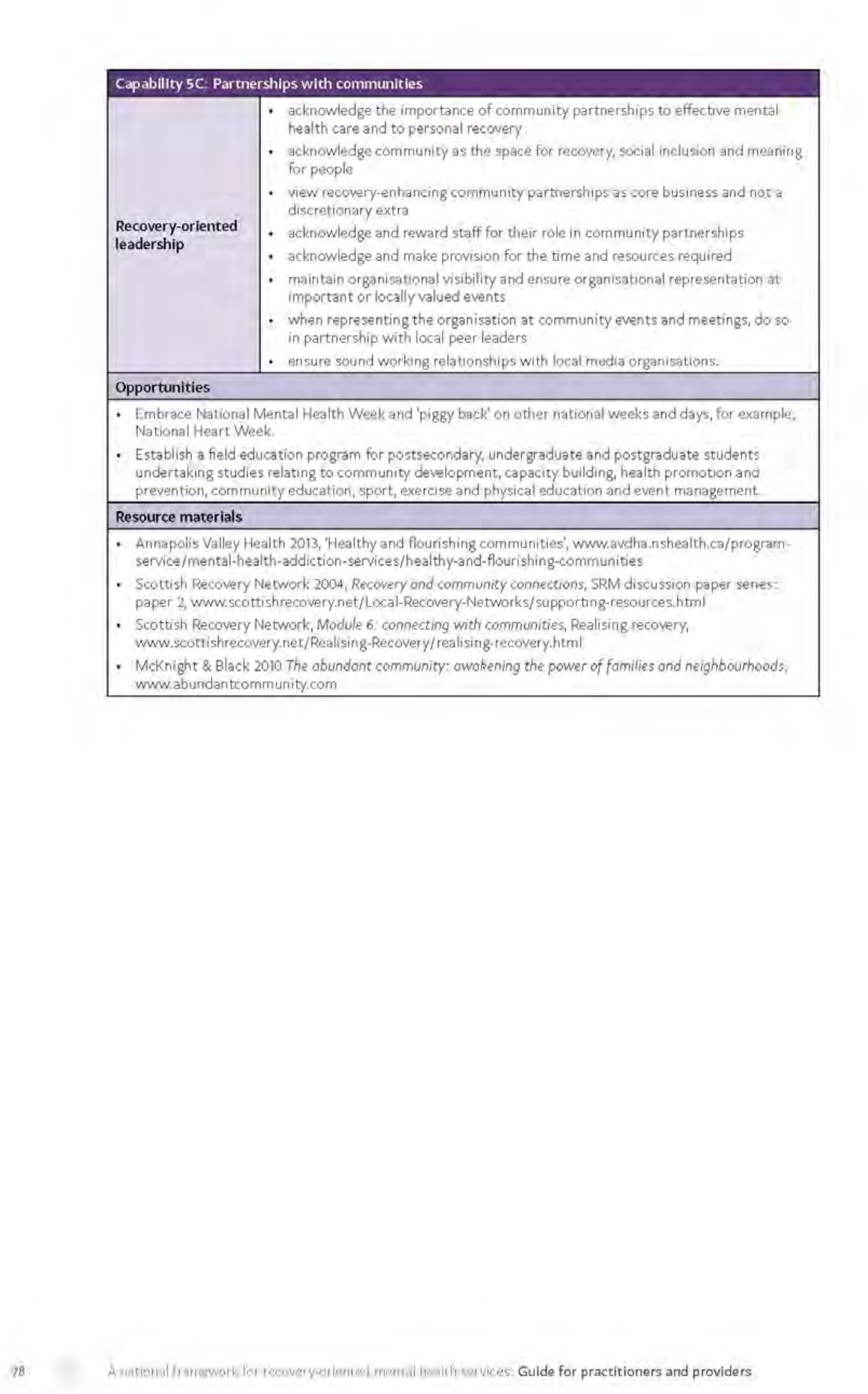

Capability 5C: Partnerships with communities	
Recovery-oriented leadership	• acknowledge the importance of community partnerships to effective mental health care and to personal recovery • acknowledge community as the space for recovery, social inclusion and meaning for people • view recovery-enhancing community partnerships as core business and not a discretionary extra • acknowledge and reward staff for their role in community partnerships • acknowledge and make provision for the time and resources required • maintain organisational visibility and ensure organisational representation at important or locally valued events • when representing the organisation at community events and meetings, do so in partnership with local peer leaders • ensure sound working relationships with local media organisations.
Opportunities	
• Embrace National Mental Health Week and 'piggy back' on other national weeks and days, for example, National Heart Week. • Establish a field education program for postsecondary, undergraduate and postgraduate students undertaking studies relating to community development, capacity building, health promotion and prevention, community education, sport, exercise and physical education and event management.	
Resource materials	
• Annapolis Valley Health 2013, 'Healthy and flourishing communities', www.avdha.nshealth.ca/program-service/mental-health-addiction-services/healthy-and-flourishing-communities • Scottish Recovery Network 2004, *Recovery and community connections*, SRM discussion paper series: paper 2, www.scottishrecovery.net/Local-Recovery-Networks/supporting-resources.html • Scottish Recovery Network, *Module 6: connecting with communities*, Realising recovery, www.scottishrecovery.net/Realising-Recovery/realising-recovery.html • McKnight & Black 2010 *The abundant community: awakening the power of families and neighbourhoods*, www.abundantcommunity.com	

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Appendix 6: Overview of evaluation components, questions and methods

Evaluation of NSW Community-based Mental Health Programs: Community Living Supports and Housing and Accommodation Support Initiative – CLS-HASI Evaluation Report

		Evaluation methods						
	Evaluation Questions	Review	**Quant**	Qual	Qual	Qual	Qual	**Quant**
		Program review (documentation, data collection methods)	Consumer **outcome data** (health), demographic data (MDS)	**Consumer interviews**	**Family and carer interviews**	**Interviews** with **CMOs and LHDs** in fieldwork sites	**Interviews and focus groups** with **stakeholders**	**Economic evaluation and cost modelling**
Data gathering approach/ process Key evaluation questions		From Ministry	InforMH, CHeReL link	Field visits	Field visits, phone	Field visits, phone	Phone, in person	From Ministry CHeReL link
Formative and process evaluation								
How effective are the programs in achieving their stated objectives, what improvements can be made?	all d. - y.	x	x	x	x	x	x	
- determination of eligibility criteria, meeting demands, program access/ promotion of services	d., e., s.	x				x	x	
- improved access for community-based offenders	t.		x			x	x	
- meeting the needs of older people and improved access	u.		x			x	x	
- effective referral pathways	f.					x	x	
- working of programs' structure (on hours	g.					x	x	x

		Evaluation methods						
	Evaluation Questions	Review	**Quant**	Qual	Qual	Qual	Qual	**Quant**
		Program review (documentation, data collection methods)	Consumer **outcome data** (health), demographic data (MDS)	**Consumer interviews**	**Family and carer interviews**	**Interviews** with **CMOs and LHDs** in fieldwork sites	**Interviews and focus groups** with **stakeholders**	**Economic evaluation and cost modelling**
Data gathering approach/ process Key evaluation questions		From Ministry	InforMH, CHeReL link	Field visits	Field visits, phone	Field visits, phone	Phone, in person	From Ministry CHeReL link
of support rather than packages)								
- governance structure and its impact	h.	x				x	x	
- provision of support prior to transition from inpatient units	i.					x	x	
- what factors determine effective partnerships (clinical, psycho-social)	j.	x				x	x	x
- aspects of the programs promoting success and/or failure, operational changes required	k., m.	x				x	x	x
What local variations are there in terms of both programmes implementations	l.	x				x	x	x
What changes to data collection are required	n.	x				x	x	
-targeting to relevant groups (who benefits most, least)	o., p.		x			x	x	
Provision of culturally sound support to Indigenous people	q.			x	x	x	x	

		Evaluation methods						
	Evaluation Questions	Review	**Quant**	Qual	Qual	Qual	Qual	**Quant**
		Program review (documentation, data collection methods)	Consumer **outcome data** (health), demographic data (MDS)	**Consumer interviews**	**Family and carer interviews**	**Interviews** with **CMOs and LHDs** in fieldwork sites	**Interviews and focus groups** with **stakeholders**	**Economic evaluation and cost modelling**
Data gathering approach/ process Key evaluation questions		From Ministry	InforMH, CHeReL link	Field visits	Field visits, phone	Field visits, phone	Phone, in person	From Ministry CHeReL link
Effect of integration of HASI and HASI Aboriginal	q.			x	x	x	x	
Meeting the needs of families (esp. children)	v.			x	x	x	x	
Referral pathways and linking in with mainstream community services (GPs, NDIS supports)	w.			x	x	x	x	
Operating in the context of the NDIS	x.			x	x	x	x	
Input from housing providers to local partnerships (HASI)	y.					x	x	
Subset Non-govt organisations								
Strengths of non-gov organisations contributed to program	z.			x	x	x	x	
How do NGOs interact with housing, LHD health teams, and justice services	cc., dd, ee.			x	x	x	x	
Profile of staff workforce capacity including peers	aa.					x		
Approaches to recovery; working with Indigenous and refugee consumers	bb., ff., gg.					x	x	
Collaboration within LHD	hh.					x	x	

		Evaluation methods						
	Evaluation Questions	Review	**Quant**	Qual	Qual	Qual	Qual	**Quant**
		Program review (documentation, data collection methods)	Consumer **outcome data** (health), demographic data (MDS)	**Consumer interviews**	**Family and carer interviews**	**Interviews** with **CMOs and LHDs** in fieldwork sites	**Interviews and focus groups** with **stakeholders**	**Economic evaluation and cost modelling**
Data gathering approach/ process Key evaluation questions		From Ministry	InforMH, CHeReL link	Field visits	Field visits, phone	Field visits, phone	Phone, in person	From Ministry CHeReL link
Outcomes evaluation								
How well are CLS and HASI achieving their outcomes for consumers	a., b		x	x	x	x	x	x
- provision of psycho-social / community-based supports for people to recover from mental illness	c.		x	x	x	x	x	x
- what factors determine achievement of recovery goals, stable tenancies, reductions in relapses etc.	j.			x	x	x	x	x
- how do Aboriginal consumers fare compared with non-Aboriginal consumers	r.		x	x	x	x	x	x
Recovery in the context of family relationships (children)	v.			x	x	x	x	
Linking in with mainstream community services (GPs, NDIS supports)	m.			x	x	x	x	x
Economic evaluation								
How cost-effective are the programs: CLS and HASI	ii.		x			x	x	x

		Evaluation methods						
	Evaluation Questions	Review	**Quant**	Qual	Qual	Qual	Qual	**Quant**
		Program review (documentation, data collection methods)	Consumer **outcome data** (health), demographic data (MDS)	**Consumer interviews**	**Family and carer interviews**	**Interviews** with **CMOs and LHDs** in fieldwork sites	**Interviews and focus groups** with **stakeholders**	**Economic evaluation and cost modelling**
Data gathering approach/ process Key evaluation questions		From Ministry	InforMH, CHeReL link	Field visits	Field visits, phone	Field visits, phone	Phone, in person	From Ministry CHeReL link
How well costed are the hours of support?	jj.		x			x	x	x

Appendix 7: Evaluation questions

Evaluation of NSW Community-based Mental Health Programs: Community Living Supports and Housing and Accommodation Support Initiative – CLS-HASI Evaluation Report

Prepared for NSW Ministry of Health, 2022

Program effectiveness

1. How well have CLS and HASI achieved their outcomes?
2. What differences are CLS and HASI making to consumers?
3. To what extent have CLS and HASI met their objectives in regard to providing community-based psychosocial supports that support people in their recovery from severe mental illness?
4. Is demand being met?
5. What most determines the acceptance or rejection of applicants?
6. How effectively are referral pathways functioning? What improvements can be made?
7. How has the programs’ structure (based on hours of support rather than packages) worked or not worked?
8. How has the programs’ governance supported the programs? What improvements can be made to the programs’ governance?
9. How has the programs’ capacity to commence supports to people prior to discharge from inpatient units worked or not worked?
10. What are the critical factors that lead to success in regards to:

a. effective partnerships between clinical and psychosocial supports

b. achievement of consumers’ recovery goals

c. reductions in relapses and avoidable hospitalisations

d. supports delivered to boarding house consumers previously supported by Boarding House HASI and transition of these consumers to the National Disability Insurance Scheme (CLS)

e. stable tenancies (HASI)

f. integration of RRSP funds with HASI funds including effective transition of low needs consumers to other supports

g. exit from the programs.

11. What aspects of the programs are promoting success and/or failure?
12. What locally specific variations are there in terms of the implementation of the programs?
13. Are changes to the programs' operation required?
14. Are changes to data collection and/or monitoring required?
15. How effectively have the programs reached the relevant target groups?
16. Which target groups are benefiting from the programs the most? What improvements are needed to better meet the needs of target groups that are not benefiting from the programs as much as others?
17. How effective and culturally appropriate are supports for Aboriginal people? What has been the effect of integrating Aboriginal HASI with the broader HASI program?
18. How do Aboriginal consumers fare compared with non-Aboriginal consumers?
19. How is access for people with mental illness who are living in social or community housing being promoted and ensured? Are referrals linked to anti-social behaviour warnings resulting in improved and appropriate access?
20. How is access for community-based offenders being improved?
21. How effectively are the programs meeting the needs of older people? How has access for older people improved?
22. How is recovery in the context of family relationships being realised? How are the needs of consumers' families and especially their children being addressed?
23. How well have consumers been linked or referred to services including GPs, NDIS and other services?
24. How are the programs operating in the context of the NDIS?
25. What do housing providers contribute to local partnerships in each program, but especially in HASI?

CMOs

26. How do CMOs contribute to the programs?
27. What is the profile of the non-government organisation staff in terms of qualifications and experience, including the peer workforce?
28. What approaches to recovery are prevalent in CMOs? How do these approaches align or differ? How are these differences managed?
29. How do CMOs interact with Local Health District mental health teams? How could this be improved if necessary?

30. How do CMOs interact with housing providers? How could this be improved if necessary?
31. How do CMOs interact with Corrective Services? How could this be improved if necessary?
32. What strategies are CMOs using to ensure that service delivery for Aboriginal consumers is culturally appropriate and that Aboriginal communities and organisations are appropriately engaged with the programs?
33. How are CMOs working with refugees?
34. How are CMOs funded in the same Local Health Districts (in both HASI and CLS) operating together?

Financial issues

35. How cost-effective are the programs?
36. How well costed are the hours of support?

Appendix 8: Evaluation methods

Evaluation of NSW Community-based Mental Health Programs: Community Living Supports and Housing and Accommodation Support Initiative – CLS-HASI Evaluation Report

Prepared for NSW Ministry of Health, 2022

Contents

Tables

Figures

1 Introduction

This appendix contains detail about the methods of data collection and analysis for the evaluation; about the processes for community research control and peer research; and about limitations of the methodology and data collection. Further information can be found in the evaluation plan (Giuntoli et al. 2018).

The evaluation adopted a mixed-method, longitudinal research design to answer the evaluation questions.

The mixed-methods design allowed us to collect information from various sources and to combine the information. Its aim was to comprehensively and reliably assess the effectiveness and outcomes of CLS-HASI.

The longitudinal research design encompassed:

- two waves of qualitative data collection (interviews and focus groups) and
- analysis of linked quantitative data from before, during and after consumers were in CLS-HASI.

This enabled us to see how the programs developed over time and what the longer-term outcomes for consumers were.

First-round interview findings were reported to the NSW Ministry of Health. The findings could inform changes to the programs while the evaluation was ongoing.

The evaluation methods are described in detail below. They were:

- a document review
- fieldwork interviews with CLS-HASI consumers, family and carers, CMOs and LHDs in three sites
- interviews and focus groups with state-wide organisational stakeholders
- case studies describing the housing pathways of CLS-HASI consumers
- analysis of MDS program data, consisting of consumer outcome and demographic data
- analysis of linked data about outcome measures that are routinely collected by government departments
- economic evaluation, consisting of program cost effectiveness analysis and program cost modelling.

The evaluation approach also included processes for community research control and peer research.

2 Community research control and peer research

In order to enable research control from local Aboriginal communities, the research team invited representatives from an Aboriginal Community Controlled Health Organisation (ACCHO) in each of the three fieldwork sites to participate in an Aboriginal Evaluation Committee. This committee was to ensure that evaluation design and conduct were sensitive to Aboriginal ethical concerns. One ACCHO had capacity to accept the invitation. They provided feedback to the evaluators on research methodologies and outputs.

The evaluation methodology also included peer research strategies. That means mental health consumers and Aboriginal consumers contributed to evaluation design, data collection and analysis (evaluation plan Giuntoli et al. 2018). In general, peer researchers are increasingly involved in research and evaluation, so that their service user experience informs data collection and analysis. They can help the research team to clarify questions and identify priorities. They can also give a unique perspective on content, methodology and processes of the project. The peer research in this evaluation involved:

regarding mental health peer research: the lived experience of the research team’s mental health peer researcher informed fieldwork methodology. While conducting the first round of fieldwork, the team member organised the recruitment of local mental health peer researchers in all three fieldwork sites. These local researchers provided advice and input on fieldwork setup, interviews, qualitative data analysis and draft reports.

regarding Aboriginal consumer peer research: this was organised through an Aboriginal Social Policy Research Centre (SPRC) staff member who acted as Aboriginal advisor on the evaluation. It also occurred through the UNSW Community Reference Panel (CRP) Aboriginal staff members. They gave advice on interview wording and approaches for Aboriginal CLS-HASI consumers and their families. The CRP is a new initiative and an innovative way of ensuring research is culturally and ethically competent. It also promotes Aboriginal perspectives in the research.

3 Document review

We reviewed CLS and HASI program documents provided by the NSW Ministry of Health. These documents describe how the programs are meant to operate. This includes their structure, governance, support provision, monitoring and intended outcomes.

The purpose of the review was to outline the expected features and functioning of CLS-HASI. This was then compared to the evaluation findings. It enabled the evaluation to assess to what extent and in which ways program implementation and outcomes matched program intent. Analysis of program documents was done thematically, according to the program logic and evaluation questions. The document review is provided as **Appendix 9**.

4 Fieldwork interviews

We conducted two rounds of interviews in three fieldwork sites. We selected the fieldwork sites in consultation with the NSW Ministry of Health. They were in different types of locations: a metropolitan site, a regional site and a rural site. The two interview rounds happened in the second half of 2018 and the second half of 2019.

Interviews were with:

- CLS-HASI consumers
- their families and carers (in other words, their informal supporters)
- CMO staff and managers
- LHD staff and managers.

Recruitment of consumers and families was at arm’s length, that means through the local CMOs and LHDs. Interviews were semi-structured, that is based on open-ended questions. There was opportunity to ask follow-up questions and discuss related topics that might come up. Questions explored the participants’ experiences of CLS-HASI and additional themes covering the evaluation questions.

All interviews with consumers, CMOs and LHDs were conducted face-to-face. The interviews with family members were held over the phone. We conducted a total 103 interviews in the fieldwork sites (**Table 1**). Interview numbers varied slightly between fieldwork sites, from 24 to 32 (**Table 2**).

Table 1 Sample for qualitative data collection

	Number of participants	Interviews Round 1	Interviews Round 2	Repeat interviews (both R1 and R2)	Total number of interviews (Rd1 & 2)	Number of focus groups*
Fieldwork sites						
Consumers	50	40	26	16	66	
CMOs	25	15	13	3	28	
LHDs	6	4	3	1	7	
Family and carers	2		2		2	
Total in fieldwork sites	83	59	44	20	103	
Stakeholders						
Peaks and government agencies	10	5	5	3	10	1
CMOs and LHDs	18		1		1	4
Total stakeholders	28	5	6	3	11	5
Total qualitative sample	111	64	50	23	114	5

Note: * The focus groups had between 2 and 10 participants.

Table 2 Number of people interviewed by fieldwork site

Fieldwork site	Consumers	CMOs	LHDs	Family and carers	Total
Metropolitan	13	13		1	27
Regional	14	7	2	1	24
Rural	23	5	4		32
Total	50	25	6	2	83

Some characteristics of the 50 consumers who took part in interviews were:

- 14 received support through CLS and 36 received support through HASI
- 30 were men and 20 were women
- they were aged from below 20 years to over 65 years. More than half were aged between 30 and 50 years (**Table 3**)
- they had various ethnic backgrounds. The largest groups were people with Anglo-Saxon (19) and Aboriginal (14) backgrounds (
- **Table 4**)
- they had varying lengths of experience with the programs. At their first interview, they had been in CLS-HASI for between three weeks and 10 years.

Table 3 Consumer age at first interview

Age in years	Number of consumers interviewed
Under 20	1
20 – 29	5
30 – 39	14
40 – 49	14
50 – 59	11
60 – 64	4
65 and above*	1
Total	50

* Note: Age 65 is the cut-off age for the NDIS (that is, the NDIS is only open to people who make an application before they turn 65). It is also the entry age to access NSW Health older people mental health services.

Table 4 Consumer ethnic background

Background	Number of consumers interviewed
Aboriginal Australian	14
Anglo-Saxon	19
Other European	4
Asian	2
Pacific	4
African	2
Not known	5
Total	50

Of the 25 CMO staff and managers who took part in fieldwork interviews, three were mental health peer workers, and three were workers with an Aboriginal background. Among those 25 interviewees, the length of employment with their CMO varied between one month and more than 10 years.

The interview sample included fewer family members and carers than expected. CMOs advised that only few of their CLS-HASI consumers had connection with family members and carers, and that most of those did not wish to participate in the evaluation.

Interviews were audio-recorded, transcribed and analysed thematically using the software NVIVO. Analysis themes mirrored the evaluation questions.

5 Interviews and focus groups with stakeholders

Twenty-eight organisational stakeholders took part in the qualitative data collection (**Table 1**). They participated in individual interviews or focus groups, depending on personal preference and practicality. A range of organisations was represented. They included local program partners, state-wide peak bodies and government departments. The organisations were:

- CMOs and LHDs from non-fieldwork sites across NSW
- NSW Health staff
- Aboriginal Medical Services
- Mental Health Coordinating Council (MHCC)
- Community Housing Industry Association (CHIA) NSW
- Corrective Services NSW
- Being
- Mental Health Carers NSW
- Centre for Aboriginal Health, NSW Health

The interviews and focus groups were audio-recorded, transcribed and analysed thematically using the software NVIVO. Analysis themes mirrored the evaluation questions.

6 Case studies

DCJ put together case studies of 3 CLS and 3 HASI consumers. The case studies describe the pathway of the consumer from their first application for housing assistance. They were anonymised to protect the consumers' privacy.

The case studies demonstrate how CLS-HASI can support some consumers with finding appropriate housing. They also show the barriers and challenges.

7 Program data analysis

The CLS-HASI Minimum Data Set (MDS) is routinely collected by CMOs for all program consumers in each reporting month. It includes demographic data, details of program entry, exit and support services received as well as mental health diagnoses, risk factors and some self-reported outcome data, for example the Living in the Community Questionnaire (LCQ) from commencement of MDSV2.

All Program data presented in the final evaluation report and the appendices are based on two versions of the MDS. MDS version 1 (MDSV1) included CLS from January 2017 and HASI and RRSP from October 2017. For this reason, average numbers in the evaluation reports are based on the period from November 2017, when the full MDSV1 data were available.

Program data transitioned in May 2019 to CLS-HASI MDS version 2 (MDSV2). This version includes more detail in many program areas, including the final 5 months of the evaluation. Where possible, numbers were merged across both MDS versions. Otherwise, content from both MDS versions is presented separately due to different classifications, reporting durations and sample sizes.

MDSV1 and MDSV2 data were provided to by InforMH (NSW Health system information and analytics branch) to the NSW Ministry of Health Centre for Health Record Linkage (CHeReL) to undertake the evaluation data linkage. The data covered all available past and current CLS-HASI consumers as at September 2019.

The evaluation was complicated by the implementation of the new CLS-HASI MDSV2 during the study period. The new MDS version adds valuable new content for program activity but was only available for the final 5 months of the evaluation. It created integration issues for comparison between versions due to changed content and structure of some data items. For this reason, MDS data analyses generally present both MDS version figures to support transparency and interpretation of results.

The number of program consumers in the combined MDS versions was 5,533 (**Table 5**). The program sample was comprised of 2,653 consumers who had exited prior to May 2019 and appeared only in MDSV1, and 914 consumers who entered after April 2019 and appeared only in MDSV2. There were 1,966 consumers who had MDS reported support activity across both MDS versions, giving a total sample of 5,533 individual consumers.

Table 5 CLS-HASI sample for linked quantitative data collection

	CLS-HASI consumers	CLS-HASI by MDS version
CLS-HASI MDSV1 – to April 2019	4,619	2,653
CLS-HASI MDSV2 – from May 2019	2,880	914
Reporting in both MDS versions		1,966
Total MDSV1 and MDSV2		5,533

Source: CLS-HASI MDSV1 and MDSV2 to September 2019, n=5,533.
Note: Consumers across CLS and HASI collated across multiple dates, programs, and support episodes.

Analysing MDS data for the evaluation had three objectives:

1. provide a profile of the demographic characteristics of CLS-HASI consumers and compare this to people on the wait lists for the programs (the comparison group for the evaluation).
2. analyse data linkage outcomes for CLS-HASI consumers before, during and after participation in the programs, and compare these outcomes with the wait list group.
3. integrate consumer support services and outcomes with program cost modelling for the economic components of the evaluation.

This section provides details of each of these evaluation components as well as associated limitations.

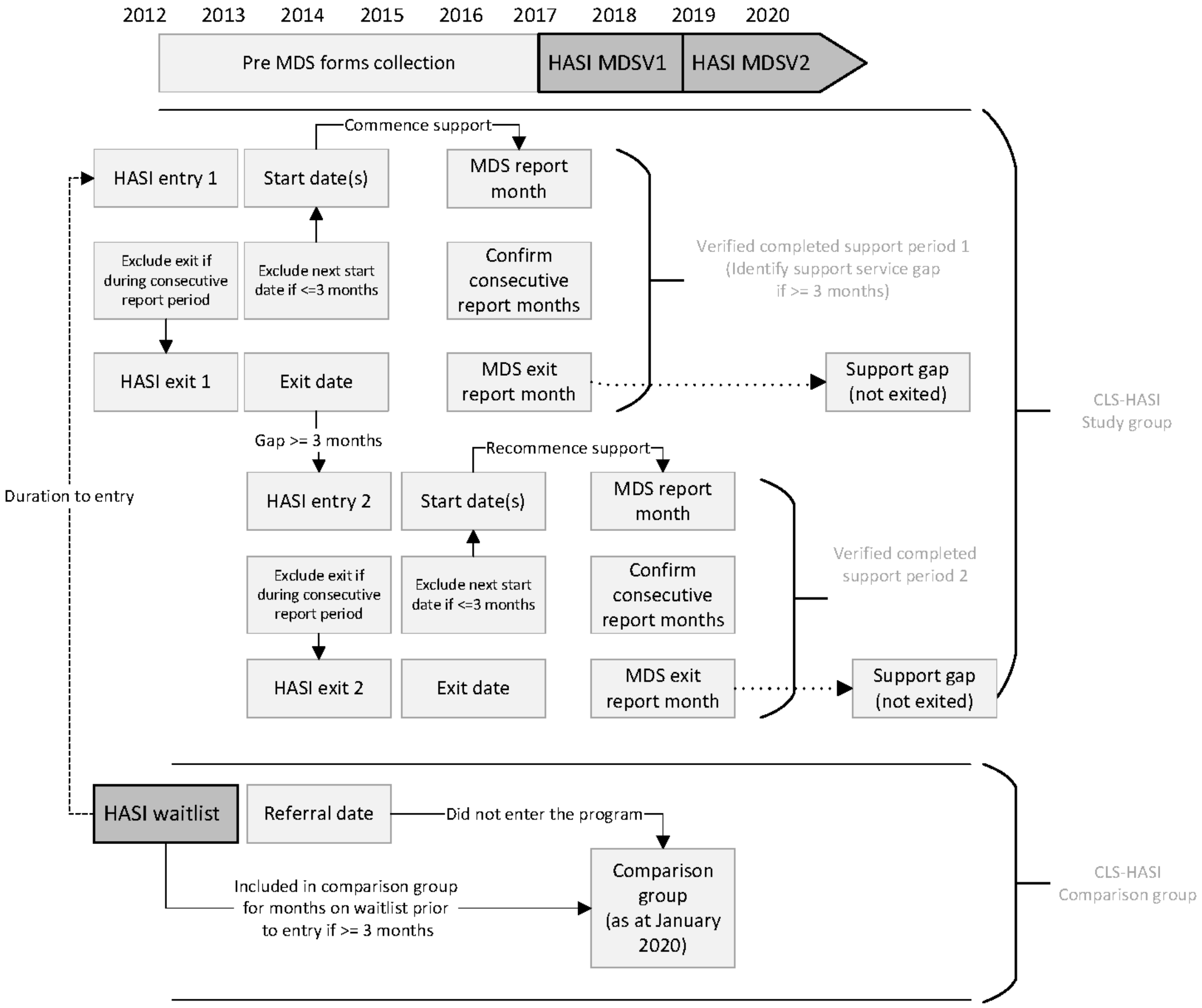
Preliminary data issues and preparation

The initial phase of the data analysis required multiple steps to validate program start dates and establish single episodes of support. This was necessary as many consumers had multiple exit and entry dates in the MDS versions, for example due to transition to another sub program (historically for CLS, HASI or RRSP), service provider (for example through re contracting) or location. The before and after program entry longitudinal analyses were developed based on initial (first) entry points and continued until a final program exit. Interim entry and exits were consolidated into complete consumer episodes to provide a pre-program comparison, excluding secondary ‘entry’ points, where consumers were already receiving support from the programs.

To begin with the entry dates from MDSV1 data were cross validated with active reporting months and years. It was known at commencement of the project that data migration to the CLS-HASI MDSV1 during 2017 resulted in some inconsistencies with original start dates, many of which were loaded with default dates at migration rather than historical program entry dates. As program start dates are a critical baseline for the evaluation the MDS, entry dates were reviewed and updated by CMOs in preparation for the evaluation.

The process of identifying consolidated episodes of support firstly required integration of all support activity across each MDS version and then integrating MDSV1 and MDSV2. The MDS versions were provided from the CHeReL separately, with unique deidentified consumer PPN codes as the linkage key to combine support pathways across versions. As the MDS is reported monthly, the duration of time between re-entry was calculated for each consumer based on reporting months and year, and compared with the multiple entry and exit dates, **Figure 1**.

Figure 1: CLS-HASI program start date validation



The start date validation developed assumptions underpinning a merged consumer episode of program support. Initial first entry dates were used as base entry points and subsequent entry periods for the same consumer were identified and duration calculated between events. Re-entry within 3 months was assumed to be due to administrative transfer between sub programs, locations or service providers and were combined as a related program support period. The same 3-month assumption was applied to multiple programs exit dates per consumer so that an actual exit date was only recognised if a subsequent re-entry did not occur within the following months. This validation process was critical to establishing consolidated total episodes of support to provide the basis for comparative time series activity in the linked data sources.

The start date consolidation process was used to derive the total concurrent number of consumers in the program each month. These figures were cross validated with source CLS and HASI sub program reporting which confirmed the approach produced consolidated program entry and exit points in line with aggregated source figures.

In addition to the validation of consumer support episodes, MDSV2 introduced enhanced data content that contributed to many aspects of the program data. However, the transition from May 2019 introduced multiple new data items that changed from the previous MDSV1 and shifted the basis of many items, for example previous yes/no responses were expanded to multiple response variables. Where relevant each MDS version figures are presented in the evaluation reposts to support clarity and interpretation.

The MDS data provide reporting of program support for the period consumers are in the program. However, due to the system migration to MDSV1 during 2017, complete study group monthly records were available only from November 2017 when the migration was completed. This means that although historical start dates were available, monthly support details were reported only following commencement of the new MDSV1.

8 Linked data analysis

The data linkage for the evaluation included CLS-HASI program data (from both MDS versions as above) with multiple sources of routinely collected healthcare, housing and correctional services data, **Figure 2**. The linkage was undertaken through the NSW Ministry of Health Centre for Health Record Linkage (CHeReL). Each data source was linked to the CLS-HASI study group and assigned a unique deidentified reference ID (PPN) as a linkage key. The CHeReL undertook probabilistic linkage where datasets provided name, gender and age for matching. Where only statistical linkage keys (SLKs) were available deterministic linkage was used. CHeRel linkage reports confirmed matching rates were consistent with NSW Ministry of Health Master Linkage Key (MLK) regular checking indicating that missing of true matches and false positive rates are low, estimated to be below 0.5%.

Preliminary phases subsequently linked the program data files with each source to develop the time series framework of source data activity relative to the entry and duration in the program. Several data linkage sources include multiple file for separate components, for example the MH-OAT was provided in separate source files for K10, HoNOS and LSP, and housing data was received with 3 separate sources across housing applications, tenancy and other support. Each source file was individually linked to the merged MDS study group in preparation for development of the time series framework and analyses.

Time series framework

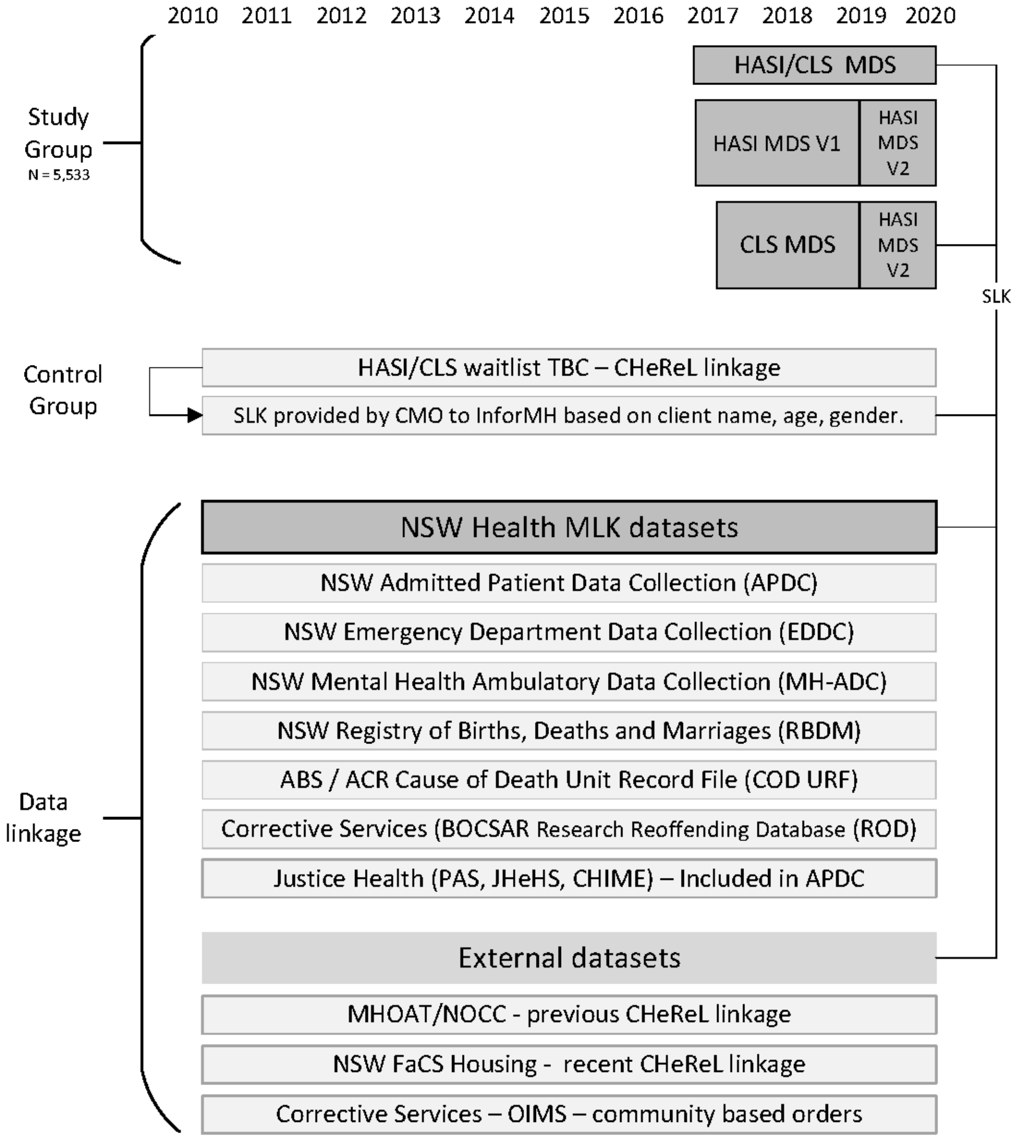
Following merging of each linkage source dataset with the consolidated MDS versions, the datasets were developed into a longitudinal time series framework to define before, during and after CLS-HASI support time periods. As retrospective data were available through the linkage this provided at least two years prior to entry (initial entry of consolidated support periods).

The variation in consolidated support timeframes across consumers results in characteristic right censoring of post program entry data resulting from variation in total support periods, actual exit points, as well as those who were still in the program at the end of the evaluation period in September 2019.

For this reason, the number of support periods before censoring were calculated for each consumer as the basis of adjustment offsets in regression analyses, to provide comparative before and during program rates of events and outcomes.

The core time series analyses developed before and during CLS-HASI support for 2 years prior and 2 years following entry to the programs. Supplementary analyses were separately undertaken using all available data, ie including data following program exit, to examine the extent that outcomes were sustained following exit. In these analyses' figures were also separately adjusted for right censoring based on observed support months before the end of the evaluation study period. Data following program exit were not available for MH-OAT mental health outcomes (K10, HoNOS and LSP) as routine reporting is only undertaken while consumers remain in the programs.

Figure 2: CLS-HASI data linkage sources



Statistical analyses

Longitudinal analysis was undertaken using negative binomial regression for most datasets based on event count outcomes. Negative binomial models were used given the characteristic high dispersion in most data sources. Comparative testing was undertaken using Poisson regression which produced generally consistent results, given that most outcome changes before and during program support were highly significant.

Descriptive statistics are presented as percentages where constant variables provide a basis. As the program MDS and linked data sources comprise large data samples with unit records over time, some variation in count figures for individual consumers resulted in proportions not summing to 100%. This was generally minor and is noted in footnotes where relevant. Healthcare utilisation is presented as mean counts per consumer per year, adjusted for right censoring, to estimate mean annual difference. Statistical significance is defined as $p<0.05$, figures are presented with 95% confidence intervals where relevant.

The mental health indicators were examined in line with methods of mean difference, count of groups and effect size to assess clinically significant change in line with methods proposed by the Australian Mental Health Outcomes and Classification Network (AMHOCN, 2008). The effect size (ES) examines the magnitude of a treatment effect based on before and after change and the standard deviation of the pre score where Cohen’s scores of 0.2 are defined as small, 0.5 as medium and 0.8 a large effect. These ranges in ES are used to assess clinically meaningful change and have been calculated at an individual level (Eisen, Ranganathan, Seal, & Spiro, 2007).

The CLS-HASI waitlist did not provide a sufficient sample for comparative statistical analyses. For this reason, the comparative analyses are based on repeated measure longitudinal data for the same individuals before and after entering the program. Further details of the target comparison group are provided in following section.

Study group

The study group is defined from program data across versions 1 and 2 of the CLS-HASI MDS from January 2017 to September 2019 (n=5,533). The migration of program data to MDSV1 occurred at different times during 2017, with CLS available from January, but the majority of HASI and transitioning RRSP data available in MDSV1 from November 2017. The linkage timeframes around the study group were defined from January 2015 to January 2020 to provide 2 years prior and at least 4 months post program entry for outcomes in the time series analyses.

As noted above, the MDS data versions provide monthly support details for the study group during their time in the programs, but only from the point the MDSV1 implementation was completed in November 2017. For this reason, examination of support or survey responses over time is limited for the many consumers who were in the program during the new MDSV1 introduction and had previous support history.

Comparison group

The evaluation aimed to establish a comparison group from potential consumers who were placed on program waitlists. As this target group were eligible for the programs, they were therefore similar in support needs to those already in CLS-HASI. This was anticipated to provide a control group of several hundred comprised of individuals meeting program eligibility and therefore likely comparative baseline characteristics.

The CLS-HASI waitlist data were comprised of 312 records containing 195 unique identifiers (PPNs). Duplicate records for some consumers were checked to identify multiple referral dates and to assess relative to subsequent entry to the program. This approach was taken as it was not known in advance how many waitlisted individuals would go on to enter the program and over which timeframes. Where waitlist individuals remained on the list for several months, this period was potentially a comparison subgroup to supplement the comparison group sample size.

Between March 2018 and June 2019, the NSW Ministry of Health counted 195 people on the waitlist (**Table 6**). From this final comparison group, 94 (48%) were excluded as they entered the program within 1 month of being placed on the waitlist. Of the remaining 101, a further 47 entered the program, the majority within 3 months following waitlisting. The longest time on the waitlist was 9 months.

Table 6: CLS-HASI length of wait times

Waitlist outcome	Waitlist (n)	Waitlist (%)
Less than 1 month on waitlist before program entry	94	48%
1 to 2 months on waitlist before entry	24	12%
2 to 3 months on waitlist before entry	11	6%
3 or more months on waitlist before entry	12	6%
Did not enter the programs	54	28%
Waitlist total	**195**	**100%**

Source: NSW Ministry of Health CLS-HASI waitlist data

This left a target comparison group sample of 54 who did not enter the program at all. During the data linkage to each source dataset, the number of comparison group individuals varied with the proportion having no activity reported before or after being placed on the waitlist. For this reason, the remaining comparison group was reduced to several individuals that had reported events in any of the 2 years before and after placement on the waitlist, for each data source.[1] These small comparison group sample sizes were not sufficient to support statistically significant analyses. The waitlist records basic demographic details and is provided in **Table 7** below for reference.

Table 7: CLS-HASI study and comparison group demographic characteristics

	Consumers	**%**	Comparison	%
Age				
18 and under	134	2.4%	0	0.0
19 to 24	539	9.7%	8	11.0
25 to 34	1,094	19.8%	17	23.3
35 to 44	1,357	24.5%	18	24.7
45 to 54	1,277	23.1%	17	23.3
55 to 64	880	15.9%	11	15.1
65 and over	252	4.6%	2	2.7
Gender				
Male	2,909	52.6%	33	45.2%
Female	2,584	46.7%	40	54.8%
Indeterminate	7	0.1%	0	0
Not known	33	0.6%	0	0
Identify as LGBTI				
No	4,534	98.2	N/A	N/A
Yes	141	3.1	N/A	N/A
Persons of Aboriginal origin				
Aboriginal	684	12.2	3	4.1
Torres Strait Islander	18	0.3	1	1.4
Aboriginal & Torres Strait Islander	38	0.7	0	0.0
Indigenous – not further specified	8	0.1	0	0.0
Subtotal	748	13.3	4	5.5

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[1] Largest linked datasets: Community mental health: 6 individuals, Hospital admissions: 5 individuals.

	Consumers	**%**	Comparison	%
Neither Aboriginal / Torres Strait Islander	4,375	78.0	21	28.8
Declined to respond	6	0.1		
Unknown	477	8.5	44	60.3
Country of birth				
Australia	4,660	84.2%	N/A	N/A
New Zealand	120	2.2%	N/A	N/A
England	50	0.9%	N/A	N/A
Vietnam	35	0.6%	N/A	N/A
China	33	0.6%	N/A	N/A
India	32	0.6%	N/A	N/A
Philippines	28	0.5%	N/A	N/A
Other countries	575	10.3%	N/A	N/A
Preferred language				
English	5,221	94.4%	N/A	N/A
Other	141	2.5%	N/A	N/A
Southern European	43	0.8%	N/A	N/A
Gaelic	35	0.6%	N/A	N/A
Arabic	32	0.6%	N/A	N/A
Vietnamese	20	0.4%	N/A	N/A
Mandarin	16	0.3%	N/A	N/A
Cantonese	15	0.3%	N/A	N/A
Hindi	10	0.2%	N/A	N/A
Total	5,533	100.0	73	100.0

Source: CLS-HASI MDS to September 2019 n=5,533

Note: MDSV2 changed name to Aboriginal and Torres Strait Islander Origin (ATSO)

Some percentages do not sum to 100% due to multiple responses across study periods.

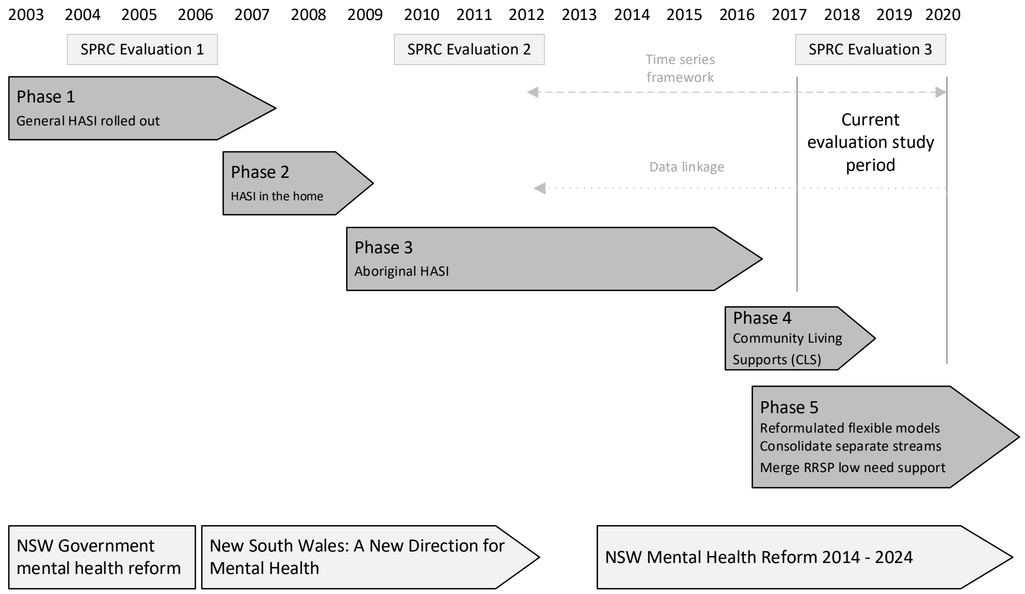
Final comparison group = 54 due to entry same month as waitlisted and 2 entering prior to evaluation period and subsequently placed on waitlist.

9 Economic evaluation

The economic component of the evaluation integrated quantitative outcomes from the data linkage with program cost data. This section describes the economic component methodology including cost and outcome data sources and the cost effectiveness Markov model specification.

The current HASI evaluation was undertaken in context of two previous program assessments and the ongoing implementation of HASI phases. The current third evaluation period built on previous work, with an emphasis on the recently reformulated flexible hours based model, compared to previous package-based support with generally consistent support over time, **Figure 3**. HASI is a long-standing program that now consolidates multiple smaller HASI streams, including the Resource and Recovery Support (RRSP) and Aboriginal HASI into a single program.

Figure 3: CLS-HASI phases and economic evaluation framework



Source: CLS-HASI history and economic evaluation framework

Program cost data

The CLS-HASI program cost was compiled from finalised annual acquittal reports. These are audited statements provided for each CMO with figures broken down by expenditure categories. The source acquittal reports were provided as PDF files and were manually collated into summary figures in Microsoft Excel by CMO, funding period and expense category. Final figures were indexed at 2.5% per annum in line with NSW Ministry of Health guidance.

The acquittal reports showed substantial variation in the level of detail and expense categories reported. As there are no standardised cost categories, expenses were summarised into core groups including employee expenses, administrative expenses, operational expenses, motor vehicle expenses, repairs and maintenance, accruals and leave entitlements, depreciation expense and ‘other’ expenses. This provided consolidated categories across all CMOs for aggregate reporting.

The cost data was then cross validated with aggregate program cost data from the NSW Ministry of Health. This process was necessary as the aggregate NSW Ministry of Health figures were audited from CMO invoicing and the cost category details were only available through acquittal reporting. The validation process confirmed aggregate CMO costs per year, with supplementary cost categories for each service provider.

The CMO costs accounted for almost all program expenditure, about 99 %. Additional head office and partner agency related costs were allocated based on discussions with program partners and estimated costs from the previous HASI evaluation.

Program outcomes and costs

The quantitative linked data outcomes before and after entry to the CLS-HASI program was integrated to the economic modelling. The economic evaluation examines health resource use before and after entry including hospital admissions and lengths of stay (LOS), emergency department presentations, community mental health services, corrective services (including prison) and community corrections. The changes in health services following program entry establish cost offsets in the cost effectiveness analyses where services decline. Housing data linkage from DCJ Housing was also part of the quantitative analysis but is not included in the cost offsets as consumers are eligible for housing support whether they are a CLS-HASI consumer or not. This approach was also undertaken for the previous HASI evaluation (Bruce, Mc Dermott, Ramia, Bullen, & Fisher, 2012).

The program costs and outcomes are based on evaluation data and published program valuation sources, Table 8. Hospital inpatient costs are a predominant cost category and were calculated based on admission length of stay and Australian Refined Diagnosis Related Groups (AR-DRGs) cost weights. The most prevalent DRGs from the data linkage were for schizophrenia (DRG U61Z 68%) and major affective disorders (U63Z 13%). The data linkage coding provided general diagnosis groups and was examined by average cost per day (Total DRG cost divided by DRG LOS). This showed that average inpatient cost per day for the study group was between $1,360 and $1,740 for the main DRGs accounting for 92% of admissions. In line with the conservative approach taken in the modelling the lowest cost per day was used, which was for the highest reported schizophrenia DRG. The modelling is focused on the incremental change in the number of admissions and the associated length of stay, valued at the DRG average cost per day.

Table 8 Model parameters used in economic modelling

Parameter	Unit	Value	Distribution	Range	Source
Costs					
Program costs	Per consumer	$35,754	Gamma	S.D. $46,867	Ministry of Health
Admissions	Per day	$1,439	LOS		1: Calculated from DRG
Admitted LOS program	days	23.6	Gamma	SD 2.1	program data linkage
Admitted LOS Pre program	days	49.4	Gamma	SD 2.5	program data linkage
Emergency Department	Per presentation	$718	Constant		2: NHCDC Round 22
MH Ambulatory	Per contact	$263	MHAMB LOS		3: IHPA round 22
MH-AMB program	contacts	48.5	Gamma	SD 2.3	program data linkage
MH-AMB Pre program	days	53.9	Gamma	SD 2.4	program data linkage
Prison	days	$251	Sentence		4: RoGS
Community corrections	days	$24	CCO		5: NSW Corrections
Outcomes					
QALY program	QALY weight	0.517	Beta	SD 0.47	6: K10 bridging algorithm
QALY Pre program	QALY weight	0.485	Beta	SD 0.44	6: K10 bridging algorithm

DRG = Diagnostic Related Group, CCO=Community corrections order, RoGS=Report of government services, LOS=length of stay

Sources:

1: Independent Hospital Pricing Authority, DRG cost weights, round 22.

2: NHCDC Round 22 Emergency Department line-item average cost per separation, actual, by jurisdiction, Appendix 16.

3: IHPA National Hospital Cost Data Collection Report: Public Sector, Round 22 (Financial Year 2017-18), Table 3, page 11, indexed to 2019-20.

4: Australian Government, Productivity Commission, Report on Government Services (RoGS) 2019. Table 8A.17 Recurrent expenditure per prisoner and per offender per day. Net operating expenditure.
5: NSW Corrective Services, Fact sheet 2, Community Corrections, indexed to 2019-20
6: (Mihalopoulos, Chen, Iezzi, Khan, & Richardson, 2014)

Emergency department costs are based on NSW average cost per presentation reported by the Australian Independent Hospital Pricing Authority (Independent Hospital Pricing Authority, 2020). Community mental health costs are calculated using Australian Independent Hospital Pricing Authority reported costs for average cost per episode, reflecting multiple support services (Independent Hospital Pricing Authority, 2020).

The modelling parameters include estimated outcome distributions and variation to establish the framework for assessing joint model uncertainty in all parameters. All cost figures are reported in 2019-20 Australian dollars indexed using the Consumer Price Healthcare Index (Australian Bureau of Statistics, 2020).

Economic outcomes

The economic evaluation also aimed to integrate mental health outcomes into the economic modelling through the Kessler Psychological Distress Scale (K10), which is a routinely collected measure. The K10 is a self-report measure of psychological distress used to measure changes in a person’s mental health over time. The K10 scores before and after program entry were used to estimate QALYs using bridging transformation algorithms (Mihalopoulos et al., 2014). A QALY is a measure of health outcome that combines length of life with health-related quality of life. QALYs are used in economic evaluation to help understand how effective health programs are at improving people’s health and wellbeing. This approach is an innovative recent method of developing validated cost effectiveness modelling using estimated QALYs from routinely collected NOCC reporting data.

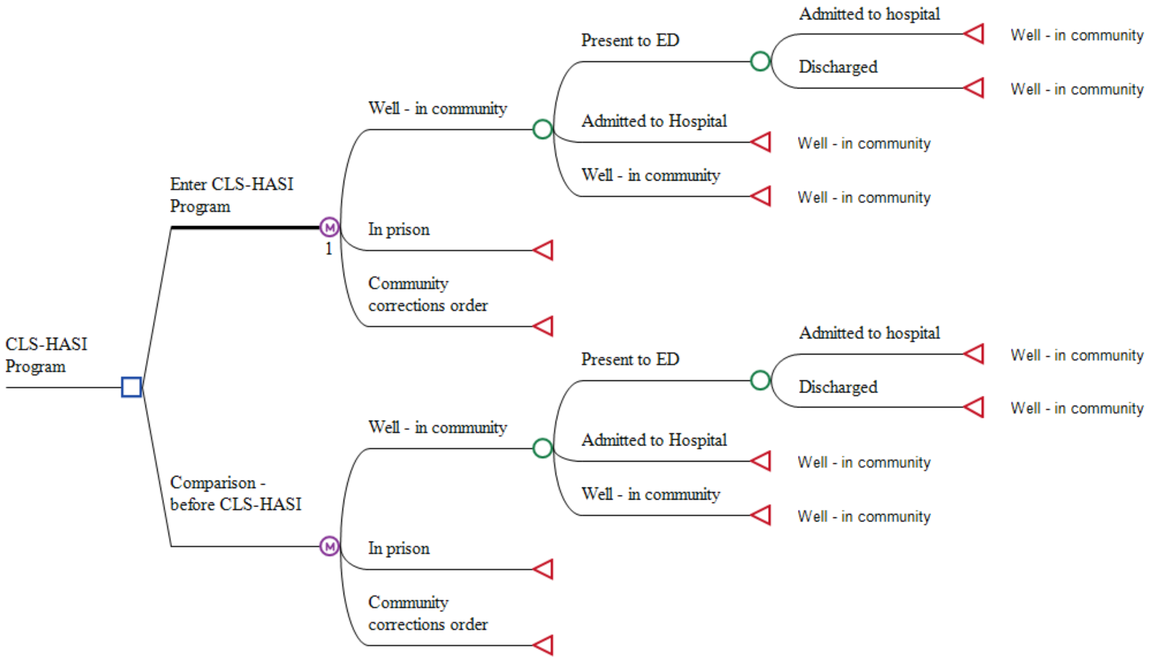
Economic modelling

The economic component of the evaluation developed a Markov model framework to assess health service use, program costs and outcomes and to estimate cost effectiveness, **Figure 4**. The model defines transition probabilities of being admitted to hospital, presenting to an emergency department or receiving community mental health services. Pathways are also defined for being in prison or placed on a community corrections order. The structure uses corresponding pathways to define events before and after entry to the CLS-HASI programs.

The base case model is a 5-year timeframe, with supplementary shorter conservative scenarios developed for 2-year and 1-year periods. The model simulates 10,000 replications to provide an estimate of the mean costs and QALYs per person. Variation in all model parameters was assessed using the bootstrapping resampling technique of Probabilistic Sensitivity Analysis (PSA) to quantify the joint uncertainty in the data based on defined distributions for each model parameter input. The model cost effectiveness bootstrap scatter plots for each scenario are provided in **Appendix 11** for reference.

The modelling was undertaken from the perspective of the NSW Ministry of Health as the lead program funding agency. The economic modelling was developed in TreeAge Pro 2021 Release 1.2.

Figure 4: Economic CLS-HASI Markov model structure



10 Strengths and limitations of the methodology

Strengths

This CLS-HAS program evaluation was the third independent assessment of the programs, as the support model has been developing over the past decade. Many of the core NSW Ministry of Health datasets were the same as previous evaluations, which supports validation of consumer outcomes over time.

The current project had a number of extensions from previous evaluations, which added to and built on the cumulative CLS-HASI program evidence base including substantially larger study group sample sizes in the data linkage developed by the NSW Ministry of Health CHeReL. The current study group was 5,533 consumers compared to 895 in the previous 2012 evaluation. This added statistical power across longitudinal analyses including across important program subgroups.

The data linkage added new data sets that were not part of the previous HASI evaluations including:

- NSW Department of Communities and Justice (DCJ) – Research Offender Database (ROD) provided through BoCSAR
- NSW Department of Communities and Justice (DCJ) – Community based orders through the OIMS system
- NSW Department of Communities and Justice (DCJ) Housing – including public housing applications, tenancy and housing assistance
- New CLS-HASI MDSV2 for the final 5 months of the study period – providing new program data content not previously available

The data linkage provided retrospective pre-program baselines for comparison following program entry, as well as extended activity to examine the extent that outcomes were sustained following program exit.

The economic Markov modelling developed enhanced cost effectiveness estimates using recently developed bridging algorithms using mental health outcomes (K10) to develop cost per Quality Adjusted Life Year (QALY).

The Markov modelling approach also provided the framework to assess variation using the bootstrapping resampling technique of Probabilistic Sensitivity Analysis (PSA) to quantify the joint uncertainty in all model parameters. This supported estimated 95% confidence intervals for cost effectiveness results, which combined with conservative model assumptions and supplementary model scenarios contributes to overall confidence in evaluation findings.

The mixed-methods design triangulated and cross validated qualitative and quantitative outcomes.

Limitations

The success in accessing the programs presented a limitation for the evaluation, as the original target comparison group was based on waitlisted individuals who either did not enter or were on the waitlist for sufficient duration to assess comparative outcomes.

As most people placed on the CLS-HASI waitlist entered the programs, mostly within a few months, the cohort did not establish a sufficient comparison sample. While this limited independent validation of the program outcomes, the primary evaluation analyses were also planned to be longitudinal repeated measures for the same consumers, with a comparison group if numbers were sufficient. The previous HASI evaluations also did not establish comparison groups, demonstrating the difficulty in identifying a suitably matched comparative cohort.

The planned target comparison group would have had limitations if available due to potential selection and other biases, ie mental health programs such as CLS-HASI are not able to exclude eligible consumers for a randomised control design study. A target comparison group of several hundred people is needed to develop program subgroup alignment and matching of baseline characteristics, for example using propensity score matching.

Although the data linkage provided large samples for most outcome data and the longitudinal analyses used repeated measures for the same individuals, effectively providing self-controlling for many consumer characteristic baselines, the comparison group would have added further to statistical rigor and validation of program effects.

The program data in the CLS-HASI MDSV1 required retrospective review and update of consumer start dates by service providers to confirm default dates loaded during migration to the new MDS version in 2017. The start dates were cross validated against MDS reporting months for periods following MDSV1 commencement for reasonability. Start dates prior to MDSV1 commencement in 2017 were assumed to be accurate, but minor variation from actual start dates is possible.

Many consumers had multiple start and exit dates across the CLS-HASI MDS versions, for example due to transition between programs, service providers or locations. Following the review and update of program start dates, a consolidation process was undertaken to combine multiple periods into single support periods per consumer, to exclude before and after analysis of interim entry point baselines. The consolidation assumptions were tested for consistency, but minor exceptions are possible. This is unlikely to influence outcome analyses as the initial start date per consumer provided the primary baseline. It is possible that minor exceptions occurred, which may have resulted in minor variation in subsequent start and exit dates.

Research has shown potential inherent tendency for consumer outcomes to stabilise following an escalated episode and return to a longer-term average. This ‘regression to the mean’ may partially contribute to consumer outcomes observed through the data linkage time series analyses. While this is a potential limitation in quantifying consumer outcomes attributable to the programs, this does not suggest consumers would necessarily recover (or continue to escalate) in the absence of CLS-HASI program support.

As for all outcome analyses based on administrative data, there are potential quality issues and missing variables for some consumers. The NSW Ministry of Health has invested in ongoing improvement in mandatory reporting protocols and the new specification of MDSV2.

There was some variation in outcome reporting, for example the proportion of consumers assessed using the LSP-16 was substantially lower than the K10 and HoNOS measures, which limited the before and after analyses of the LSP-16.

Direct comparison with previous HASI evaluations was limited due to potential changes in study group baseline characteristics as well as consolidation and reformulation of support models, for example increased flexibility of support compared to previous fixed packages.

11 References

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Appendix 9: Review of CLS-HASI program documents

Evaluation of NSW Community-based Mental Health Programs: Community Living Supports and Housing and Accommodation Support Initiative – CLS-HASI Evaluation Report – 2022

Contents

1 Introduction

This short review of Community Living Supports (CLS) and Housing and Accommodation Support Initiative (HASI) program documents provided by the NSW Ministry of Health (Ministry) describes the intended set up of the programs, including their structure, governance, support provision, monitoring and intended outcomes. The purpose of the review for the evaluation was to outline the anticipated features and functioning of CLS-HASI, which could then be compared to the evaluation findings. This enabled the evaluation to assess to what extent and in which ways program implementation and outcomes on the ground matched program intent. The structure of the document review corresponds to findings sections in the other reports.

Both CLS and HASI programs provide support to people who have a severe mental illness so that they can live and participate in the community in the way they want to. The programs operate under an integrated model of support based on local organisational partnerships and are available across NSW. Support is intended to be recovery-oriented and individualised. Hours of support that can be varied in response to the consumer’s changing needs.

HASI began operating in 2003 and offered packages of fixed support hours for consumers. In 2016/17 CLS was introduced. It adopted the more flexible hours-of-support model. In 2017/18, HASI was re-tendered and also adopted the CLS flexible hours-of-support model. During the re-tender, all HASI programs (HASI in the Home, Aboriginal HASI and HASI) were consolidated into a single program.

At the time of this report, the Ministry was working on a comprehensive, updated manual for the HASI and CLS programs. The purpose was to clarify Ministry expectations and to make the operation of the programs more consistent across the state.

2 Program structures

This section describes the program principles, intended program partnerships, governance arrangements and responsibilities of program partners.

2.1 Program principles

According to the program manuals, the underpinning principles of CLS-HASI are:

1. People receiving supports are active partners in their care
2. Collaboration between clinical and psychosocial supports
3. Flexibility and individualised care
4. Family and/or carers as active partners
5. Recovery focused
6. Community oriented
7. Sensitive and quality services
8. A partnership of responsible agencies, people with mental health conditions and their family and/or carers
9. Respect and communication between partners
10. Responsiveness to feedback

2.2 Organisational partnerships

CLS and HASI core partnerships are between the Ministry and community-managed organisations (CMOs). The Ministry provides funding and oversight, while CMOs have been contracted by the Ministry to deliver support services to program consumers.

At the local level, CMOs work with local health district (LHD) community mental health services and other providers as required to support consumers, e.g. drug and alcohol programs, medical and allied health practitioners, and education and employment services. The programs also have a strong partnership with the NSW Department of Communities and Justice (DCJ) and community housing providers for social housing.

Local partnerships are meant to also include a wide range of Aboriginal community organisations and programs such as Aboriginal Community Controlled Health Organisations (ACCHOs), Aboriginal Medical Services (AMS) and NSW Aboriginal Land Councils.

2.3 Governance

The Ministry manages the overall programs and oversees issues that affect CLS-HASI. CMOs, LHDs, DCJ, Corrective Services NSW (CSNSW) and other stakeholders are routinely consulted on program matters.

Elements of the CLS-HASI program governance include:

- The **Stakeholders Forum** addresses local issues that may have broader program implications.
- The **Peak Stakeholders Forum** discusses program issues from the perspective of key populations and priorities and provides advice on policy and operational matters.
- **Local Selection and Coordination Committees** meet regularly at the local level to select CLS-HASI consumers and to coordinate the ongoing support provided. Local Selection and Coordination Committees may be separate or combined depending on local circumstances.
- CMOs consult with **Aboriginal Community Reference Groups** to build recognition of the programs among local Aboriginal communities, promote referrals into the programs and sustain links between CMOs and local Aboriginal communities.

2.4 Responsibilities of program partners

According to the Ministry's program manual, all partner agencies involved in CLS-HASI must commit to:

- delivering services according to the principles underpinning the programs (see above)
- building strong, collaborative working relationships with partners
- regularly communicating with other partner agencies, discussing ways to improve consumer outcomes and strengthening service coordination
- fulfilling their agreed roles and responsibilities, and meeting legal requirements and ethical standards
- respecting the confidentiality and privacy of people receiving CLS-HASI support
- being accountable for the supply of services, fulfilling contractual monitoring and reporting obligations, and efficiently using program resources
- providing culturally and linguistically appropriate services
- proactively monitoring each consumer's progress; in most cases this monitoring role will be undertaken by the CMO.

The roles of local partners as specified in the Ministry's program manuals include:

CMOs:

- building the consumer's capacity for daily living skills; in attending appointments; in maintaining medication; to prepare for discharge from inpatient units; in personal relationships; in finding and maintaining stable accommodation
- facilitating the consumer's access to treatment, economic participation, social opportunities, physical health assessments and activities, other services relevant for the individual consumer; this may include transport provision
- working with the consumer, and their family/community if the consumer agrees, to develop individual support plans; coordinate support arrangements; establish and maintain relationships with support providers; meet the consumer's cultural needs
- for Aboriginal consumers, supporting participation in Aboriginal community activities
- establishing and maintaining Local Aboriginal Cultural Reference Groups – the Ministry requires CMOs to fulfil this task to ensure the services are culturally appropriate and respected by Aboriginal communities. Coordination can be through informal, culturally and locally appropriate ways.

LHD community mental health services:

- provide clinical support to consumers where appropriate
- support with medication adherence; recognising signs of relapse; managing life stressors; developing individual support plans; linking to other treatment services
- engaging family and carers if the consumer agrees
- applying for Community Treatment or Guardianship Orders
- local operational management of CLS-HASI, including monitoring and developing Service Level Agreements (SLAs) with CMOs.

DCJ and other social housing providers:

- identifying potential CLS-HASI consumers and referring them to the LHDs
- facilitating consumer access to tenancy support.

Corrective Services NSW/Justice Health:

- supporting engagement and sharing information
- referring people in custody, on community-based court orders or exiting prison to LHDs.

3 Support provision

3.1 Priority groups

CLS-HASI is for people with severe mental illness who are aged 16 years or above, who want to engage with psychosocial support services and have the desire and ability to live in the community with support. A critical program objective of CLS-HASI is to ensure that people who would otherwise be hospitalised frequently or indefinitely are effectively supported to live well and recover in the community.

CMOs and LHDs are required to prioritise people with the highest and most complex need. The priority groups of the CLS-HASI programs are:

- **people living in social housing** – providing appropriate supports aims to support people maintain their tenancies and reduce the risk of people losing their tenancies, rent arrears or other issues arising from their mental health condition.
- **people serving community-based detention orders** – these people can have difficulties accessing the mental health support they require. CMOs are encouraged to liaise with the consumers' supervising officer, particularly around conditions in the legal order.
- **Aboriginal people** – after a separate Aboriginal HASI stream was integrated into HASI in 2017/18, Aboriginal people remain a priority group. CMOs are required to continuously improve strategies to engage Aboriginal people and build trust with local communities. The must make efforts to provide culturally appropriate support, including conducting regular staff training.
- **people living in boarding houses** – this group has been recognised as highly vulnerable and often lacking contact with support services. CMOs conduct outreach to boarding houses to identify potential CLS-HASI consumers. The Ministry reports this was particularly relevant when Boarding House HASI concluded and existing boarding house residents were transitioned to the NDIS. CLS-HASI was seen as a transitory option at the time.
- **people leaving prisons** – prioritising people leaving prisons who have severe mental health conditions is intended to ensure continuity of support and therefore a smooth transition to living in the community. The goal is to also reduce recidivism.
- **refugees** – in locations that have been identified as refugee settlement areas these people are a priority for CLS-HASI. Refugees often have complex mental health conditions related to experiences of trauma.

3.2 Referral process

Any person or organisation can refer someone for CLS-HASI supports. People can also self-refer. Referrals can be made to CMOs or LHD community mental health teams. The person who is being referred, or their legal guardian, must give informed consent.

Eligible applicants who are not admitted to the programs should be placed on a register of applications (a waiting list), and Local Selection and Coordination Committees should review this list regularly. CMOs and LHDs should inform unsuccessful applicants about other relevant support and arrange referrals if the person requests.

Vacancies in CLS-HASI arise when support hours become available. Support hours are specific to each LHD. The hours available must be allocated to people with the highest support need, even if the number of hours is sub-optimal. As more hours become available, they should be added to the hours already allocated, and in the meantime other services should be utilised.

3.3 Support plans and reviews

When consumers enter CLS-HASI, an Individual Support Plan is developed collaboratively between the consumer, their family and/or carers if the consumer agrees, the CMO and the LHD community mental health teams. It identifies the goals of the person for their recovery, which services will be delivered and the roles and responsibilities of each of the partners in the support of the individual.

Individual Support Plans should reflect the person’s specific psychosocial and cultural support needs. This includes mental and physical health improvement, access to education, training or employment, access to other services or facilities as needed, appropriate cultural and language support, and consideration of religion and sexuality.

Individual Support Plans should be reviewed at least every 13 weeks, to ensure that CLS-HASI supports respond to any changing needs. This may involve different types of support or a change in number of support hours. Reviews involve the consumer, their family and/or carers if the consumer agrees and all program partners. After each review, the CMO worker has to make sure that the revised/new Individual Support Plan is given to the consumer and service providers.

Each consumer should also have a Mental Health Care Plan, a current risk assessment and risk management plan.

3.4 Managing hours of support

As the needs of CLS-HASI consumers will likely fluctuate and change over time, the support provided requires constant review. As much as possible, consumers should be matched to the most appropriate level of support according to their needs.

CMOs, in collaboration with LHD mental health services, should regularly monitor the use and availability of hours of support allocated for their area. If there are unutilised hours, a plan should be developed for how best to allocate these hours. This may involve an increase in hours for consumers requiring extra support and/or support being offered to additional people on a short-term basis (e.g. to a person discharged from an inpatient unit who requires support as they transition back into the community).

CLS-HASI consumers may access additional supports from the National Disability Insurance Scheme (NDIS). In these circumstances, there should be no duplication between the NDIS disability supports and the CLS-HASI supports for consumers.

3.5 Engaging families and carers

Families and carers are considered important partners in delivering CLS-HASI. Successful engagement may improve outcomes for the consumer. Where the person receiving CLS supports has given consent for their family and/or carers to be actively involved they may play an important part in supporting the person and helping to identify recovery goals and promote community participation. In this instance the nominated family member or carer should be invited to participate in all Individual Support Plan reviews.

Families and carers may sometimes need information or assistance to better support themselves and/or the CLS-HASI consumer. Often the partnership arrangements of the programs can either provide this support or provide information about appropriate services. When providing CLS-HASI supports to Aboriginal consumers, ensuring a trauma-informed and recovery-oriented environment may require provision of support to other family members as well.

3.6 Exit pathways

Some of the reasons why people might exit CLS-HASI include and are not limited to:

- they no longer need the support and have achieved their goals
    - in this case, the CMO can assist the person to access any services they may still need, and they can help the person liaise with their housing provider to clarify any tenancy obligations
- the support is insufficient to meet their needs

    - the CMO and/or the mental health care provider, with the consumer and their family and/or carers, will explore options to move to a program with a higher level of support. People should not leave CLS-HASI until appropriate alternative support is confirmed.
- the consumer chooses to no longer receive support
    - CMO providers are encouraged to use assertive engagement and outreach approaches to attempt to encourage the consumer to continue to receive support. However, participation in CLS-HASI is voluntary.

When an individual exits CLS-HASI, the CMO should discuss with the individual their experiences in the program and their reasons for leaving.

4 Program data collection

The CLS-HASI monitoring system consists of three components: Minimum data set, service reporting and annual program reports.

4.1 Minimum data set

A minimum data set (MDS) was established to provide standardised data collection relating to consumer characteristics and the support and funded hours they receive. The MDS also records outcome measure scores from the Living In the Community Questionnaire (LCQ). The MDS has been developed and modified over time, in consultation with program partners. InforMH provides specifications for the MDS to CMOs.

CMOs are required to collect data for every consumer on a monthly basis and submit it to InforMH for analysis and reporting. The LCQ should be completed at least every six months and scores for all 26 questions should be recorded in the MDS.

InforMH generates a monthly report, showing a summary of the data that was submitted. This displays 22 indicators showing consumer characteristics, support activities and other information including achievements against benchmarks.

4.2 Service reporting

Service data reflects the flow of consumers into CLS-HASI and monitors the management of the register of applicants (the waiting list), as well as other service level data as necessary. The Ministry provides a template to record data on new applications, rejections of new applications, registers of applications and new applications. CMOs are required to complete the service data form on a quarterly basis and submit it to the Ministry. The Ministry monitors the data. These reports provide some illustration of the extent to which CLS-HASI meet demand for supports.

4.3 Annual program report

Once a year, CMOs are required to submit an annual report. This will be qualitative and allow for narrative accounts of service development activities, governance arrangements, quality improvement activities, consumer case studies and other descriptions of service delivery. It will also provide opportunity to feed back to the Ministry any plans for the following year and any other issues not accommodated elsewhere in the monitoring framework. The Ministry will provide a template for this report.

Appendix 10: Quantitative analysis results of outcomes for CLS-HASI consumers

Evaluation of NSW Community-based Mental Health Programs: Community Living Supports and Housing and Accommodation Support Initiative – CLS-HASI Evaluation Report

Prepared for NSW Ministry of Health, 2022

Contents

Tables

Figures

1 Introduction

This appendix presents statistical analysis results from the data linkage. The results offer further detail to program outcomes in section 4 of the full analysis report.

The figures are presented as change in year 1 following entry to the CLS-HASI programs. These are core findings including the time series outcomes for all consumers who entered the programs and had not been formally exited as at the end of the evaluation period in September 2019. This also includes consumers who may not be receiving support but had not been exited in the MDS data.

All results are calculated using regression methods adjusted for the number of months consumers were observed following entry. This gives consistent time periods for comparative before and after results given the characteristic right censored data resulting from consumers being in the program for varying timeframes or entering the program with limited months of follow up before the end of the study period.

The CLS-HASI programs support people who have a severe mental illness live and participate in the community the way that they want to. The program reflects NSW mental health reform towards early intervention and community-based care to maintain people’s mental health and wellbeing in the community. The aim is to offer support that helps reduce or avoid escalation of episodes that may result in inappropriate and repeating hospital presentations, tenancy risk or behaviour leading to contact with the Justice system.

In this context, this section examines CLS-HASI program outcomes across mental and physical health, healthcare service use of hospital, emergency department and community mental healthcare, housing status and stability, as well as contact with corrective services and community-based orders. The analysis is based on the CLS-HASI consumer data linkage undertaken by the NSW Centre for Health Record Linkage (CHeReL). Results are presented across two years prior to entering and two years following entry to the program. In line with the methodology the analyses are a time series framework examining individual consumers retrospectively before they joined the program and changes following program entry.

The evaluation attempted to establish a potential comparison group using program waiting lists, however as many individuals entered the program shortly after being waitlisted, there were insufficient sample sizes to support statistically significant analyses. The data linkage contained large samples of consumers before and after program entry across each linked data source which supported statistically significant results across most outcomes.

Each section presents an overarching total program outcome followed by subgroup analysis across gender, age groups, level of CLS-HASI program support and Aboriginal status.

2 Mental health outcome scales

This section examines mental health outcomes reported through the NSW Mental Health Outcomes and Assessment Tools (MHOAT) including the Kessler 10 (K10), the Health of the Nation Outcome Scales (HoNOS) and the Life Skills Profile - 16 (LSP - 16).

The metal health indicators have been examined in line with methods of average difference, count of groups and effect size to assess clinically significant change in line with methods proposed by the Australian Mental Health Outcomes and Classification Network (AMHOCN, 2008).

The overall change in average outcome scores following program entry gives an indication of overarching effect and is presented at the beginning of each outcome section. In addition to the overall outcome change it is important to examine results in relation to variation in before and after program scores, to assess the relative size of changes for individual consumers. The effect size (ES) examines the magnitude of a treatment effect based on before and after change and the standard deviation of the pre score where Cohen’s scores of 0.2 are defined as small, 0.5 as medium and 0.8 a large effect. These ranges in ES are used to assess clinically meaningful change and have been calculated at an individual level (Eisen, Ranganathan, Seal, & Spiro, 2007). Each outcome assessment measure in the following sections shows the ES results across sub groups as supplementary results.

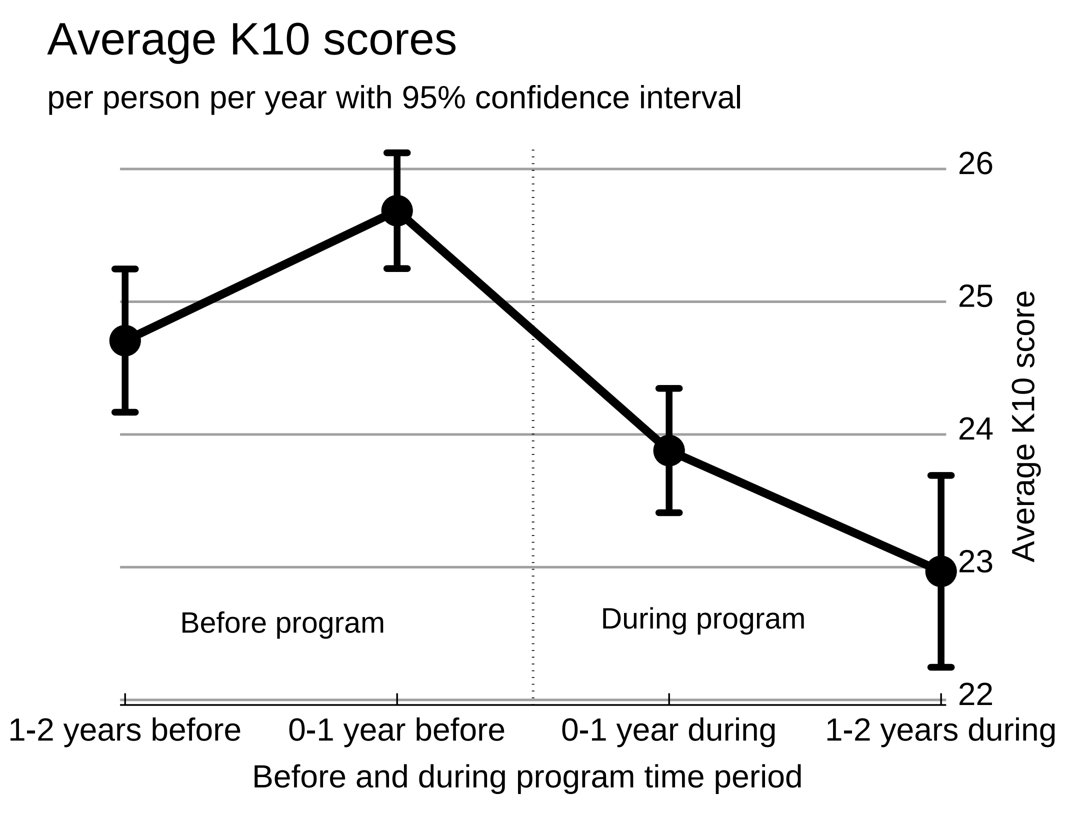
Overall, consumer mental health outcomes show significant improvement following entry to the programs, with levels of psychological distress decreasing.

2.1 Kessler 10 (K10)

The Kessler 10 (K10) is routinely used in Australia as an established screening survey for serious mental illness in the general population, (Kessler et al., 2003). The K10 is scored using a five-level response scale where 1 is the minimum score for each item (not experienced) and 5 is the maximum score (always experienced), giving a minimum possible score of 10 and a maximum possible score of 50 (Australian Bureau of Statistics, 2007-08).

Consumers’ level of psychological distress decreased significantly in the year following program entry by an average of 1.8 points from 25.6 to 23.8 ($p<0.001$, n=1,579), **Figure 1**. This decreased level of distress continued into year 2 post program entry with a average K10 score of 22.9.[1]

Figure 1: Average K10 scores per person pre and post program entry



Source: CLS-HASI linked NSW Mental Health Outcomes and Assessment Tools (MHOAT) n=1,579 Notes: Average K10 scores with 95% confidence intervals shown as vertical bars.

In addition to the overall improvement (decrease) in average K10 scores, 30% of consumers showed a clinically meaningful improvement based on effect size. Around 17% had marginally worse levels of psychological distress and the remaining 53%, while having improved scores did not change at a sufficient magnitude to be considered clinically meaningful, Table 1.

Across demographic subgroups, female consumers had higher levels of psychological distress than males before and after program entry, although both groups had statistically significant improvement after joining CLS-HASI. Female and male consumers showed similar levels of clinically meaningful improved scores at around 30%.

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[1] Repeated measures for same consumers, excluding consumers who did not have at least one K10 score before and after entry to the program.

Table 1: Average K10 score and change before and after program entry

Group	n	%	Average K10 score prior	post	p-value	Change in K10 (%) Better	Worse	No change
Gender								
Male	678	53.6	24.0	22.3	0.001	30.7	15.6	53.7
Female	588	46.5	26.9	25.0	0.002	29.3	18.4	52.4
Age group								
19 to 24	110	8.7	27.0	24.1	0.029	37.3	10.9	51.8
25 to 34	290	22.9	25.0	23.4	0.043	29.3	16.6	54.1
35 to 44	318	25.1	24.8	23.5	0.095	24.8	18.2	56.9
45 to 54	282	22.3	26.1	24.0	0.010	32.3	19.2	48.6
55 to 64	201	15.9	24.8	22.8	0.040	31.3	15.4	53.2
65 and over	60	4.7	25.8	24.5	0.451	31.7	18.3	50.0
Support level								
Low	503	39.7	25.1	23.6	0.010	29.8	15.7	54.5
Medium	728	57.5	25.6	23.7	0.001	29.5	17.7	52.8
High	35	2.8	25.3	23.2	0.384	42.9	17.1	40.0
Aboriginal status								
Non-Aboriginal	1,079	90.3	25.3	23.4	0.001	29.4	17.0	53.7
Aboriginal	116	9.7	25.6	24.6	0.448	34.5	19.0	46.6
Total	1,266	100.0	25.4	23.6	0.001	30.0	16.9	53.1

Source: CLS-HASI linked NSW Mental Health Outcomes and Assessment Tools (MHOAT) n=1,266 Notes: Year prior and post program entry excluding consumers without at least one score before and after. Aboriginal total = 1,195 due to missing Aboriginal status.

By age the younger 19-to-24-year group achieved more clinically meaningful improvement as well as substantially less consumers with worse outcomes. High support level consumers achieved notably higher levels of clinically meaningful improvement even though the smaller size group did not have a statistically significant change in average K10 scores overall. This is a positive outcome despite the small number of high support consumers, as effect size calculations are independent of sample size.

Similarly, Aboriginal consumers with high variation in scores and a smaller sample size did not have a statistically significant change in average K10 scores before and after program entry but achieved a higher proportion of clinically meaningful improvements (34.5%) compared to non-Aboriginal consumers (29.4%).

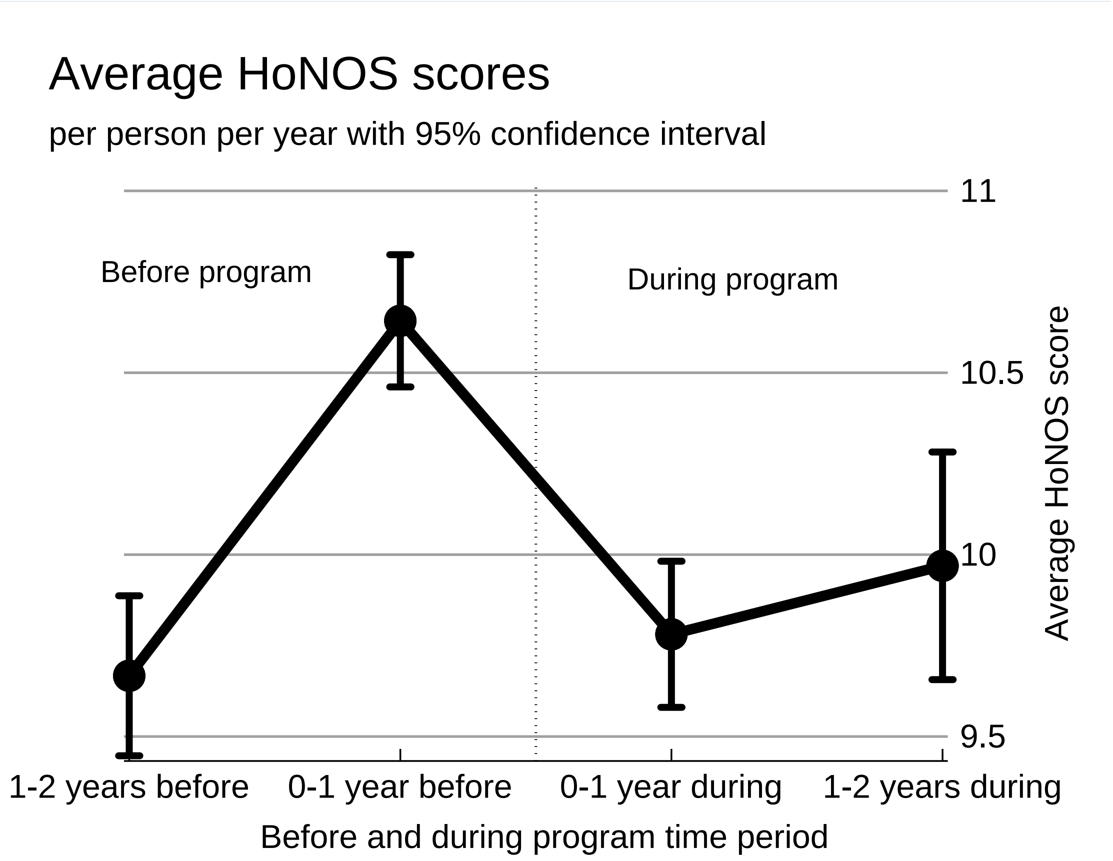
The profiles of improvements in consumer psychological distress with women having higher levels than men and younger consumers achieving higher levels of improvement are consistent with the previous HASI evaluation, (Bruce et al., 2012). This evaluation extends the findings through longer follow up timeframe and larger study group sample sizes.

2.2 Health of the Nation Outcome Scales (HoNOS)

The Health of the Nation Outcome Scales (HoNOS) is a clinician rated instrument of 12 scales across four domains of behaviour, impairment, symptoms and social functioning. As for the K10 a lower HoNOS score indicates an improvement.

Consumer average HoNOS scores decreased (improved) significantly in the first year following entry to the CLS-HASI programs by 0.8 from 10.6 to 9.8 (p<001, n=2,813), **Figure 2**. The improvement was sustained into the second-year post entry at an average score of 9.9.

Figure 2: Average HoNOS scores per person pre and post program entry



Source: CLS-HASI linked NSW Mental Health Outcomes and Assessment Tools (MHOAT) n=2,813 Notes: Average inpatient days with 95% confidence intervals shown as vertical bars.

Consistent with the K10 improvement, a third of consumers (33.1%) achieved a clinically meaningful improvement based on calculated HoNOS effect size, Table 2. These positive results reflect similar improvements reported in the previous HASI evaluation, which reported a decrease in average HoNOS score of 1.0 and 34.3% of consumers showing a clinically significant improvement based on effect size (Bruce et al., 2012).[2]

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[2] 2012 HASI Evaluation reported a mean HoNOS score of 10.8 before and 9.8 during HASI, indicating an improved outcome.

Table 2: Average HoNOS score and change before and after program entry

			Average HoNOS			Change in HoNOS (%)		
Group	n	%	prior	post	p-value	Improve	Worse	No change
Gender								
Male	1419	55.2	10.8	10.1	0.001	35.0	25.2	39.8
Female	1153	44.8	10.3	9.7	0.005	31.4	23.7	44.9
Age group								
19 to 24	257	10.0	11.1	10.7	0.365	33.5	28.4	38.1
25 to 34	561	21.8	10.3	9.7	0.071	34.1	25.3	40.6
35 to 44	667	25.9	10.6	9.9	0.015	31.9	23.1	45.0
45 to 54	632	24.6	10.8	9.9	0.004	34.7	22.9	42.4
55 to 64	403	15.7	10.2	9.7	0.132	32.5	25.3	42.2
65 and over	35	1.4	9.7	8.7	0.398	34.3	25.7	40.0
Support level								
Low	1063	41.3	10.3	9.5	0.001	34.4	24.0	41.6
Medium	1436	55.8	10.7	10.1	0.006	32.3	24.4	43.3
High	74	2.9	11.9	11.5	0.625	37.8	35.1	27.0
Aboriginal status								
Non-Aboriginal	2146	88.5	10.5	9.8	0.001	33.0	24.5	42.5
Aboriginal	279	11.5	10.8	10.3	0.210	33.7	24.0	42.3
Total	2572	100.0	10.6	9.9	0.001	33.1	24.4	42.5

Source: CLS-HASI linked NSW Mental Health Outcomes and Assessment Tools (MHOAT) n=2,572 Notes: Year prior and post program entry excluding consumers without at least one score before and after. Aboriginal total = 2,425 due to missing Aboriginal status.

Male consumers had slightly higher HoNOS scores to female consumers before and following program entry, with both men and women having statistically significant improvements after entry to the CLS-HASI programs, Table 2. Improvement by age reflected substantial variation around the largest sample size age groups of 35-44 and 45-54 with statistically significant decreases in average scores. Improvement was consistent across all ages based on effect size at above 30% for all age groups.

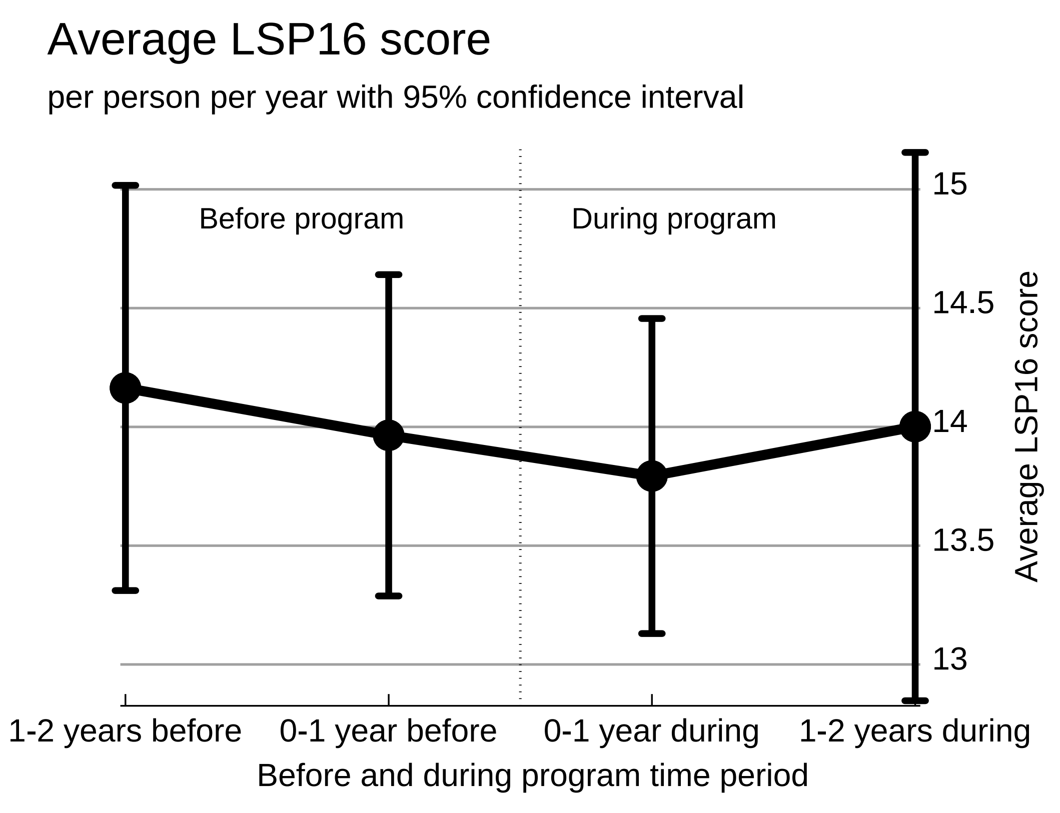
High support level consumers had a slightly decreased average HoNOS score post entry but reflecting the small sample size and high variation was not statistically significant. Most consumers with low and medium level support (around 98%) showed statistically significant improved scores and clinically meaningful effect size improvement in around a third of consumers.

Consumers of Aboriginal and Torres Strait Islander origin had average HoNOS scores above non-Aboriginal consumers before and after program entry, but still improved post program by a similar average score level of 0.6. Reflecting the smaller Aboriginal sample size and variation, the improvement for Aboriginal consumers was not statistically significant.

2.3 Life Skills Profile - 16 (LSP - 16)

The Life Skills Profile - 16 (LSP - 16) was developed by an Australian clinical research group to assess a consumer's abilities with respect to basic life skills. Its focus is on the consumer's general functioning and disability rather than their clinical symptoms. All items are answered on a four-point scale, with higher scores indicating a greater degree of disability and zero representing good functioning. A total LSP score is calculated by adding individual scores together with a possible range from 0 to 48. Items with missing data are excluded from the calculation.

Figure 3: Average LSP scores per person by gender



Source: CLS-HASI linked NSW Mental Health Outcomes and Assessment Tools (MHOAT) n=1,510 Notes: Average inpatient days with 95% confidence intervals shown as vertical bars.

The MH-OAT reported LSP data show a low proportion of responses at program admission which limited the before and after comparison of outcomes. LSP scores at admission were available for less than 1% of consumers, compared to around 43% for K10 and 38% for HoNOS. From the available LSP scores, the slight improvement from 14.1 in the year before program entry to 13.8 in the year following entry was not statistically significant and highly variable, with a standard deviation of 7.1, Table 3. The previous HASI evaluation reported a similarly high variation in LSP average scores of 6.6 (Bruce, Mc Dermott, Ramia, Bullen, & Fisher, 2012).

Male consumers had higher (poorer) LSP scores before and after entering the program, the reverse of results for the K10, where men had better scores before and after entry. This opposite pattern was reported in the previous HASI evaluation and has been observed in other Australian research (Bruce et al., 2012; Eagar et al., 2005).

Table 3: Average LSP score and change before and after program entry

			Average LSP score			Change in LSP (%)		
Group	n	%	prior	post	p-value	Improve	Worse	No change
Gender								
Male	714	57.7	14.6	14.5	0.663	26.5	23.7	49.9
Female	524	42.3	13.4	12.9	0.275	26.2	22.3	51.5
Age group								
19 to 24	95	7.7	15.1	14.9	0.840	27.4	25.3	47.4
25 to 34	256	20.7	14.2	14.2	0.905	25.0	23.1	52.0
35 to 44	338	27.3	14.1	13.7	0.477	25.4	25.4	49.1
45 to 54	296	23.9	14.3	13.8	0.387	29.1	19.9	51.0
55 to 64	192	15.5	13.9	13.9	0.929	25.0	24.5	50.5
65 and over	61	4.9	12.4	10.8	0.175	26.2	18.0	55.7
Support level								
Low	481	38.9	13.5	13.1	0.408	27.9	22.0	50.1
Medium	720	58.2	14.4	14.2	0.479	25.3	23.6	51.1
High	37	3.0	16.2	16.5	0.843	27.0	27.0	46.0
Aboriginal status								
Non-Aboriginal	1071	90.8	14.0	13.6	0.136	26.4	21.6	52.0
Aboriginal	108	9.2	14.7	15.4	0.404	25.0	35.2	39.8
Total	1238	100.0	14.1	13.8	0.298	26.3	23.1	50.6

Source: CLS-HASI linked NSW Mental Health Outcomes and Assessment Tools (MHOAT) n=1,238 Notes: Year prior and post program entry excluding consumers without at least one score before and after. Aboriginal total = 1,179 due to missing Aboriginal status.

All LSP-16 summary scores and all HoNOS summary scores apart from Depression were higher (worse) in involuntary episodes. This research indicates that community LSP-16 scores are notably higher for diagnoses of schizophrenia (13.1), personality disorder (13.9) and higher for substance misuse (16.3). Where LSP scores relate to inpatient episodes, average LSP scores for schizophrenia were 17.3. Schizophrenia diagnoses have increased to around 44% of the CLS-HASI study group.

Overall, the slight improvement in LSP scores before and after program entry were not statistically significant reflecting the small decrease in average score of 0.3 and high variation (standard deviation 7.1). Examination of individual LSP questions showed that an addition one point of average score was accounted for through question 16, which contributed 2.1 to the total average score, where most questions are below or around one point on average. This question covers capacity to work, with a high proportion of responses for limited sheltered work or not capable of work at all.[3]

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[3] LSP question 16: What sort of work is this person generally capable of (even if unemployed, retired or doing unpaid domestic duties)? Responses: 0=Capable of full time work, 1=Capable of part time work, 2=Capable only of sheltered work, 3=Totally incapable of work.

3 Accessing community mental health services

The evaluation data linkage included the Mental Health Ambulatory (MH-AMB) data collection through the NSW Ministry of Health. This gives details of community mental health services accessed by CLS-HASI consumers before and after entry to the program including care planning and management, clinical review and assessment and medication activity. Services cover a continuum of care across clinical acute and extended services, early intervention and prevention, and rehabilitation. Based on principle service categories, the community mental health services are around 20% acute clinical, 25% extended clinical, 20% rehabilitation clinical, and around 12% mental health service not otherwise specified. The remainder of services cover consultation assessment, early intervention, and emergency.

Table 4: Number of community mental health contacts by service category

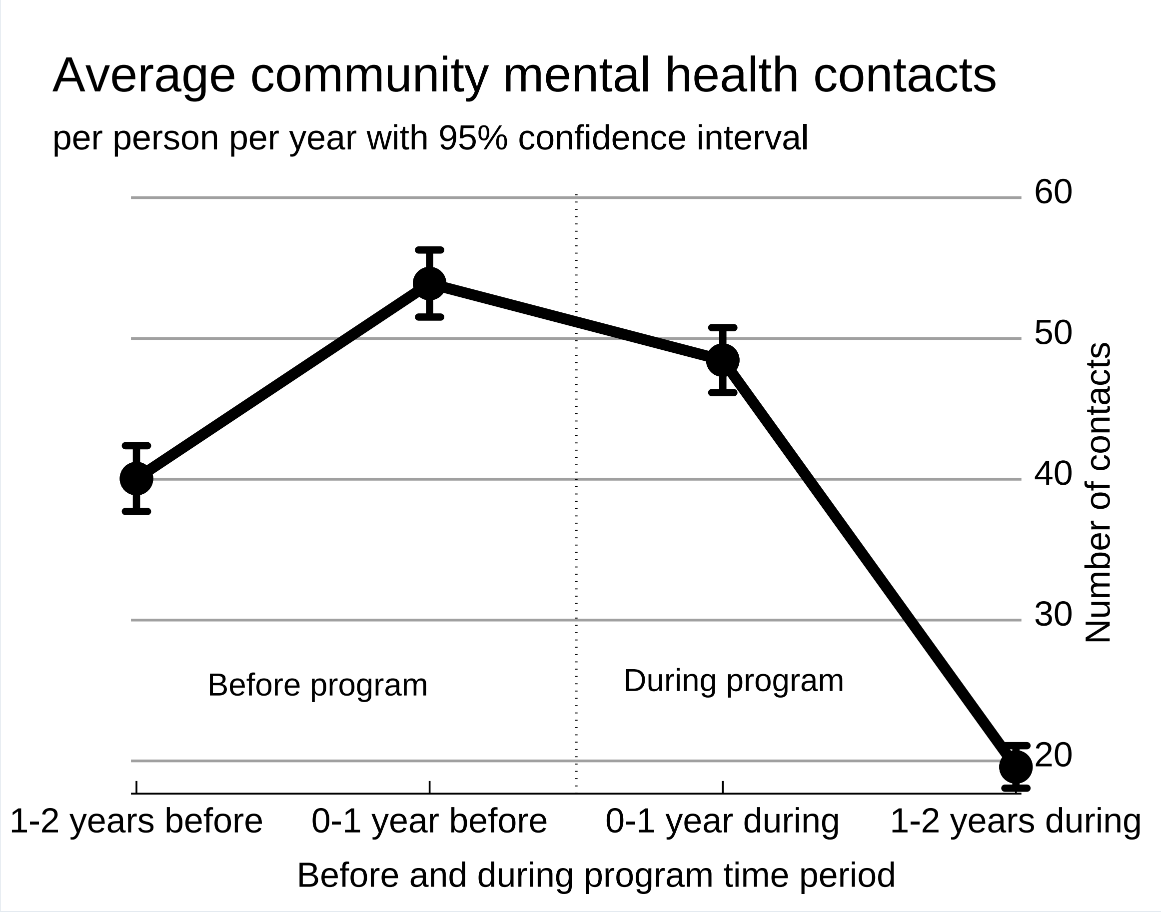
Principal Service Categories	Contacts	%
Extended - Clinical	253,916	28.76
Acute - Clinical	196,935	22.31
Rehabilitation - Clinical	162,855	18.45
Non acute - Clinical/social	70,811	8.02
MH Service not otherwise specified	69,062	7.82
Early Intervention - Psychosis	15,725	1.78
Mental Health Promotion	15,201	1.72
Mental Illness Prevention	14,303	1.62
Rehabilitation - Social	13,231	1.5
Consultation (to a Mental Health Service)	12,389	1.4
Promotion, Prevention or Early Intervention	10,715	1.21
Consultation (to a service unit not fu	10,317	1.17
Emergency/acute - Clinical/social	9,625	1.09
Extended - Social	7,874	0.89
Emergency - Clinical	6,119	0.69
Early Intervention - General	5,363	0.61
Acute - Social	5,344	0.61
Early Intervention - Depression	1,219	0.14
Early Intervention - Anxiety	828	0.09
Research	585	0.07
Emergency - Social	333	0.04
Total	882,750	100

Source: CLS-HASI linked NSW Mental Health Ambulatory Data Collection. n=3,052

The number of times a consumer contacted community mental health services decreased slightly in the first year after entering CLS-HASI by 5.4 contacts (10%), Figure 4. In contrast, the previous HASI evaluation showed an increase in contact in the year following program entry.

In this evaluation, consumers who remained in CLS-HASI longer than 1 year had much less contact with community mental health services than before the programs (63.7%, or 34 fewer contacts, a drop from 53.9 to 19.6 contacts). The decrease may reflect mental health recovery and less need for support

Figure 4: Mental Health Ambulatory contacts per person per year



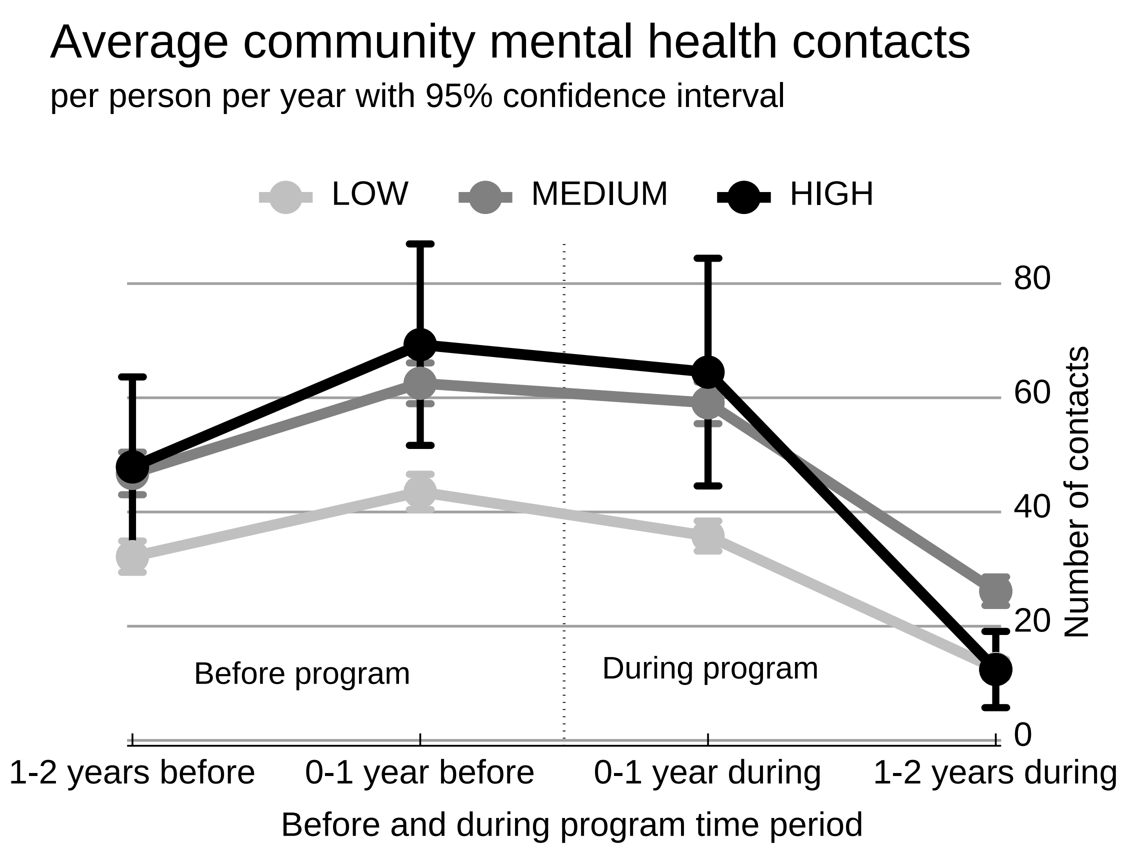
Source: CLS-HASI linked NSW Mental Health Ambulatory Data Collection. n=3,052
Notes: Average contacts with 95% confidence intervals shown as vertical bars.

Male consumers had slightly more community mental health contacts than females although both groups showed a similar trend in significantly decreased contacts in year 2 following CLS-HASI entry. The decrease in contacts in year 2 were significant across all age bands from the highest levels in the 35 to 44 year group to the lower levels for 65 years and over consumers.

By level of CLS-HASI support, low support consumers accessed community mental health services at much lower levels than medium and high support, Figure 5. Medium and high level CLS-HASI support consumers sustained community mental health contact in year 1 around pre program levels (no statistically significant change), compared to the low level subgroup, which decreased by 7.7 contacts per year in year 1 (p<0.001).

The substantial decrease in community mental health contacts in year 2 following CLS-HASI entry was statistically significant across all levels, with the highest decrease in high support consumers with a decline of 80.8% to levels similar to the total study group.

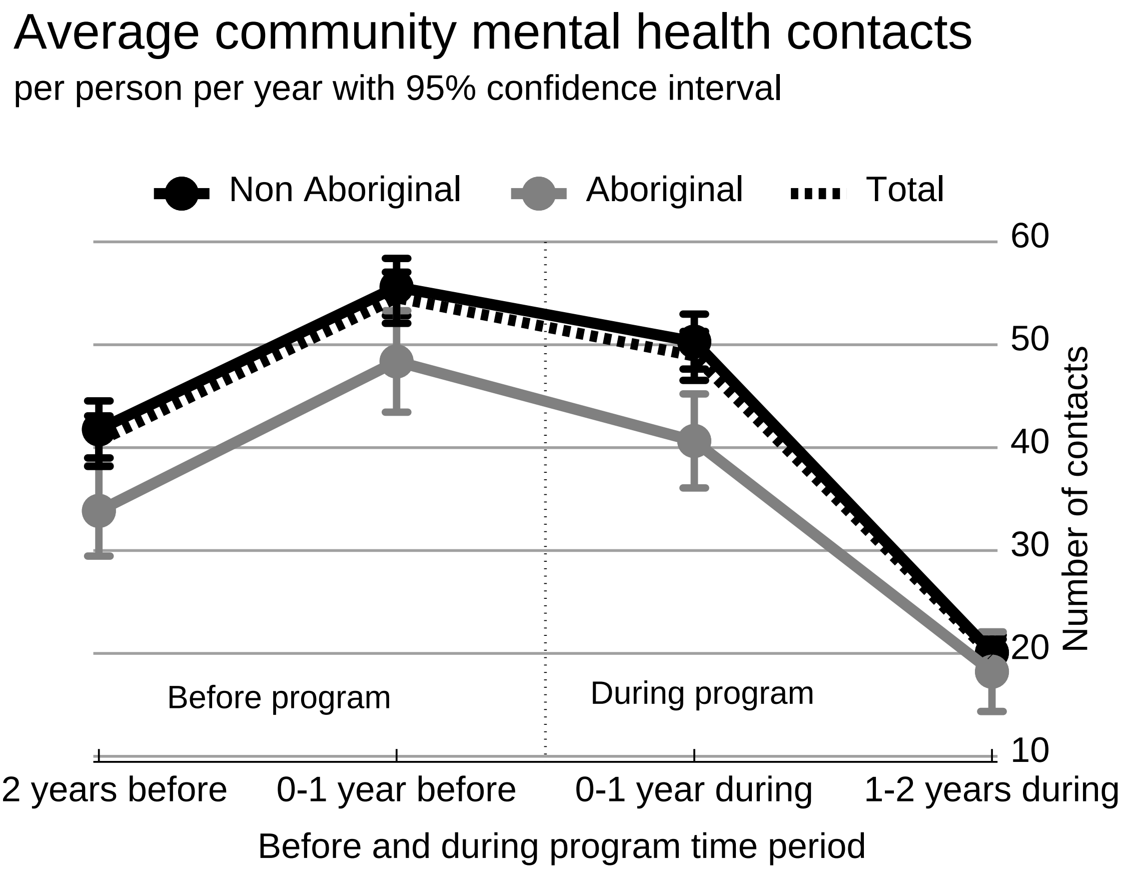
Figure 5: Mental Health Ambulatory contacts per person by level of support



Source: CLS-HASI linked NSW Mental Health Ambulatory Data Collection. n=3,052
Notes: Average contacts with 95% confidence intervals shown as vertical bars.

Aboriginal consumers accessed community mental health at lower levels to non-Aboriginal consumers before and after entry to the program, Figure 6. Aboriginal consumers still reflect a similar decrease in community mental health services in year 1, declining by 7.7 contacts, compared to a 5.3 reduction for non-Aboriginal consumers. Both Aboriginal and non-Aboriginal consumers had sharply lower community mental health contacts in year 2 following CLS-HASI entry, decreasing by 30.2 and 35.5 contacts per year respectively.

Figure 6: Mental Health Ambulatory contacts per person by Aboriginal status



Source: CLS-HASI linked NSW Mental Health Ambulatory Data Collection. n=3,052

Notes: Average contacts with 95% confidence intervals shown as vertical bars.

4 Social inclusion

Recent MDSV2 data show that consumers received almost one hour per month of support for educational or vocational activity or work.[4] This was about the same for different consumer subgroups.[5] In the MDSV2, 81 consumers (1.5%) said they were enrolled in TAFE, 19 consumers (0.3%) were enrolled at University, and 63 consumers (1.1%) said they were in other educational courses.[6] There was no other program or linkage data on consumers' formal learning activities.

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[4] This is a new item in MDSV2 reporting the number of hours spent to support consumers to access educational or vocational activities or work including employment, volunteer work, workshops, short courses, long courses etc.

[5] Total average 0.74 hours per month.

[6] MDSV2 for the final 5 months of the study period. Based on self-reported LCQ education questions; TAFE includes TAFE, Technical or Vocational training; Other courses include job preparation, adult education and hobby courses.

5 Reduced hospital stays

Consumer mental health has been examined across hospital admissions, length of stay as well as the number of involuntary mental health hospital admissions before and after entering the program. This section includes mental health hospital usage, community mental health contacts and mental health outcomes reported through the NOCC. Each health service type is presented as the change in admissions or length of stay for the two years prior and two years following entry to CLS-HASI. Further details of statistical analysis methods are in Appendix 8.

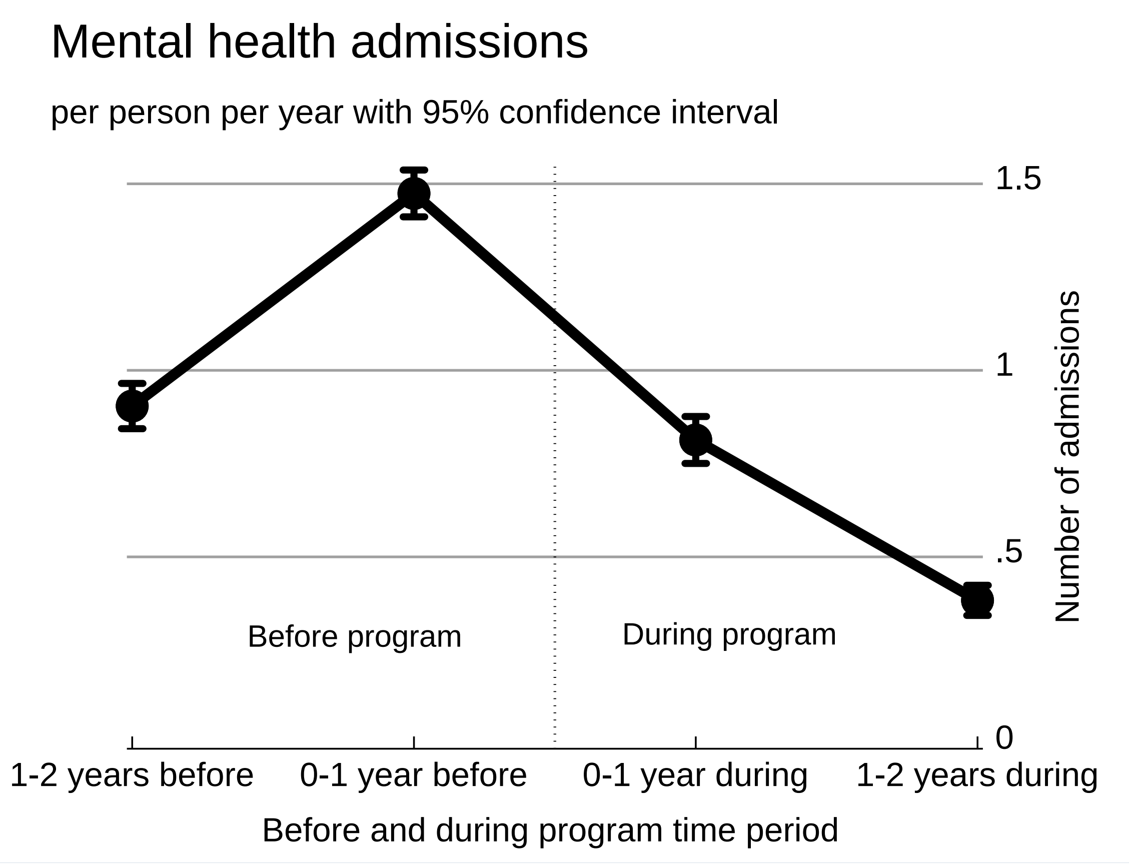
The results are presented in context of the previous HASI evaluation, which showed significant reduction in using mental health services following entry to the programs. This evaluation had substantially larger sample sizes and cross validates previous results. As presented in the methodology, the comparison group was not sufficient to do statistically significant analyses. The figures presented are based on repeated measure longitudinal linked data for the same group of consumers, which is sufficient basis for statistical tests.

The health care figures generally reflect an increased use of services between two years and one year prior to entering the program. Overall, there was a substantial decline in total hospital admissions for consumers following entry, with substantial declines in the first year as well as sustained reductions during the second year.

5.1 Mental health hospital admissions

The number of mental health hospital admissions is an important outcome measure reflecting consumer patterns of escalation and recovery. Mental health hospital admissions decreased significantly in the year following entry to the programs by 44.8%, from 1.5 to 0.8 admissions per person per year. This decrease was statistically significant (p<001, n=3,338). Year 2 showed a further 29% decrease, a total decline of 74% following program entry to 0.4 hospital admissions per year, Figure 7. These results reflect similar findings in the previous HASI evaluations (Bruce et al., 2012; Muir et al., 2006).

Figure 7: Mental health hospital admissions per person per year



Source: CLS-HASI linked NSW Admitted Patient Data Collection (APDC) n=3,338
Notes: Average admissions with 95% confidence intervals shown as vertical bars.

The rates of mental health hospital admissions were separately analysed across study subgroups. Female consumers experienced slightly higher rates of hospital admissions before and after program entry than males. The post program reductions in admissions were separately statistically significant for females and males in line with the overall trend. The gender difference continued across the study period, although the decrease in mental health admissions following entry was similar for male and female consumers. This result is consistent with the previous HASI evaluation, which also reported higher rates of mental health admissions for females (Bruce et al., 2012).

The rates of mental health hospital admission declined significantly across all consumer age groups in the year following program entry. Those under 24 and over 55 years of age declined but not statistically significantly, due to decreased sample sizes in these groups.

Consumers were grouped by level of support defined as low (five hours or less per week), high (five hours per day or more), and medium support as the remaining range between high and low.[7] Total mental health admissions by level of support showed consistent significant post program decreases for low and medium support level groups. High level support consumers showed lower rates of hospital admissions but not statistically significantly different due to higher variation and the smaller study group sample size.

The rates of mental health hospital admissions for consumers of Aboriginal and Torres Strait Islander origin (Aboriginal) decreased significantly following program entry, consistent with the overall study group. Although the rate of admissions for Aboriginal consumers showed a similar decrease after entering the program, the average length of stay for those admitted to hospital was lower for Aboriginal consumers as presented in the following section.

5.2 Total number of days in hospital

When consumers were admitted to hospital due to mental illness, the average number of days in hospital decreased, **Figure 8**, black line. The number of days fell by 52.2% per person in year 1 following program entry, from 49.4 to 23.6 days. This is statistically significant ($p<0.001$). Those consumers who stayed in CLS-HASI into year 2 had a further 22.6% fewer hospital days down to an average of 12.4 days per person per year. This is a total decrease of 74.8%. The decrease is similar to findings in the previous HASI evaluation (Bruce et al., 2012).

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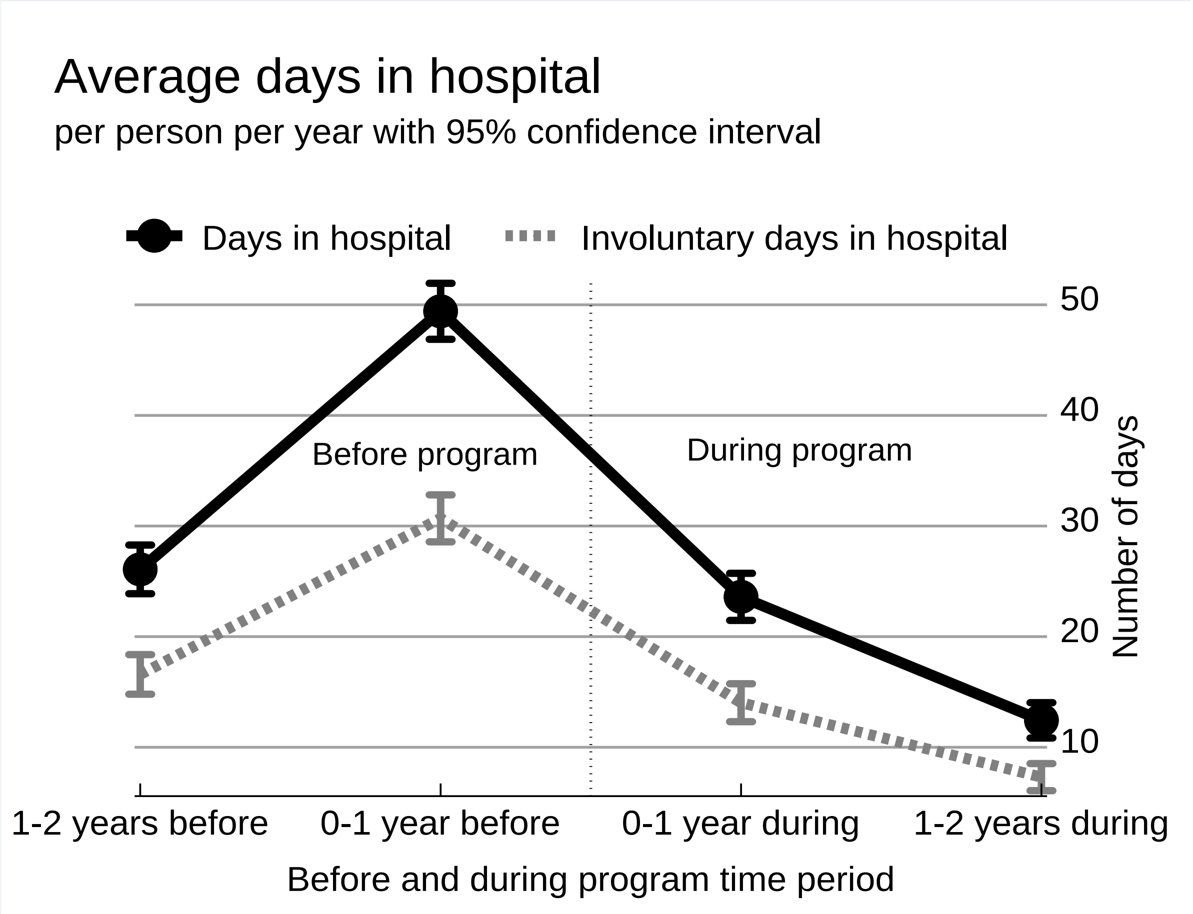
[7] level of support changes for consumers during their time in the program in line with need. The level of support groups presented in this section are based on average level of support per consumer during their time in the program.

Figure 8: Mental health inpatient days before and during program



Source: CLS-HASI linked NSW Admitted Patient Data Collection (APDC) n=3,338
Notes: Average inpatient days with 95% confidence intervals shown as vertical bars.

The number of involuntary[8] days in hospital also became lower once a person entered CLS-HASI. Of the average 49.4 mental health hospital days in the year prior to program entry, 30.7 days were involuntary (62%), **Figure 8** dotted line. There was a significant decrease of 54.3% in year 1 following entry to the program from 30.7 to 14.0 days. Involuntary hospital days reduced a further 21.9% for consumers who stayed in the program into year 2. This represents a total decrease of 76.2% to 7.3 days per person per year.

The pattern of reduced days in hospital after entering the programs was separately examined across study subgroups. Male and female consumers had similar significant decreases in mental health inpatient days following CLS-HASI entry. In line with the decline in hospital admission rates by age group, the decrease in days in hospital per year decreased significantly across all consumer age groups in the year following program entry.

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[8] Whole or part days that the person was an involuntary patient under the Mental Health Act.

Average mental health hospital days decreased significantly following program entry across all support level groups, Table 5.

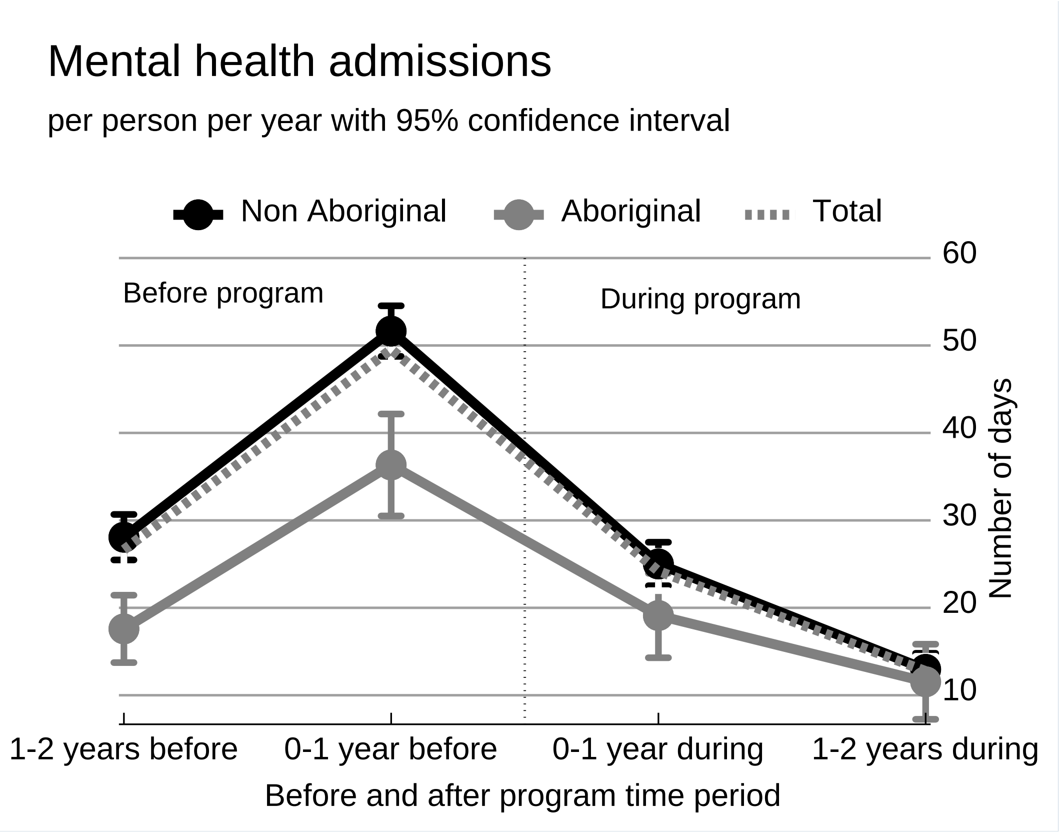
Table 5: Change in mental health inpatient days per person by level of support

Level of support	Change	p-value	95% confidence intervals	
			upper	lower
Low	- 25.6	<0.001	- 29.8	- 21.6
Medium	- 33.0	<0.001	- 37.8	- 28.3
High	- 29.2	<0.001	- 45.2	- 13.2

Source: CLS-HASI linked NSW Admitted Patient Data Collection (APDC) n=3,338
Note: First year post entry based on year prior to entering the program.

Although the reduced post program rates of total hospital admissions for Aboriginal consumers were consistent with the overall study group, the average number of days in hospital were substantially lower for Aboriginal consumers before and after program entry compared to non-Aboriginal consumers, **Error! Reference source not found.** Both Aboriginal and non-Aboriginal consumer days in hospital decreased significantly following entry to the CLS-HASI programs by 26.6 and 17.22 days respectively.

Figure 9: Total hospital days per person per year by Aboriginal status



Source: CLS-HASI linked NSW Admitted Patient Data Collection (APDC) n=3,338
Notes: Average inpatient days with 95% confidence intervals shown as vertical bars.

5.3 Involuntary mental health hospital admissions

Within the mental health inpatient days in hospital a substantial proportion of admissions to psychiatric units were reported as involuntary. [9] Of the average 49.4 mental health hospital days in the year prior to program entry, 30.7 days were involuntary (62%), Figure 8, dotted line. There was a significant decrease of 54.3% in average involuntary admitted days in year 1 following entry to the program from 30.7 to 14.0 days. Involuntary hospital days reduced a further 21.9% for consumers who stayed in the program into year 2, a total decrease of 76.2% to 7.3 days per person per year.

In line with the total decline in mental health days following entry to the program, involuntary days decreased significantly across consumer subgroups. The decreases were consistent for male and female consumers, across all age groups and by level of support. The number of involuntary days for Aboriginal consumers was again lower before and after program entry but still decreased significantly following program entry.

5.4 Emergency department presentations

This section presents consumer emergency department presentations before and after entry to the CLS-HASI programs. As noted in the previous HASI evaluation, the use of emergency departments generally indicates an urgent episode and is likely to occur more frequently if mental health care is not being received or is or is not suitable for a consumer (Bruce et al., 2012).

In line with previous sections the emergency department linked data analyses covered two years prior and two years post program entry and examined consumer subgroups by gender, age group, level of program support and Aboriginal status.

The escalation to an emergency department episode at a time of crisis is reflected in the high proportion of consumers that arrive by police or correctional service vehicles, around 47% of total presentations. A high number arrived by private car, around 41% with only a small proportion (around 2%) arriving by ambulance or hospital transport. Around three quarters of all emergency department presentations

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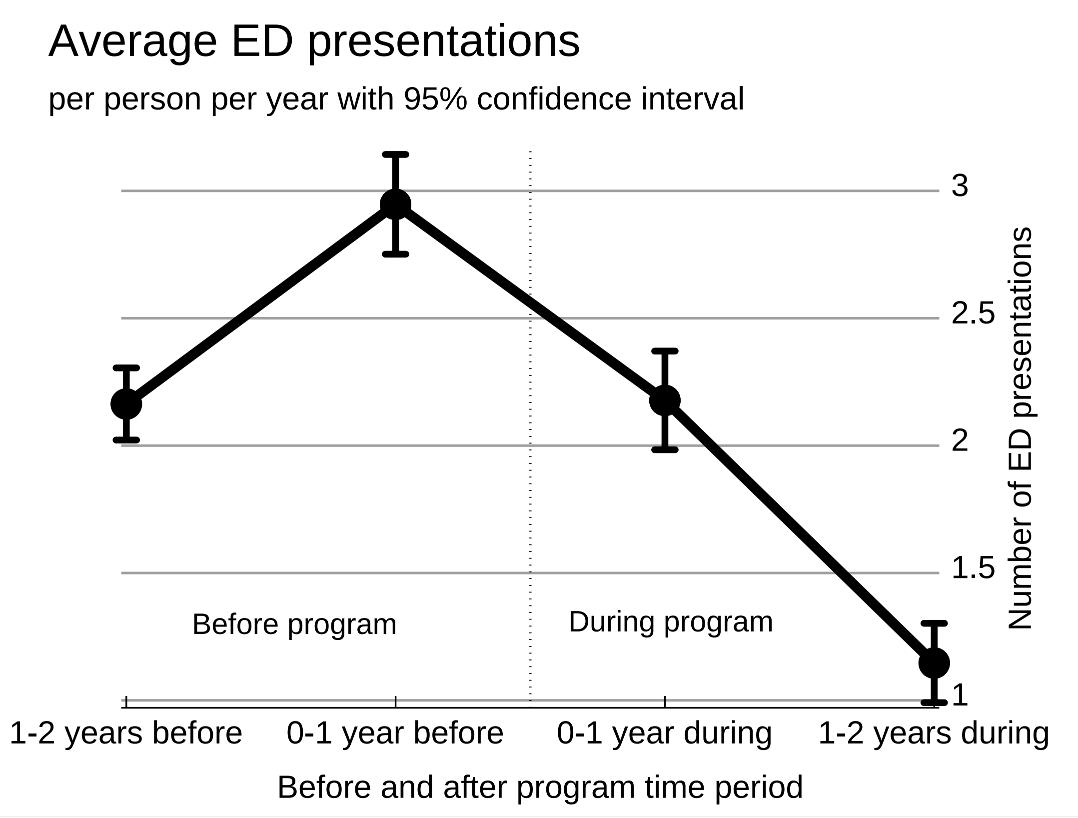
[9] Reported in admitted patient linked data as the number of days or part days of the episode of care that the person was an involuntary patient under the Mental Health Act, minus the sum of leave days occurring during the episode.

resulted in a hospital admission (25%) or transfer to another hospital (51% of total contacts).

The pattern of emergency department presentations showed an increase in the year prior to program entry, possibly reflecting escalating mental health status, followed by a significant decrease in presentations after entry to the program, Figure 10. At ED presentation around 25% of consumers were diagnosed with a mental health or behavioural disorder.[10] During the time consumers were in the programs, the number of ED presentations decreased by 26.1% in year 1 following entry to the program from 2.9 to 2.2 per person per year ($p<0.001$). This decrease extended a further 35% in year 2 following entry to 1.1 presentations, a total decrease of 61.1%.

This trend reflects similar significant decline in rates of hospital admissions and number of admitted days and is consistent with the previous HASI evaluation, which reported a decline in ED presentations following entry to the HASI program, from 2.8 to 1.7 per person in the year following program entry.

Figure 10: Emergency department presentations before and after program entry



Source: CLS-HASI linked NSW Emergency Department Data Collection (EDDC) n=4,192
Notes: Average ED presentations with 95% confidence intervals shown as vertical bars.

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[10] Based on ICD-10 analysis codes (Mental health and behavioural disorders F00-F99).

Female consumers presented to ED slightly more frequently than males but still decreased significantly following entry to the programs. Decreases across age groups reflected high variation, with the most significant declines in the 45 to 54 years and 65 and over age bands. By level of support most consumers in the low and medium groups decreased in line with the total study decline. While low and medium level support consumers have similar ED deceases post entry, high level support consumers had fewer ED presentations prior and following entry and the rate of presentations did not decrease following entry.

Consumers identifying as Aboriginal had higher numbers of ED presentations before and after program entry with higher variation. Although ED contacts decreased following program entry, they remained above non-Aboriginal consumers. Further details are in the Aboriginal focus report.

The data linkage includes healthcare activity following exit from the CLS-HASI programs. Supplementary analysis was undertaken including ED presentations following program exit, to examine whether the reduced ED activity was sustained post program. This shows that stabilised healthcare levels are sustained following exit, although not at as low levels reported during time in the program. When data was included for activity following program exit, the total number of ED presentations decreased by 19.9%, compared to the during program decline of 26.1%. The decrease was also lower in year 2 when post exit activity was included, with a 28.8% decline compared to 35% for during program data. This indicates that the reduced emergency department use is sustained following program exit well below the level occurring before entry to the CLS-HASI programs.

6 Safe and secure housing

Supporting stable housing is a central element of the CLS-HASI programs to offer a secure setting for consumers to improve and sustain their mental health. Stable housing may then prevent or reduce the risk of declining mental health impacting ongoing tenancy which may result from employment stability, hospital admission, antisocial behaviour or contact with the Justice system.

The data linkage includes CLS-HASI consumer contact with NSW DCJ Housing for consumers accessing housing services across tenancy, waitlists and other housing product supports. The program MDS profiles indicated around 43% of consumers were accessing social housing at entry to the programs. The DCJ Housing linkage extends the program housing profile reported through the MDS in level of public housing detail and importantly to show retrospective pathways to examine services before and after accessing the program.

Based on the housing data linkage, around 17% of consumers were public housing tenants on entry to the programs.[11] Many consumers had been tenants for several years with a average tenancy period of 6.6 years at entry. The analysis focused on the two years prior and two years post entry to examine the impact of the programs. This gave a sample of around 28% of consumers who had a change in status of their waitlist or housing outcome during the study period and before and after CLS-HASI entry (n=1,539).

6.1 Accessing housing

The housing data include details on types of services accessed, waitlist registers across priory lists, as well as the status of changes in applications. There was a significant increase in the number of consumers registered on housing waitlists following entry to the CLS-HASI programs, Table 6. The increases were consistent across housing registers (denoted HR) as well as transfer registers (TR), although contact was predominantly (83%) for new applications. The number of DCJ Housing applications increased from 465 in the year prior to 711 in the year following entry to the program. In addition to general housing register applications, most consumers were placed on priority registers including priority homeless, priority medical, priority at risk and priority disability.

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[11] 929 consumers of the study group of 5,533 = 16.8%

Table 6: Housing register contacts by category before and after program entry

Application category	2 years prior	1 year prior	1 year post	2 years post	Total %
HR General	72	116	169	76	24.7%
HR Priority Homeless	42	58	102	19	12.6%
HR Priority Medical	16	39	84	36	10.0%
HR Priority at Risk	15	52	74	19	9.1%
HR Priority Disability	12	25	48	22	6.1%
HR General Medical	10	21	38	19	5.0%
TR Medical	19	21	32	10	4.7%
HR General Disability	8	18	27	22	4.3%
HR Priority Tenancy Reinstatement	14	22	24	11	4.0%
TR Escalated Severe Medical Condition	16	11	23	10	3.4%
TR Escalated at Risk	9	15	15	11	2.8%
HR Priority Transfer	5	10	16	9	2.3%
HR Community Housing Transfer	5	9	12	9	2.0%
TR Escalated Relocation Portfolio	6	6	7	9	1.6%
Other	30	42	40	18	7.4%
Total	**279**	**465**	**711**	**300**	**100.0%**

Source: CLS-HASI linked NSW Department of Communities and Justice Housing. n=1,539
Notes: HR=Housing Register. TR = Transfer Register. UC=under occupancy. Cell values less than 5 shown as <5 to protect confidentiality. Total contacts reported greater than consumer sample due to multiple applications over time for some consumers.

The changes in DCJ Housing applications mostly occurred shortly following entry to the program, reflected in the lower number of contacts in year 2 post entry. Some consumers had multiple applications for changed circumstances or transfers, resulting in the higher number of contacts than consumers (1,755 applications for the study sample of 1,539 consumers).

Following the increased numbers of consumers being placed on housing register waitlists there was also a corresponding increase in housing status following entry to the CLS-HAS program, Table 7. Of the 711 consumers on waitlists in the year following program entry, the number housed also increased, with over half reported as DCJ Housing tenants or housed by community housing providers. Most consumers receiving housing in year 1 were on a priority waitlists (67.3%), with around 15% housed through each of the general housing register and transfer register. The increase in eligible housing registers was the pathway for 249 consumers to establish public housing tenancy in the year following program entry.[12] Priority waitlist consumers were housed in year 1 after an average wait time of 9.7 months, substantially faster than reported general waitlist times.

Table 7: Housing register contacts by status before and after program entry

Application status	2 years prior	1 year prior	1 year post	2 years post	Total %
Housed	201	262	318	101	50.3%
Active/Live	46	137	260	137	33.0%
Housed by other Housing Provider	26	44	74	33	10.1%
Suspended for a Period	6	17	57	27	6.1%
Other	<5	<5	<5	<5	0.5%
Total	**279**	**465**	**711**	**300**	**100.0%**

Source: CLS-HASI linked NSW Department of Communities and Justice Housing. n=1,539
Notes: Cell values less than 5 shown as <5 to protect confidentiality. Total number reported greater than consumer sample due to multiple applications over time for some consumers.

In line with previous outcome sections, the changes in DCJ Housing contacts were separately analysed across program subgroups. As described in the methodology regression analyses are adjusted for the time each consumer was in the programs to give comparable rates of change in housing applications before and after entry to the CLS-HASI programs. The average number of contacts per person per year increased statistically significantly by 45.3% in the year following entry to the program from 0.28 to 0.41 (p<0.001), **Figure 11**.

The increase in DCJ Housing applications in year 1 post program was consistent across all subgroups. Consumers showed consistent increased contacts across gender and all age groups in year 1 following program entry, except for 65 years and over. Low and medium level support consumers showed similar significantly increased housing applications post entry, but high support consumers did not increase following entry. Aboriginal consumers showed a higher statistically significant increase in housing applications in year 1 following CLS-HASI entry (increased 0.23 to 0.49), above rates of non-Aboriginal consumers (increased 0.10 to 0.49), **Figure 12**.

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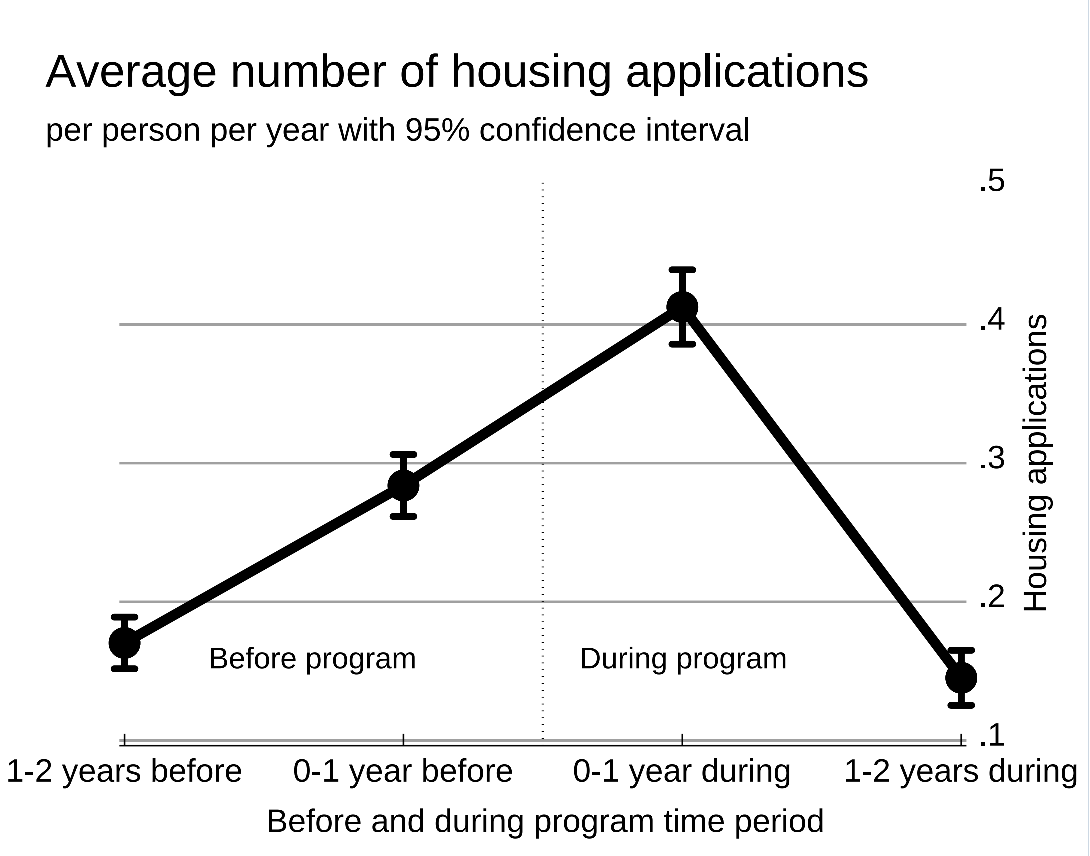
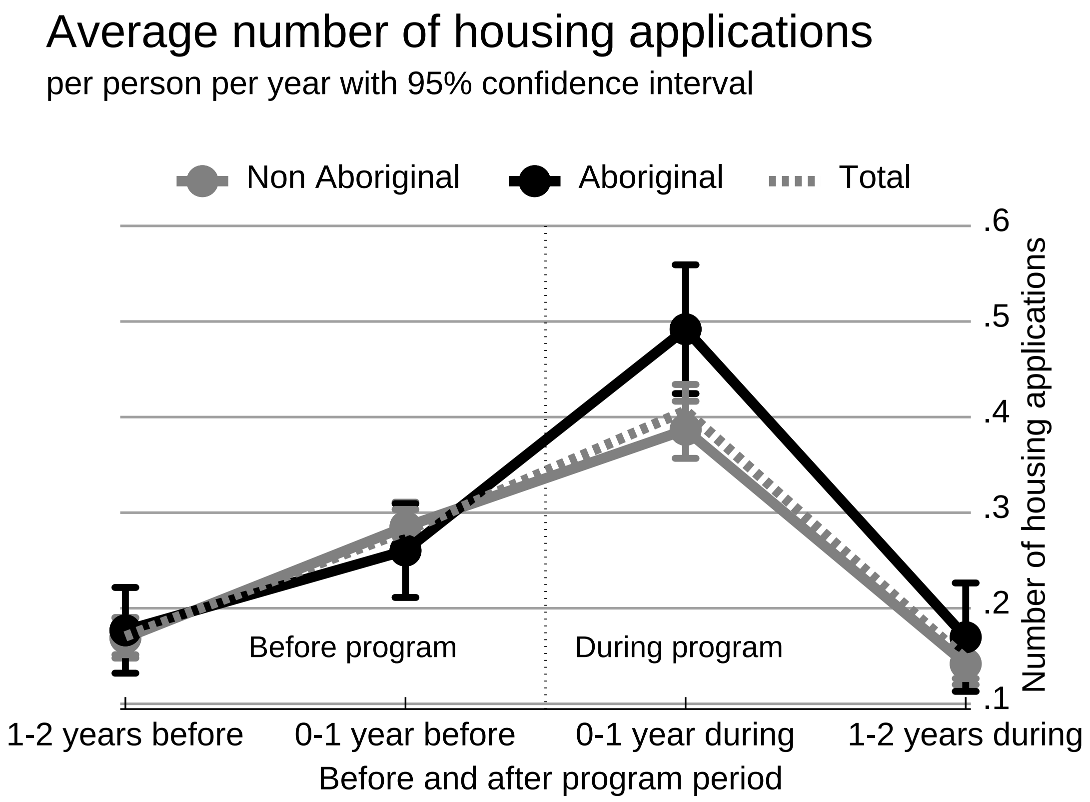
[12] Housed status of 318 in year 1 is based on housing register data covering total change across housing and transfer applications. Tenancy start and end date data show 249 new tenancies in year 1.

Figure 11: Average housing applications before and during program



Source: CLS-HASI linked NSW Department of Communities and Justice Housing. n=1,539
Notes: Average contacts with 95% confidence intervals shown as vertical bars.

Figure 12: Average housing applications before and during program by Aboriginal status

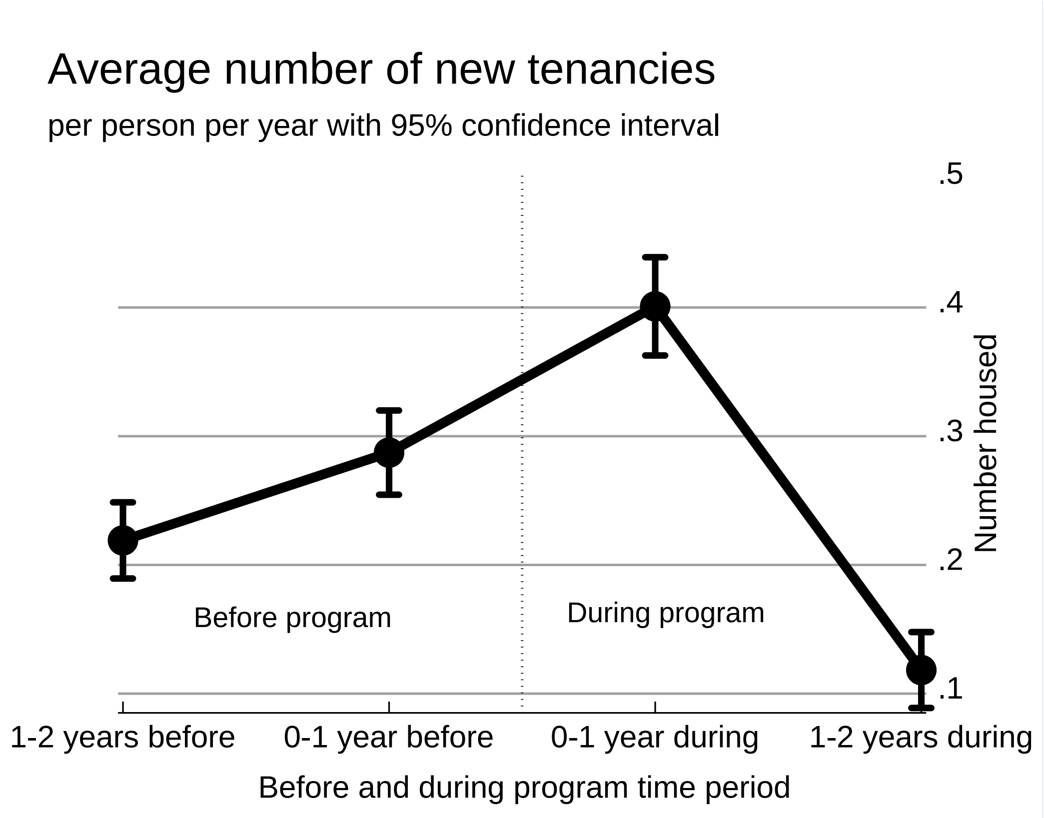


Source: CLS-HASI linked NSW Department of Communities and Justice Housing. n=1,539 (Non-Aboriginal n=1141, Aboriginal n=301, Aboriginal status not known n=97)
Notes: Average contacts with 95% confidence intervals shown as vertical bars.

New public housing tenancies increased by 39.6% following entry to the CLS-HASI programs from 0.29 to 0.40 per person per year ($p<0.001$),**Figure 13**. The increase in the rate of new tenancies was consistent across gender and statistically significant for younger people 19 to 25 years and the 35 to 54 year age groups. Other age groups showed modest increases but not statistically significant.

Low and medium support level consumers showed similar increases in new tenancy rates. Consistent with no increased housing applications for high support consumers, there were no new public housing tenancies at all for this higher complexity group of consumers.

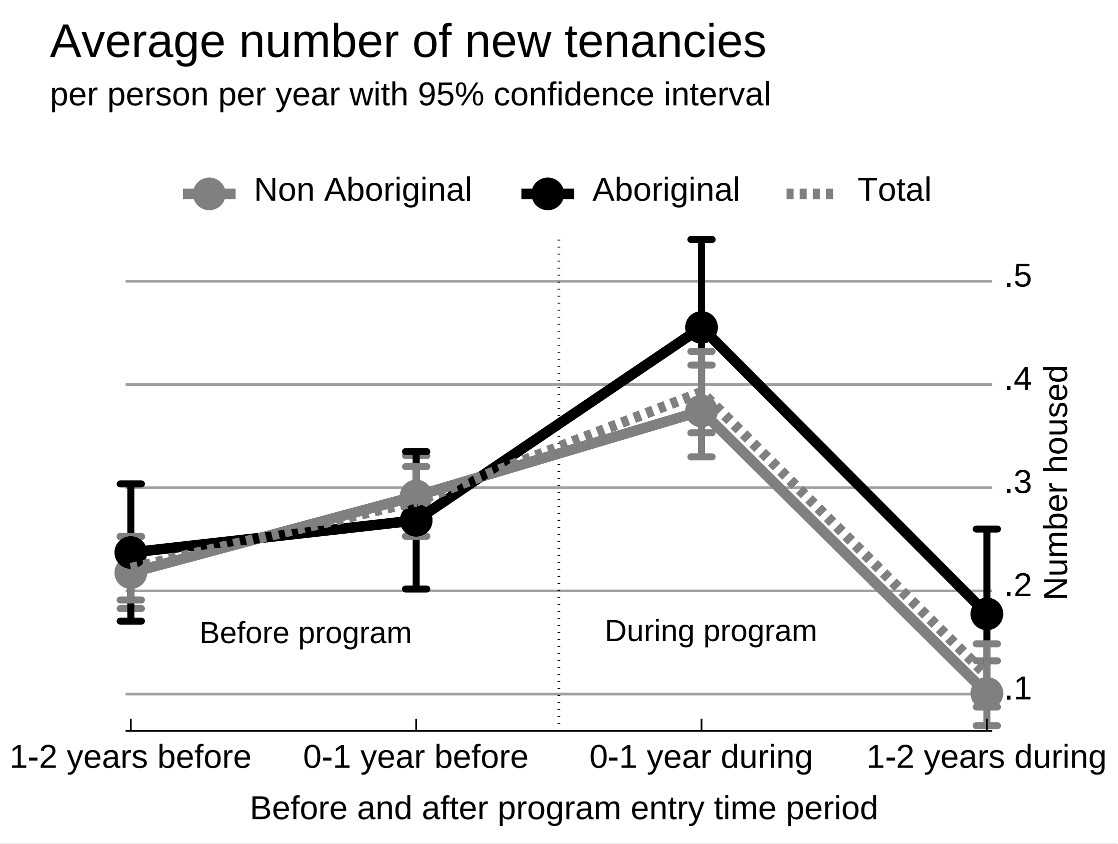
Figure 13: New public housing tenancies per person before and during program



Source: CLS-HASI linked NSW Department of Communities and Justice Housing. n=657
Notes: Average contacts with 95% confidence intervals shown as vertical bars.

In line with the higher increase in public housing applications for Aboriginal consumers, there was a corresponding higher rate of tenancies that commenced during the first year following entry to CLS-HASI, **Figure 14**. Aboriginal consumers increased 0.19 to 0.46 new tenancies per person compared to a more moderate increase among non-Aboriginal consumers, both statistically significant.

Figure 14: New public housing tenancies per person by Aboriginal status



Source: CLS-HASI linked NSW Department of Communities and Justice Housing. n=657 (Non-Aboriginal n=1141, Aboriginal n=301, Aboriginal status not known n=97)
Notes: Average contacts with 95% confidence intervals shown as vertical bars.

6.2 Maintaining housing

Program consumers also accessed additional DCJ housing support including 68 rental bonds in year 1 following program entry, a slight decline from the year prior to entry. Private Rental Subsidies (PRS) were received by 17 consumers, an increase from 8 for the year prior to CLS-HASI entry. Private Rental Subsidies give eligible consumers medium-term accommodation until an offer of social housing occurs. Eight consumers also accessed assistance for rental arrears in year 1 post entry as well as 5 consumers supported through Start Safely, the DCJ Housing program to support victims of family and domestic violence.

Program reporting introduced with MDSV2 additionally includes consumers resident in public housing receiving an anti-social behaviour warning or strike during the reporting period. Only 2 consumers received a warning, no consumers received a strike.[13]

6.3 Public housing exits and reasons for vacating

Separate from the number of new public housing tenancies, the linked housing data gives details of public housing tenancy exits and the reasons for vacation, Table 8. Tenant initiated exits increased in the year following CLS-HASI entry, presumably reflecting transition to more suitable accommodation. Vacation related to medical, mobility and disability as well as well as at risk or due to harassment reduced substantially following entry to the CLS-HASI programs.

Table 8: Housing tenancy reasons for vacating before and after program entry

Reason for vacation	2 years prior	1 year prior	1 year post	2 years post	Total %
Tennant initiated exit - required notice	19	17	21	4	29.0%
Tennant initiated exit - short notice	<5	<5	10	<5	7.6%
Transfer - Medical, mobility and disability	6	8	0	<5	7.1%
Transfer - at risk / harassment	5	8	<5	0	6.7%
Other	30	36	32	6	49.5%
Total	62	72	<65	12	100.0%

Source: CLS-HASI linked NSW Department of Communities and Justice Housing. n=657
Notes: Cell values less than 5 shown as <5 to protect confidentiality. Total ‘other’ figure aggregated for 27 vacation reason codes, all with fewer than 5 cases each.

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[13] DCJ Housing have established a warning and strike system for antisocial behaviour where a third strike results in accommodation notice of termination.

7 Reduced criminal offences

Escalation of mental health episodes may result in situations that lead to contact with police and the corrective services system. For this reason, the CLS-HASI data linkage included the NSW Bureau of Crime Statistics and Research's (BoCSAR) Reoffending Database (ROD) covering finalised legal actions within the NSW Criminal Justice System. Additionally, program linkage was undertaken with content from the NSW Department of Communities and Justice Offender Inmate Management System (OIMS) to include community based correctional orders.[14] This section presents criminal justice and community corrections outcomes for consumers prior to and following entry to the program.

Non custodial sentences are sentences imposed on a defendant that do not involve being held in custody. This category includes: suspended sentences, intensive corrections orders, community supervision or work orders, fines, and other non-custodial orders.

This data summary relates only to Community Correction Orders (CCOs) within the OIMS dataset. Other custodial data are already included in the CHeReL linkage through the BoCSAR routinely updated collection. (Note: Data only for CCOs supervised by NSW Corrective Services)

Community Correction Order (CCO) with/without supervision: On 24 September 2018, CCOs replaced Community Service Orders and good behaviour bonds. Courts can use CCOs to punish offenders for crimes that do not warrant imprisonment or an ICO, but are too serious to be dealt with by a fine or lower level penalty. CCOs are served in the community for up to three years and the court may impose one or more of the following conditions: supervision, community service work (up to 500 hours), curfew (<12 hours daily), program treatment, alcohol/drug abstention, non-association or place restriction.

7.1 Charges in the criminal justice system

NSW corrective service custodial and non-custodial offences decreased dramatically following entry to the CLS-HASI programs from around 0.8 offences per person in the year prior to entry to almost zero, **Figure 15**. There was a total of 830 offences committed by 401 consumers over the two years prior and post entry.

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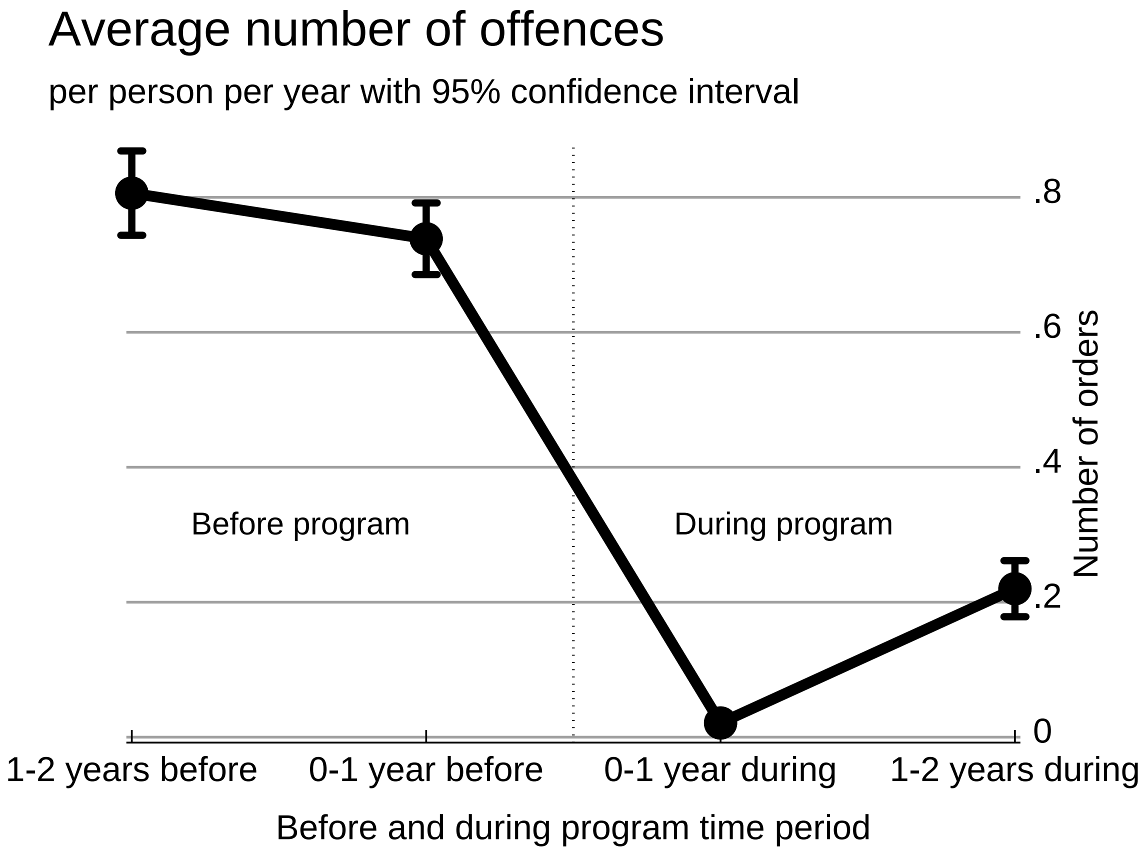
[14] Formerly the NSW Department of Corrective Services

Figure 15: Average number of charged offences before and during program entry



Source: CLS-HASI linked NSW Bureau of Crime Statistics and Research's Reoffending Database (ROD). n=401
Notes: Average number of offences with 95% confidence intervals shown as vertical bars.

The analysis is based on principal offences considered during a court appearance, which in some cases includes secondary minor offences.[15] The number of offences per person were similar for men and women in the year prior to program entry, although offences committed by men declined slightly from the earlier second year prior to entry. Of the total linked sample (n=401), men accounted for around 70% of total offences (n=279) and woman around 30% (n=122). The decrease per person following entry to the programs was remarkable and statistically significant for male (0.73) and female (0.69) consumers (p<001), Table 50.

Of the total offences committed, around 80% resulted in a guilty outcome and around 15% resulted in mental health dismissals. The remaining small number of cases were withdrawn or found not guilty. Court rulings imposed fines in around 25% of cases and 12% of outcomes resulted in a prison sentence, Table 9. There were

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[15] ROD data used is based on court appearances where at least one offence was proven. The linked records use the Principal Offence determined from the most serious penalty in that court matter.

around 10% of cases resulting in a supervised bond and 10% in unsupervised bonds.

Table 9: Number and type of penalty before and after program entry

Type of penalty	2 years prior	1 year prior	1 year post	2 years post	Total %
Fine	118	76	<5	10	24.7%
No penalty	72	88		6	20.0%
Imprisonment	59	36		<5	11.9%
Bond with supervision	55	32		<5	10.6%
Bond without supervision	46	32		<5	9.6%
Other penalties	23	25	<5	5	6.5%
Conviction only	15	15		<5	3.9%
Bond without conviction without supervision	15	10		<5	3.1%
Suspended sentence with supervision	11	7			2.2%
Community Correction Order with supervision	<5	12	<5	<5	1.8%
No conviction recorded	6	6		<5	1.7%
Juvenile probation order	8	<5			1.3%
Pre-reform or Children's Community Service Order	6	<5			1.0%
Juvenile control order	5	<5			0.8%
Suspended sentence without supervision	6	<5			0.8%
Total	**446**	**347**	**<5**	**34**	**100.0%**

Source: CLS-HASI linked NSW Bureau of Crime Statistics and Research’s Reoffending Database (ROD). n=401

Notes: Cell values less than 5 shown as <5 to protect confidentiality. Total offences greater than number of consumers due to multiple orders per person in some cases. Not guilty outcomes are shown as no penalty.

The decline in offences following entry to the programs was consistent across age bands and level of program support. Although high level support is a small subgroup there were no offences reported post program for high support consumers. The decline in offences after entering the programs was also consistent for Aboriginal and non-Aboriginal consumers with similar outcomes for both groups.

Separate analysis was undertaken to include corrective services data after exit from the programs. This showed the decreased rates of offences in year 2 following program entry were still reduced when post program exit offences were included but not by as much as during program support. From the near zero level in year 1 during program support, the year 2 average number of offences declined 0.3 per year compared to 0.5 during program support (to around 0.4 offences per year compared to 0.2).

The fines were an average of around $530 for those imposed prior to program entry. In addition to having almost no fines in the year following entry, the average cost of fines declined to around $320.

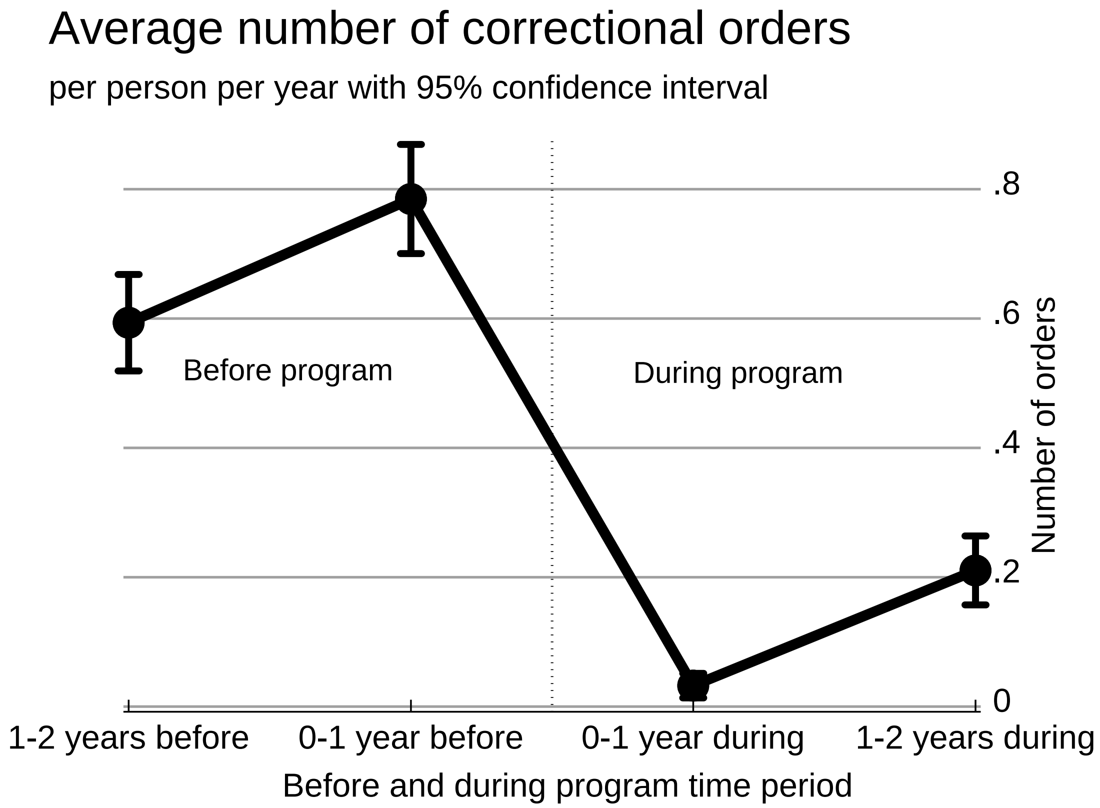
Prison sentences were around 10 months on average with substantial variation from two weeks to 2.5 years.

7.2 Community corrections orders

The CLS-HASI data linkage included the NSW Offender Inmate Management System (OIMS) covering details of community based correctional orders. For minor types of offences consumers may be placed on various types of court or police based community corrective orders for crimes that do not warrant imprisonment but are too serious to be dealt with by a fine or lower level penalty.

Of the total study group (n=5,533), 185 consumers were placed on a correctional order within the two years prior or two years post program entry (3.3%). Orders were separately identified for those commencing while consumers were in the program and those that commenced following exit from CLS-HASI. As for all pre and post program regression, analyses the number of months each consumer remained in the program was used to calculate exposure time for rates per person per year to adjust for variation of consumer program support periods.

Figure 16: Average number of correctional orders pre and post program entry



Source: CLS-HASI linked NSW Offender Inmate Management System (OIMS). n=185
Notes: Average number of orders with 95% confidence intervals shown as vertical bars.

In line with the substantial decrease in correctional service offences, community correction orders declined significantly to almost zero following CLS-HASI program entry (**Figure 16**). The number of orders pre program and the significant decrease following entry was similar for male and female consumers as well as low and medium support level. There were no high level support consumers placed on corrective orders during the programs, 4 received orders following exit. Aboriginal consumers received a slightly higher number of orders but not significantly different to non-Aboriginal and both groups had a similar decline following program entry.

As for offence linked data correctional orders were examined to include events following exit from the program. There was a similar pattern for correction orders where the first year following program entry were similarly near zero and year 2 was reduced when post exit events were included, but not by as much as during program support (Average number of year 2 orders were 0.5 compared to 0.2 during program support).

Table 10: Number of correctional orders by type before and after program entry

Order description	2 years prior	1 year prior	1 year post	2 years post	Total %
Good Behaviour Bond	67	62			36.2%
Parole - Court Based	39	67			29.8%
Community Correction Orders	10	28	<5	<5	12.1%
Suspended Sentence	16	14		<5	8.7%
Parole - SPA	5	11			4.5%
Community Service Order	<5	8			3.1%
Intensive Correction Order		<5	<5	<5	2.2%
Extended Supervision		6		<5	2.0%
Drug Court Order	<5				<1.4%
Conditional Release Orders		<5			<1.4%
Home Detention		<5			<1.4%
Total	**143**	**200**	<5	**10**	100.0%

Source: CLS-HASI linked NSW Offender Inmate Management System (OIMS). n=185
Notes: SPA=NSW State Parole Authority. Cell values less than 5 shown as <5 to protect confidentiality. Total orders greater than number of consumers due to multiple orders per person in some cases.

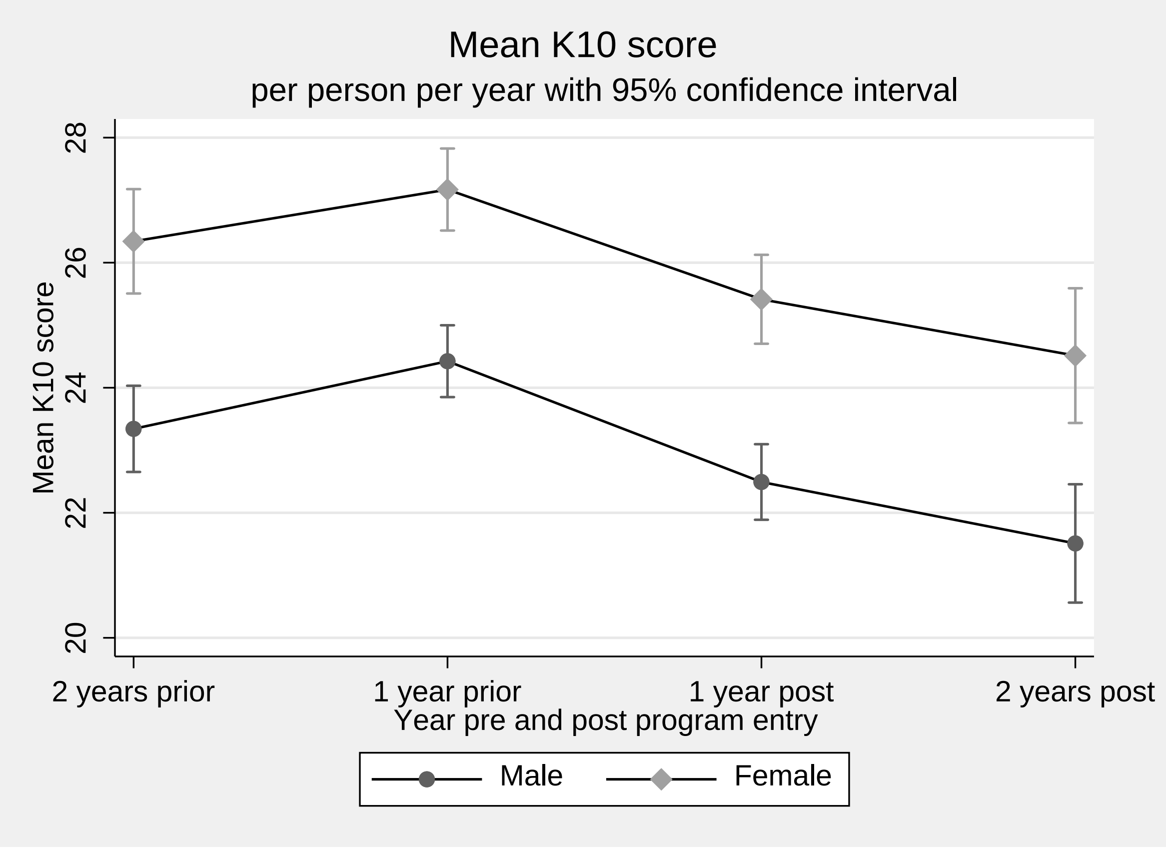
The types of offence leading to correctional orders were highly varied but were predominantly related to types of assault, damage to property, contravene apprehended violence order (AVO), minor theft or drug and alcohol offences. The few correctional orders placed in the year following program entry were minor failure to comply reporting breach or resist officer in execution of duty. The 10 orders reported in year 2 post program related to assault, theft and a driving offence.

The data included reporting of Level of Service Inventory – Revised (LSI-R) scores, an assessment tool for offenders to classify an offender's risk of re-offending. The LSI-R scores showed that over half of total orders (54.2%) were rated high or medium high risk of reoffending, but the low number of orders in the year following CLS-HASI entry were rated at lower medium risk and only around 1% were high or medium risk in year 2 post program entry.

8 Data linkage supplementary results

8.1 Mental health outcomes from linked MH-OAT data - K10

Figure 17: Average K10 scores per person, before and after program entry by gender



Source: CLS-HASI linked NSW Mental Health Outcomes and Assessment Tools (MHOAT), n=1,579

Table 11: Change in mean K10 scores per person per year

Study period year		Change	p-value	95% confidence interval			
2 years prior	-	0.98	<0.001	-	1.67	-	0.29
1 year prior (base)							
1 year post	-	1.81	<0.001	-	2.45	-	1.17
2 years post	-	2.72	<0.001	-	3.56	-	1.87

Source: CLS-HASI linked NSW Mental Health Outcomes and Assessment Tools (MHOAT), n=1,579

Table 12: Change in mean K10 scores in year following entry to program by age group

Age group	Change	p-value	95% confidence interval	
19 to 24	- 3.60	0.001	- 5.72	- 1.48
25 to 34	- 1.45	0.033	- 2.79	- 0.12
35 to 44	- 1.27	0.049	- 2.54	- 0.00
45 to 54	- 1.47	0.033	- 2.82	- 0.12
55 to 64	- 2.43	0.004	- 4.06	- 0.80
65 and over	- 3.76	0.014	- 6.76	- 0.76

Source: CLS-HASI linked NSW Mental Health Outcomes and Assessment Tools (MHOAT), n=1,579

Table 13: Change in mean K10 scores in year following entry to program by level of support

Level of support	Change	p-value	95% confidence interval	
Low	- 1.41	0.005	- 2.40	- 0.43
Medium	- 2.09	<0.001	- 2.95	- 1.24
High	- 2.00	0.406	- 6.71	2.71

Source: CLS-HASI linked NSW Mental Health Outcomes and Assessment Tools (MHOAT), n=1,579

Table 14: Change in mean K10 scores in year following entry to program by Aboriginal status

Study group	Change	p-value	95% confidence interval	
			upper	lower
Non-Aboriginal	- 1.82	<0.001	- 2.52	- 1.12
Aboriginal	- 1.09	0.307	- 3.19	1.00

Source: CLS-HASI linked NSW Mental Health Outcomes and Assessment Tools (MHOAT), n=1,579

8.2 HoNOS

Table 15: Change in mean HoNOS scores per person per year

Study period year	Change	p-value	95% confidence interval	
			upper	lower
2 years prior	-0.98	<0.001	-1.26	-0.69
1 year prior (base)	-			
1 year post	-0.86	<0.001	-1.13	-0.59
2 years post	-0.67	<0.001	-1.04	-0.31

Source: CLS-HASI linked NSW Mental Health Outcomes and Assessment Tools (MHOAT), n=1,510

Table 16: Change in mean HoNOS scores in year following entry to program by age group

Age group	Change	p-value	95% confidence interval	
			upper	lower
19 to 24	-0.60	0.182	-1.47342	0.279708
25 to 34	-0.70	0.014	-1.26868	-0.14009
35 to 44	-0.87	0.002	-1.41809	-0.32729
45 to 54	-0.93	0.001	-1.49788	-0.36247
55 to 64	-0.93	0.005	-1.57213	-0.28239
65 and over	-2.54	0.007	-4.37216	-0.71031

Source: CLS-HASI linked NSW Mental Health Outcomes and Assessment Tools (MHOAT), n=1,510

Table 17: Change in mean HoNOS scores in year following entry to program by level of support

Level of support	Change	p-value	95% confidence interval	
			upper	lower
Low	-1.18	<0.001	-1.59	-0.77
Medium	-0.60	0.001	-0.96	-0.23
High	-1.08	0.248	-2.90	0.75

Source: CLS-HASI linked NSW Mental Health Outcomes and Assessment Tools (MHOAT), n=1,510

Table 18: Change in mean K10 scores in year following entry to program by Aboriginal status

Study group	Change	p-value	95% confidence interval	
			upper	lower
Non-Aboriginal	- 0.85	<0.001	- 1.15	- 0.55
Aboriginal	- 0.56	0.166	- 1.36	0.23

Source: CLS-HASI linked NSW Mental Health Outcomes and Assessment Tools (MHOAT), n=1,510

8.3 Mental health hospital admissions

Table 19: Change in MH hospital admission rates per person per year

Study period year	days	Change	p-value	95% confidence interval	
				upper	lower
2 years prior	0.90	- 0.57	<0.001	- 0.66	- 0.48
1 year prior (base)	1.47	-			
1 year post	0.81	- 0.66	<0.001	- 0.75	- 0.57
2 years post	0.38	- 1.09	<0.001	- 1.17	- 1.02

Source: HASI CLS linked NSW Admitted Patient Data Collection (APDC) n=3,338

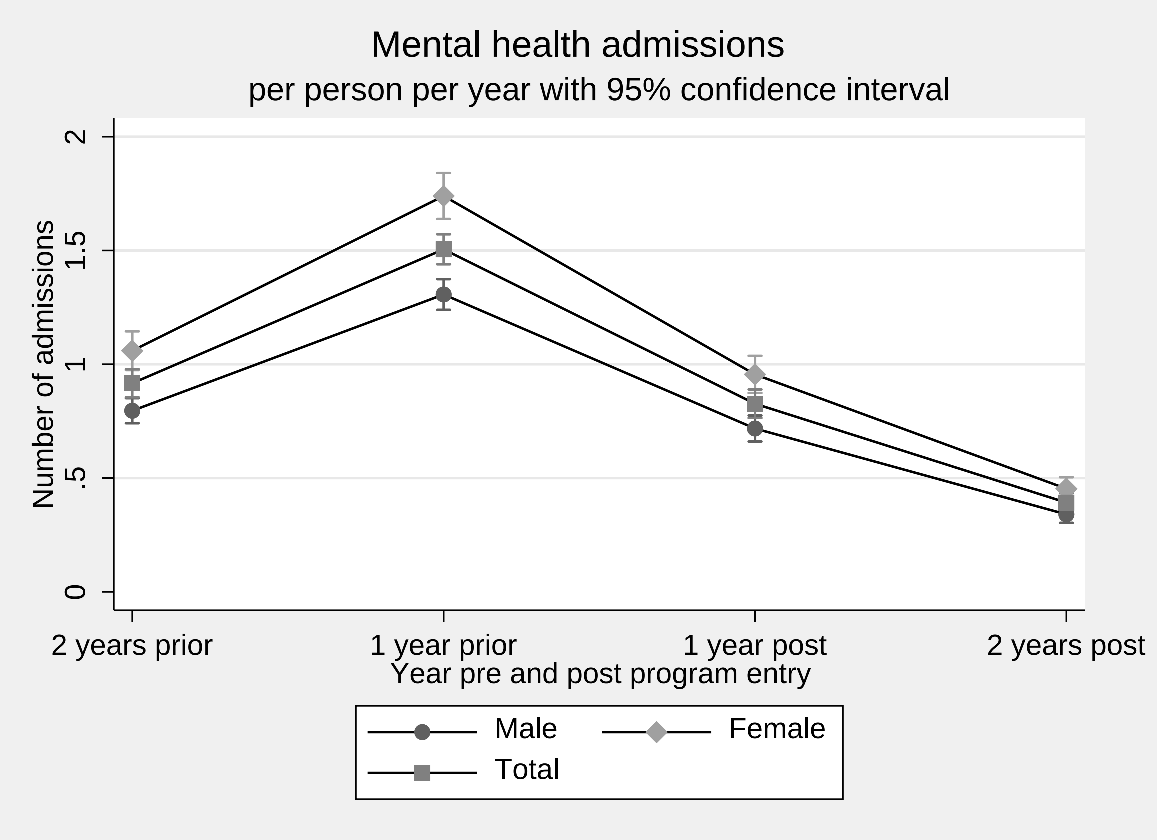
Table 20: Change in MH hospital admission rates per person per year by gender

Study group	Change	p-value	95% confidence interval	
			upper	lower
Male	- 0.65	<0.001	- 0.74	- 0.56
Female	- 0.67	<0.001	- 0.83	- 0.52

Source: HASI CLS linked NSW Admitted Patient Data Collection (APDC) n=3,338

Note: First year post entry based on year prior to entering the program.

Figure 18: Change in MH hospital admission rates per person per year by gender



Source: HASI CLS linked NSW Admitted Patient Data Collection (APDC) n=3,338

Table 21: Change in MH hospital admission rates per person per year by age group

Age group	Change	p-value	95% confidence interval upper	lower
19 to 24	- 0.64	<0.001	- 0.94	- 0.35
25 to 34	- 0.63	<0.001	- 0.82	- 0.45
35 to 44	- 0.68	<0.001	- 0.86	- 0.50
45 to 54	- 0.64	<0.001	- 0.80	- 0.48
55 to 64	- 0.77	<0.001	- 0.96	- 0.58
65 and over	- 0.77	0.026	- 1.44	- 0.09

Source: HASI CLS linked NSW Admitted Patient Data Collection (APDC) n=3,338

Note: First year post entry based on year prior to entering the program.

Table 22: Change in MH hospital admission rates per person per year by level of support

Level of support	Change	p-value	95% confidence interval upper	lower
Low	- 0.68	<0.001	- 0.79	- 0.57
Medium	- 0.65	<0.001	- 0.78	- 0.51
High	- 0.80	0.003	- 1.33	- 0.27

Source: HASI CLS linked NSW Admitted Patient Data Collection (APDC) n=3,338

Note: First year post entry based on year prior to entering the program.

Table 23: Change in MH hospital admission rates per person per year by Aboriginal status

Study group	Change	p-value	95% confidence interval upper	lower
Non-Aboriginal	- 0.66	<0.001	- 0.77	- 0.56
Aboriginal	- 0.56	<0.001	- 0.78	- 0.35

Source: HASI CLS linked NSW Admitted Patient Data Collection (APDC) n=3,338

Note: First year post entry based on year prior to entering the program.

8.4 Mental Health admitted days

Table 24: Change in MH hospital admitted days per person per year

Study period year	days	Change	p-value	95% confidence interval upper	lower
2 years prior	26.08	- 23.33	<0.001	- 26.69	- 19.98
1 year prior (base)	49.41	-	-		
1 year post	23.60	- 25.82	<0.001	- 29.12	- 22.51
2 years post	12.43	- 36.98	<0.001	- 39.97	- 33.99

Source: HASI CLS linked NSW Admitted Patient Data Collection (APDC) n=3,338

Table 25: Change in MH hospital admitted days per person per year by gender

Study group	Change	p-value	95% confidence interval upper	lower
Male	- 27.97	<0.001	- 32.78	- 23.16

Study group	Change	p-value	95% confidence interval upper	lower
Female	- 23.33	<0.001	- 27.79	- 18.87

Source: HASI CLS linked NSW Admitted Patient Data Collection (APDC) n=3,338

Note: First year post entry based on year prior to entering the program.

Table 26: Change in MH hospital admitted days per person per year by age group

Age group	Change	p-value	95% confidence interval upper	lower
19 to 24	- 15.43	<0.001	- 24.06	- 6.79
25 to 34	- 25.30	<0.001	- 33.52	- 17.07
35 to 44	- 23.26	<0.001	- 29.96	- 16.56
45 to 54	- 24.90	<0.001	- 31.46	- 18.33
55 to 64	- 35.28	<0.001	- 43.56	- 27.00
65 and over	- 39.85	<0.001	- 54.76	- 24.95

Source: HASI CLS linked NSW Admitted Patient Data Collection (APDC) n=3,338

Note: First year post entry based on year prior to entering the program.

Table 27: Change in MH hospital admitted days per person per year by level of support

Level of support	Change	p-value	95% confidence interval upper	lower
Low	- 21.73	<0.001	- 26.14	- 17.32
Medium	- 29.78	<0.001	- 34.69	- 24.87
High	- 12.93	0.149	- 30.52	4.65

Source: HASI CLS linked NSW Admitted Patient Data Collection (APDC) n=3,338

Note: First year post entry based on year prior to entering the program.

Table 28: Change in MH hospital admitted days per person per year by Aboriginal status

Study group	Change	p-value	95% confidence interval upper	lower
Non-Aboriginal	- 26.63	<0.001	- 30.44	- 22.82
Aboriginal	- 17.22	<0.001	- 24.79	- 9.65

Source: HASI CLS linked NSW Admitted Patient Data Collection (APDC) n=3,338
Note: First year post entry based on year prior to entering the program.

8.5 Emergency department presentations

Table 29: Change in ED presentations per person per year

Study period year	days	Change	p-value	95% confidence interval upper	lower
2 years prior	2.16	- 0.78	<0.001	- 1.03	- 0.54
1 year prior (base)	2.95	-			
1 year post	2.18	- 0.77	<0.001	- 1.05	- 0.49
2 years post	1.15	- 1.80	<0.001	- 2.05	- 1.55

Source: HASI CLS linked NSW Emergency Department Data Collection (EDDC) n=4,192

Table 30: Change in ED presentations per person per year by gender

Study group	Change	p-value	95% confidence interval upper	lower
Male	- 0.83	<0.001	- 1.19	- 0.47
Female	- 0.70	0.001	- 1.13	- 0.28

Source: HASI CLS linked NSW Emergency Department Data Collection (EDDC) n=4,192
Note: First year post entry based on year prior to entering the program.

Table 31: Change in ED presentations per person per year by age group

Age group	Change	p-value	95% confidence interval upper	lower
19 to 24	- 0.72	0.056	- 1.47	0.02
25 to 34	- 0.82	0.011	- 1.45	- 0.18
35 to 44	- 0.93	0.005	- 1.57	- 0.29
45 to 54	- 0.90	<0.001	- 1.31	- 0.50
55 to 64	- 0.29	0.495	- 1.12	0.54
65 and over	- 1.10	<0.001	- 1.59	- 0.60

Source: HASI CLS linked NSW Emergency Department Data Collection (EDDC) n=4,192
Note: First year post entry based on year prior to entering the program.

Table 32: Change in ED presentations per person per year by level of support

Level of support	Change	p-value	95% confidence interval	
			upper	lower
Low	- 0.94	<0.001	- 1.40	- 0.48
Medium	- 0.62	<0.001	- 0.96	- 0.29
High	- 0.52	0.296	- 1.49	0.45

Source: HASI CLS linked NSW Emergency Department Data Collection (EDDC) n=4,192

Note: First year post entry based on year prior to entering the program.

Table 33: Change in ED presentations per person per year by Aboriginal status

Study group	Change	p-value	95% confidence interval	
			upper	lower
Non-Aboriginal	- 0.69	<0.001	- 0.98	- 0.41
Aboriginal	- 1.14	0.038	- 2.22	- 0.06

Source: HASI CLS linked NSW Emergency Department Data Collection (EDDC) n=4,192

Note: First year post entry based on year prior to entering the program.

8.6 Mental health ambulatory

Table 34: Change in community mental health contacts per person per year

Study period year	Contacts	Change	p-value	95% confidence interval	
				upper	lower
2 years prior	40.04	- 13.85	<0.001	- 17.19	- 10.52
1 year prior (base)	53.90	-			
1 year post	48.46	- 5.44	0.001	- 8.76	- 2.12
2 years post	19.57	- 34.33	<0.001	- 37.15	- 31.51

Source: HASI CLS linked NSW Mental Health Ambulatory Data Collection. n=3,052

Table 35: Change in community mental health contacts per person per year by gender

Study group	Change	p-value	95% confidence interval upper	lower
Male	-5.63	0.014	-10.12	-1.13
Female	-5.23	0.037	-10.15	-0.32

Source: HASI CLS linked NSW Mental Health Ambulatory Data Collection. n=3,052
Note: First year post entry based on year prior to entering the program.

Table 36: Change in community mental health contacts per person per year by age group

Age group	Change	p-value	95% confidence interval upper	lower
19 to 24	-10.16	0.016	-18.46	-1.87
25 to 34	-7.74	0.058	-15.73	0.25
35 to 44	-5.94	0.099	-13.00	1.12
45 to 54	-2.00	0.569	-8.87	4.87
55 to 64	-2.41	0.581	-10.98	6.16
65 and over	-7.15	0.133	-16.47	2.17

Source: HASI CLS linked NSW Mental Health Ambulatory Data Collection. n=3,052
Note: First year post entry based on year prior to entering the program.

Table 37: Change in community mental health contacts per person per year by level of support

Level of support	Change	p-value	95% confidence interval	
			upper	lower
Low	-7.72	<0.001	-11.78	-3.66
Medium	-3.42	0.189	-8.52	1.68
High	-4.81	0.723	-31.43	21.81

Source: HASI CLS linked NSW Mental Health Ambulatory Data Collection. n=3,052

Note: First year post entry based on year prior to entering the program.

Table 38: Change in community mental health contacts per person per year by Aboriginal status

Study group	Change	p-value	95% confidence interval	
			upper	lower
Non-Aboriginal	-5.30	0.007	-9.16	-1.45
Aboriginal	-7.73	0.024	-14.45	-1.00

Source: HASI CLS linked NSW Mental Health Ambulatory Data Collection. n=3,052

Note: First year post entry based on year prior to entering the program.

8.7 Housing – public housing applications

Table 39: Change in public housing applications per person per year

Study period year	Applications	Change	p-value	95% confidence interval	
				upper	lower
2 years prior	0.17	-0.11	<0.001	-0.14	-0.08
1 year prior (base)	0.28	-			
1 year post	0.41	0.13	<0.001	0.09	0.16
2 years post	0.15	-0.13	<0.001	-0.16	-0.10

Source: HASI CLS linked NSW Department of Communities and Justice Housing. n=1,539

Table 40: Change in public housing applications per person per year by gender

Study group	Change	p-value	95% confidence interval	
			upper	lower
Male	- 0.16	<0.001	- 0.20	- 0.12
Female	- 0.11	<0.001	- 0.15	- 0.06

Source: HASI CLS linked NSW Department of Communities and Justice Housing. n=1,539
Note: Second year post entry based on year prior to entering the program.

Table 41: Change in public housing applications per person per year by age group

Age group	Change	p-value	95% confidence interval	
			upper	lower
19 to 24	- 0.17	0.001	- 0.27	- 0.07
25 to 34	- 0.15	<0.001	- 0.22	- 0.09
35 to 44	- 0.13	<0.001	- 0.19	- 0.07
45 to 54	- 0.11	<0.001	- 0.17	- 0.05
55 to 64	- 0.14	0.002	- 0.22	- 0.05
65 and over	- 0.10	0.290	- 0.27	0.08

Source: HASI CLS linked NSW Department of Communities and Justice Housing. n=1,539
Note: Second year post entry based on year prior to entering the program.

Table 42: Change in public housing applications per person per year by level of support

Level of support	Change	p-value	95% confidence interval	
			upper	lower
Low	- 0.11	<0.001	- 0.16	- 0.07
Medium	- 0.15	<0.001	- 0.19	- 0.11
High	- 0.08	0.377	- 0.27	0.10

Source: HASI CLS linked NSW Department of Communities and Justice Housing. n=1,539
Note: Second year post entry based on year prior to entering the program.

Table 43: Change in public housing applications per person per year by Aboriginal status

Study group	Change	p-value	95% confidence interval upper	lower
Non-Aboriginal	- 0.14	<0.001	- 0.18	- 0.11
Aboriginal	- 0.09	0.018	- 0.17	- 0.02

Source: HASI CLS linked NSW Department of Communities and Justice Housing. n=1,539

Note: Second year post entry based on year prior to entering the program.

8.8 Housing – new tenancies

Table 44: Change in public housing tenancies per person per year

Study period year	Tenancies	Change	p-value	95% confidence interval upper	lower
2 years prior	0.22	- 0.07	0.002	- 0.11	- 0.02
1 year prior (base)	0.29	-			
1 year post	0.40	0.11	<0.001	0.06	0.16
2 years post	0.12	- 0.17	<0.001	- 0.21	- 0.12

Source: HASI CLS linked NSW Department of Communities and Justice Housing. n=657

Table 45: Change in public housing tenancies per person per year by gender

Study group	Change	p-value	95% confidence interval upper	lower
Male	- 0.19	<0.001	- 0.25	- 0.13
Female	- 0.15	<0.001	- 0.21	- 0.08

Source: HASI CLS linked NSW Department of Communities and Justice Housing. n=657

Note: Second year post entry based on year prior to entering the program.

Table 46: Change in public housing tenancies per person per year by age group

Age group	Change	p-value	95% confidence interval upper	lower
19 to 24	-0.03	0.712	-0.22	0.15
25 to 34	-0.18	<0.001	-0.28	-0.09
35 to 44	-0.20	<0.001	-0.28	-0.12
45 to 54	-0.10	0.022	-0.19	-0.02
55 to 64	-0.30	<0.001	-0.41	-0.19
65 and over	-0.05	0.670	-0.31	0.20

Source: HASI CLS linked NSW Department of Communities and Justice Housing. n=657
Note: Second year post entry based on year prior to entering the program.

Table 47: Change in public housing tenancies per person per year by level of support

Level of support	Change	p-value	95% confidence interval upper	lower
Low	-0.14	<0.001	-0.21	-0.07
Medium	-0.19	<0.001	-0.25	-0.14
High	-0.22	0.248	-0.58	0.15

Source: HASI CLS linked NSW Department of Communities and Justice Housing. n=657
Note: Second year post entry based on year prior to entering the program.

Table 48: Change in public housing tenancies per person per year by Aboriginal status

Study group	Change	p-value	95% confidence interval upper	lower
Non-Aboriginal	-0.19	<0.001	-0.24	-0.14
Aboriginal	-0.09	0.093	-0.20	0.02

Source: HASI CLS linked NSW Department of Communities and Justice Housing. n=657
Note: Second year post entry based on year prior to entering the program.

8.9 Corrective services - ROD

Table 49: Change in charged offenses per person per year

Study period year	Offenses	Change	p-value	95% confidence interval upper	lower
2 years prior	0.87	0.07	0.106	-0.01	0.15
1 year prior (base)	0.79	-			
1 year post	0.03	- 0.72	<0.001	-0.77	- 0.66
2 years post	0.26	- 0.52	<0.001	-0.59	- 0.45

Source: HASI CLS linked NSW Bureau of Crime Statistics and Research's Reoffending Database (ROD). n=401

Table 50: Change in charged offenses per person per year by gender

Study group	Change	p-value	95% confidence interval upper	lower
Male	- 0.73	<0.001	- 0.80	- 0.66
Female	- 0.69	<0.001	- 0.79	- 0.60

Source: HASI CLS linked NSW Bureau of Crime Statistics and Research's Reoffending Database (ROD). n=401

Note: First year post entry based on year prior to entering the program.

Table 51: Change in charged offenses per person per year by age group

Age group	Change	p-value	95% confidence interval upper	lower
19 to 24	- 0.77	<0.001	- 0.93	- 0.62
25 to 34	- 0.78	<0.001	- 0.89	- 0.67
35 to 44	- 0.66	<0.001	- 0.76	- 0.57
45 to 54	- 0.66	<0.001	- 0.76	- 0.56
55 to 64	- 0.67	<0.001	- 0.88	- 0.45
65 and over	- 0.91	0.013	- 1.62	- 0.19

Source: HASI CLS linked NSW Bureau of Crime Statistics and Research’s Reoffending Database (ROD). n=401

Note: First year post entry based on year prior to entering the program.

Table 52: Change in charged offenses per person per year by level of support

Level of support	Change	p-value	95% confidence interval upper	lower
Low	- 0.73	<0.001	- 0.81	- 0.66
Medium	- 0.70	<0.001	- 0.78	- 0.62
High	- 0.45	0.248	- 1.22	0.32

Source: HASI CLS linked NSW Bureau of Crime Statistics and Research’s Reoffending Database (ROD). n=401

Note: First year post entry based on year prior to entering the program.

Table 53: Change in charged offenses per person per year by Aboriginal status

Study group	Change	p-value	95% confidence interval upper	lower
Non-Aboriginal	- 0.69	<0.001	- 0.76	- 0.63
Aboriginal	- 0.76	<0.001	- 0.87	- 0.65

Source: HASI CLS linked NSW Bureau of Crime Statistics and Research’s Reoffending Database (ROD). n=401

Note: First year post entry based on year prior to entering the program.

8.10 Community correction orders – OIMS

Table 54: Change in correctional orders per person per year

Study period year	Offenses	Change	p-value	95% confidence interval	
				upper	lower
2 years prior	0.59	- 0.19	0.001	- 0.30	- 0.08
1 year prior (base)	0.78	-			
1 year post	0.03	- 0.75	<0.001	- 0.84	- 0.67
2 years post	0.21	- 0.57	<0.001	- 0.67	- 0.47

Source: HASI CLS linked NSW Offender Inmate Management System (OIMS). n=185

Table 55: Change in correctional orders per person per year by gender

Study group	Change	p-value	95% confidence interval	
			upper	lower
Male	- 0.76	<0.001	- 0.87	- 0.66
Female	- 0.72	<0.001	- 0.88	- 0.57

Source: HASI CLS linked NSW Offender Inmate Management System (OIMS). n=185
Note: First year post entry based on year prior to entering the program.

Table 56: Change in correctional orders per person per year by age group

Age group	Change	p-value	95% confidence interval	
			upper	lower
19 to 24	- 0.73	<0.001	- 0.97	- 0.49
25 to 34	- 0.81	<0.001	- 0.99	- 0.64
35 to 44	- 0.77	<0.001	- 0.91	- 0.63
45 to 54	- 0.72	<0.001	- 0.90	- 0.54
55 to 64	- 0.45	0.046	- 0.89	- 0.01
65 and over	- 0.90	0.005	- 1.52	- 0.28

Source: HASI CLS linked NSW Offender Inmate Management System (OIMS). n=185
Note: First year post entry based on year prior to entering the program.

Table 57: Change in correctional orders per person per year by level of support

Level of support	Change	p-value	95% confidence interval upper	lower
Low	- 0.75	<0.001	- 0.87	- 0.63
Medium	- 0.75	<0.001	- 0.88	- 0.63
High	N/A	N/A	N/A	N/A

Source: HASI CLS linked NSW Offender Inmate Management System (OIMS). n=185
Notes: First year post entry based on year prior to entering the program. High support not reported as insufficient high support consumers (n=4)

Table 58: Change in correctional orders per person per year by Aboriginal status

Study group	Change	p-value	95% confidence interval upper	lower
Non-Aboriginal	- 0.70	<0.001	- 0.81	- 0.59
Aboriginal	- 0.83	<0.001	- 0.98	- 0.67

Source: HASI CLS linked NSW Offender Inmate Management System (OIMS). n=185
Note: First year post entry based on year prior to entering the program.

8.11 Total hospital admissions

The hospital data linkage includes all admissions for mental health as well as non mental health presentations. The majority of consumer hospital contact was for mental health related conditions and are presented in the primary results in section 4 of the full report. Analysis was undertaken to assess total hospital admissions, to examine the extent of physical health admission activity, as a supplementary outcome and for potential input to the economic evaluation. The figures show that non mental health hospital contact is a minor component of healthcare contact and does not significantly contribute to incremental change in healthcare resource usage. The total hospital figures are presented in this section for reference.

Overall total hospital admissions decreased significantly in the year following entry to the program by 24.6% from 2.4 to 1.8 admissions per person per year. This statistically significant decrease was extended in year two following program entry with a further 19% decrease (p<0.001).

Females experienced a slightly higher rate of overall hospital admissions than males by round. This difference continued from two years prior until two years post programme, although the production in admissions following entry to the programme was similar for both genders. This result is consistent with the previous HASI evaluation.

Table 59: Change in total hospital admission rates per person per year

Study period year	Change	p-value	95% confidence interval upper	lower
2 years prior	0.745	<0.001	0.667	0.832
1 year prior (base)	0			
1 year post	0.754	<0.001	0.662	0.859
2 years post	0.564	<0.001	0.483	0.659

Source: HASI CLS linked NSW Admitted Patient Data Collection (APDC) n=4,039

The number of admissions per person did not vary significantly across age groups. The level of programme support indicates that high level support consumers are less frequently admitted to hospital, although this is a small group of consumers.

The rates of hospital admissions were separately analysed across study subgroups. Female consumers experienced slightly higher rates of hospital admissions consistently before and after program entry than males, Figure 7. The post program reductions in admissions were separately statistically significant for females and males in line with the overall trend. These findings reflect are consistent with the previous HASI evaluation reflecting similar hospital admission rates and post program declines.

Table 60: Change in hospital admission rates per person per year by gender

Study period year	Change	p-value	95% confidence interval upper	lower
2 years prior - male	-0.591	<0.001	- 0.868	- 0.313
2 years prior - female	-0.652	<0.001	- 1.023	- 0.281
1 year prior (base)	1.000			
1 year post - male	-0.562	0.001	- 0.891	- 0.234
1 year post – female	-0.629	0.003	- 1.048	- 0.210
2 year post – male	-0.956	<0.001	- 1.275	- 0.638
2 year post - female	-1.162	<0.001	- 1.567	- 0.757

Source: HASI CLS linked NSW Admitted Patient Data Collection (APDC) n=4,039

The rates of total hospital admission declined significantly across all consumer age groups in the year following program, those under 24 and over 55 years of age declined but not statistically significantly due to decreased numbers in these groups.

Table 61: Change in hospital admission rates by age group

Age group	Change	p-value	95% confidence interval upper	lower
18 and under	0.125	0.891	- 1.659	1.908
19 to 24	- 0.608	0.043	- 1.198	- 0.018
25 to 34	- 0.672	0.035	- 1.298	- 0.047
35 to 44	- 0.540	0.014	- 0.970	- 0.111
45 to 54	- 0.686	0.003	- 1.133	- 0.239
55 to 64	- 0.568	0.257	- 1.553	0.415
65 and over	- 0.454	0.364	- 1.435	0.527

Source: HASI CLS linked NSW Admitted Patient Data Collection (APDC) n=4,039
Note: First year post entry based on year prior to entering the program.

Appendix 11: Economic analysis results

Evaluation of NSW Community-based Mental Health Programs: Community Living Supports and Housing and Accommodation Support Initiative – CLS-HASI Evaluation Report

Prepared for NSW Ministry of Health, 2022

Contents

Tables

Figures

1 Background

The economic component of the evaluation examined the costs of the CLS-HASI programs and the outcomes and benefits to consumers. This appendix provides supplementary details to the economic analysis presented in Section 5 of the full analysis report.

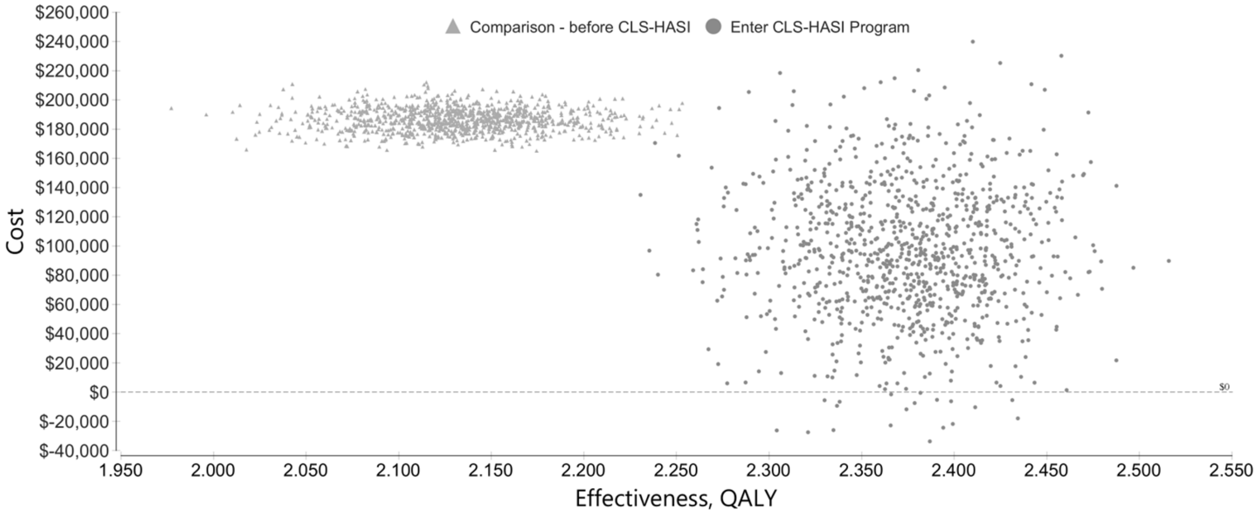
Program cost effectiveness model

The economic evaluation developed a Markov model framework which integrated program costs with the positive outcomes from the data linkage, section 4, full analysis report. The economic modelling methodology and parameters are presented in **Appendix 8**. The full analysis report presents results and bootstrap probabilistic sensitivity analysis scatter plots for the 5-year base case. A 5 year timeframe is commonly used for economic modelling as it provides perspective for sustained outcomes and cost offsets against program costs which are generally an up-front investment in the initial year. Naturally there is a characteristic trade-off between shorter timeframes and increasing uncertainty of longer multi-year perspectives. For this reason, the CLS-HASI economic modelling incorporates conservative supplementary shorter timeframe models for 2 year and 1 year periods.

2 Markov model perspective

The economic model provides a framework to evaluate the joint uncertainty in all parameters and to establish scenarios based on timeframe in the program. This develops important perspective as there is characteristic increasing uncertainty over longer timeframes. In this context the model base case is a 5-year perspective from entry into the CLS-HASI program, Figure 1. This shows a scatter plot of estimated cost and cost offsets for program consumers (right hand side) compared to before entering the program (left hand side).

Figure 1: CLS-HASI program cost effectiveness: base case 5-year timeframe

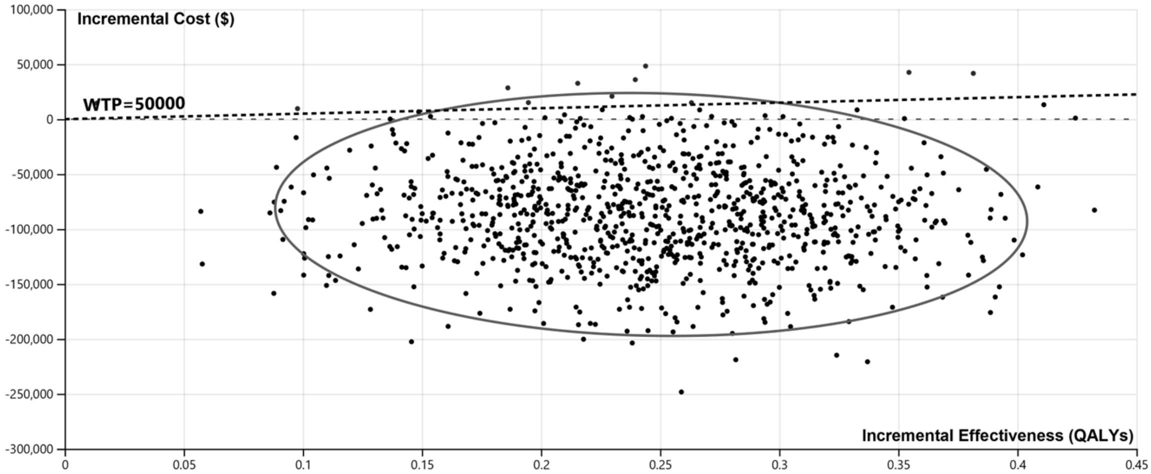


Sources: CLS-HASI data linkage, NSW Ministry of Health program cost data.
Notes: Costs and outcomes (QALYs) based on 5-year timeframe. QALYs based on K10 bridging algorithm.

These results over a 5-year timeframe indicate that the CLS-HASI program is generating more in cost offsets than the cost of the program. The average costs over 5 years of all healthcare and corrective services before program entry are around $185,000, compared to around $99,000 for the 5 years following entry, including the additional cost of program support. Further results are provided in Table 1. The program effectiveness is shown as estimated Quality Adjusted Life Years (QALYs) based on before and after K10 scores. This indicates that in addition to generating lower costs over 5 years the CLS-HASI program is also associated with improved mental health outcomes and estimated consumer quality of life.

When the 5 year estimated costs and outcomes are combined, the incremental cost and effectiveness (change following program entry) were estimated using model probabilistic sensitivity analysis (PSA), Figure 2. The results show a cost saving of around $86,000 over 5 years and a positive outcome of around 0.25 QALYs, with the ellipse indicating a 95% confidence interval. The proportion of point estimates within the 95% confidence interval and below the willingness to pay dotted line indicate the CLS-HASI program is highly likely to be cost effective with an estimated probability of 95.3%.

Figure 2: CLS-HASI program cost-effectiveness – 5-year base case



Sources: CLS-HASI data linkage, NSW Ministry of Health program cost data
Notes: Incremental costs and outcomes (QALYs) based on 5 year timeframe following program entry compared to before entry. Ellipse indicates 95% confidence interval. WTP=Willingness to pay. WTP is shown as a cost per QALY level of $50,000 in line with established Australian benchmarks (Productivity Commission, 2020)

3 Program cost effectiveness scenarios

While it is intuitive that CLS-HASI cost effectiveness may improve over extended timeframes, as the initial program investment continues to produce sustained improved outcomes, there is also inherent increasing uncertainty. From the data linkage consumer healthcare outcomes continued to improve into the second year following entry to the program, that is, outcomes improved further compared to the already positive first year. The data linkage also shows preliminary evidence that these improvements are sustained following consumers' exit from the program.

The base case 5-year model has taken a conservative approach and is based on the improved outcomes in the first year following CLS-HASI program entry. If the further improvements in year 2 following entry were included the estimated cost effectiveness would also increase. However, the economic modelling is subject to limitations related to the uncertainty of sustained outcomes and the before and after study design. For example, it is recognised that consumers often enter support programs during escalated episodes and healthcare usage and mental health outcomes may tend to eventually return to a longer-term average level. This 'regression to the mean' represents a factor that could explain a proportion of post program improvement, potentially accounting for as much as 30 percent of observed outcomes (Schilling, Petrie, Dowsey, Choong, & Clarke, 2017).

These aspects are difficult to assess accurately and do not reduce the importance of mental health support programs such as CLS-HASI. They do however highlight the need to consider scenarios to examine program outcomes and test whether program effectiveness is possibly overstated. To do this supplementary model scenarios were developed to assess estimated CLS-HASI cost effectiveness over reduced timeframes. It is plausible that adding the increased year 2 outcomes to the model could substantially cover potential regression to the mean, if it is a factor, in which case the conservative base case model is at least partially reducing or avoiding the risk of overstated outcomes.

To further assess the estimated program cost effectiveness the additional model scenarios were examined to test the sensitivity of results across shorter timeframes.

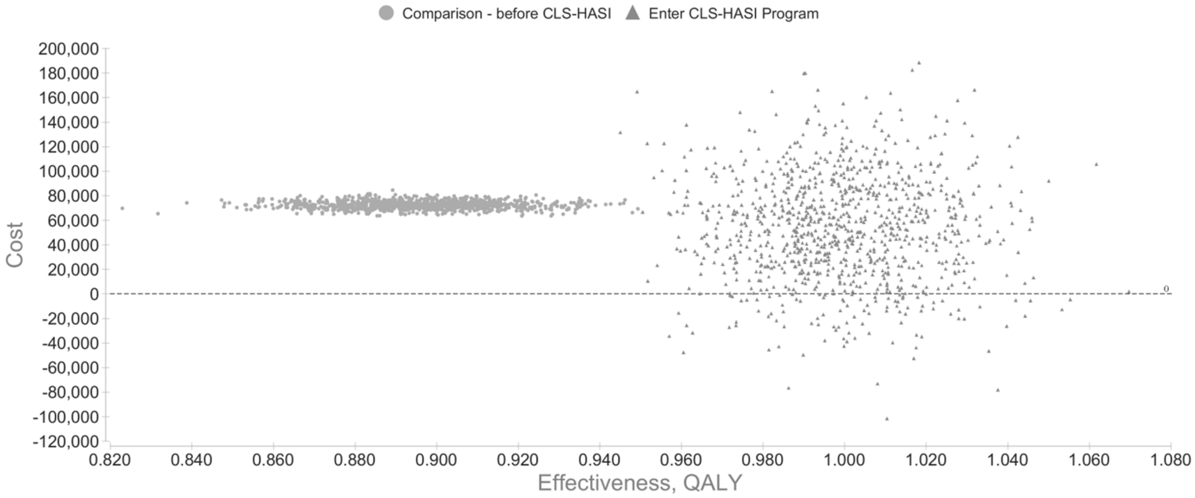
Shorter timeframe model scenarios

The recent Productivity Commission Inquiry into mental health examined mental health system service planning and reform and recommended expansion of mental health services in Australia based on outcome effectiveness and related cost effectiveness (Productivity Commission, 2020). The Productivity Commission health economic modelling indicated that service expansion is likely to be highly cost-effective. The modelling approach was very conservative based on a single year of outcomes and the report acknowledges this as a particularly conservative approach which is likely to substantially understate the value of mental health programs.

In this context, CLS-HASI economic model scenarios were developed for 1- and 2-year timeframes, Table 1. The analysis shows that the likelihood of the CLS-HASI program being cost effective increases when assessed over the base case 5-year timeframe. The figures also show that the program is potentially cost effective on a highly conservative 2-year period and may also be cost saving on this shorter timeframe. These results are underpinned by the predominant cost offset of reduced mental health hospital admissions and lengths of stay following entry to the program. The significant decrease in healthcare usage following program entry is consistent with the previous HASI evaluation which reported cost offsets in line with total program costs over 2 years (Bruce, Mc Dermott, Ramia, Bullen, & Fisher, 2012).

As for the 5-year model timeframe, bootstrapping was undertaken for the 2-year scenario, Figure 3. This timeframe shows a clustering of bootstrap cost estimates before program entry of around $72,000 over the 2 years. This is based on hospital and other data linkage service usage (left hand side of figure 3). Following entry, the variation in cost estimates in substantially higher, mainly due to the high variation in average program cost per consumer across low, medium and high levels of support. The bootstrapped estimates provide an average cost per consumer of around $58,900 following entry to the CLS-HASI program. On the horizontal axis the estimated QALYs increase from around 0.9 before entry to around 1.0 following program entry.

Figure 3: CLS-HASI program cost effectiveness: base case 2-year timeframe



Sources: CLS-HASI data linkage, NSW Ministry of Health program cost data.
Notes: Costs and QALY based on 5-year timeframe. QALYs based on K10 bridging algorithm.

When the 2 year estimated costs and outcomes are combined the incremental cost and effectiveness (change following program entry) were again estimated using model PSA, Figure 4: CLS-HASI program cost effectiveness: base case 2-year timeframe

Sources: CLS-HASI data linkage, NSW Ministry of Health program cost data.
Notes: Costs and outcomes (QALY) based on 5-year timeframe. QALYs based on K10 bridging algorithm.

This shorter 2-year timeframe shows a lower proportion of point estimates being below the $50,000 per QALY cost effective threshold. The proportion of PSA estimates within the 95% confidence interval and below the willingness to pay threshold indicate the CLS-HASI program is more likely than not to be cost effective over 2 years with a probability of 67%.

A further even more conservative 1 year model scenario was undertaken which only allows outcomes achieved in the first year following program entry to be offset against program costs. This was the timeframe used by the Productivity Commission for economic evaluation in the recent mental health inquiry report (Productivity Commission, 2020). The commission noted that this short single year timeframe was highly conservative and likely to understate estimated program cost effectiveness.

In line with each model timeframe bootstrapping was undertaken for the 1-year scenario, Figure 5. This timeframe indicates a cost estimate before program entry of around $32,000 over 1 year. This is again based on hospital and other data linkage service usage (left hand side of figure 5). Following entry, the variation in cost estimates in similarly substantially higher, as previously due to the high variation in average program cost per consumer across low, medium and high levels of support. The estimated average cost per consumer is around $43,700 following entry to the CLS-HASI programs. On the horizontal axis the estimated QALYs increase marginally from around 0.46 before entry to around 0.51 following program entry.

Figure 5: CLS-HASI program cost effectiveness: base case 1-year timeframe

Sources: CLS-HASI data linkage, NSW Ministry of Health program cost data.
Notes: Costs and QALY based on 1-year timeframe. QALYs based on K10 bridging algorithm.

The 1 year estimated costs and outcomes incremental cost effectiveness (change following program entry) was again estimated using model PSA, Figure 6. The results show an estimated cost increase of around $11,500 for the marginal positive outcome of around 0.05 QALY, with the ellipse indicating a 95% confidence interval.

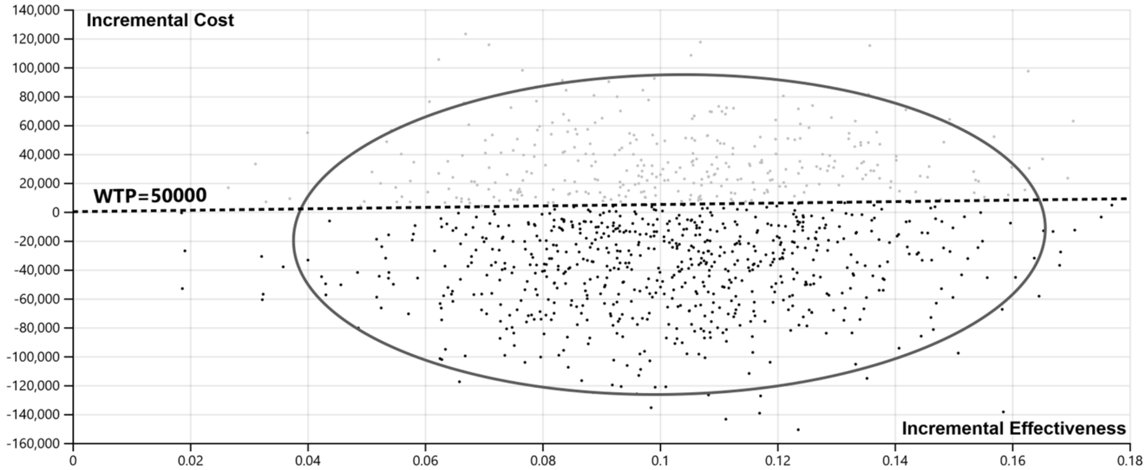
Figure 6: CLS-HASI program cost effectiveness: base case 1-year timeframe

Sources: CLS-HASI data linkage, NSW Ministry of Health program cost data.
Notes: Costs and outcomes (QALY) based on 1-year timeframe. QALYs based on K10 bridging algorithm.

This single year timeframe shows a further decrease in the proportion of point estimates being below the $50,000 per QALY cost effective threshold. The proportion of PSA estimates within the 95% confidence interval and below the willingness to pay threshold indicate the CLS-HASI program is less likely to be cost effective over 1 year with a probability of 43%.

. The results show an estimated cost saving of around $13,600 and a positive outcome of around 0.1 QALY, with the ellipse indicating a 95% confidence interval.

Figure 4: CLS-HASI program cost effectiveness: base case 2-year timeframe



Sources: CLS-HASI data linkage, NSW Ministry of Health program cost data.
Notes: Costs and outcomes (QALY) based on 5-year timeframe. QALYs based on K10 bridging algorithm.

This shorter 2-year timeframe shows a lower proportion of point estimates being below the $50,000 per QALY cost effective threshold. The proportion of PSA estimates within the 95% confidence interval and below the willingness to pay threshold indicate the CLS-HASI program is more likely than not to be cost effective over 2 years with a probability of 67%.

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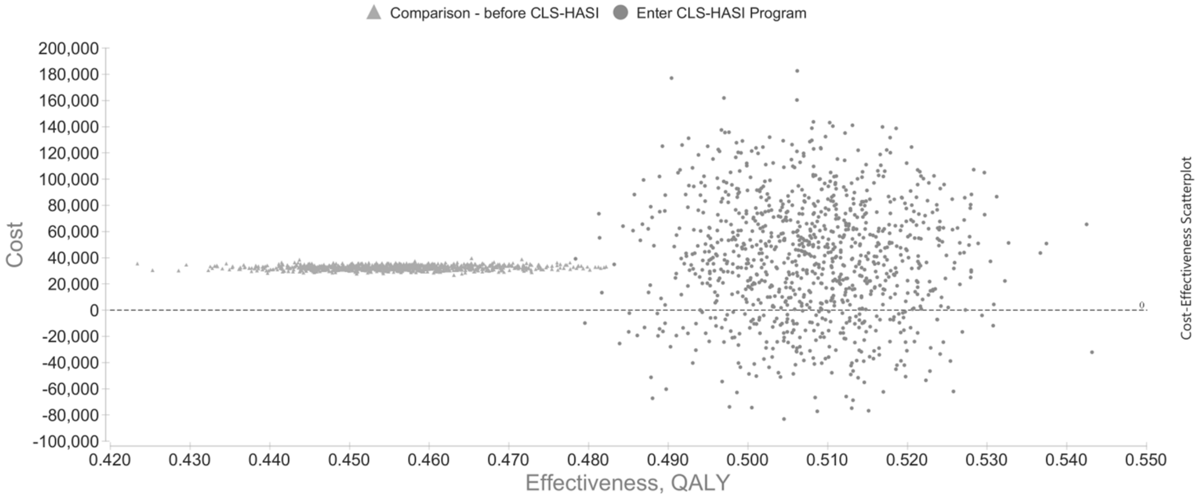

Sources: CLS-HASI data linkage, NSW Ministry of Health program cost data.
Notes: Costs and QALY based on 1-year timeframe. QALYs based on K10 bridging algorithm.

The 1 year estimated costs and outcomes incremental cost effectiveness (change following program entry) was again estimated using model PSA, Figure 6. The results show an estimated cost increase of around $11,500 for the marginal positive outcome of around 0.05 QALY, with the ellipse indicating a 95% confidence interval.

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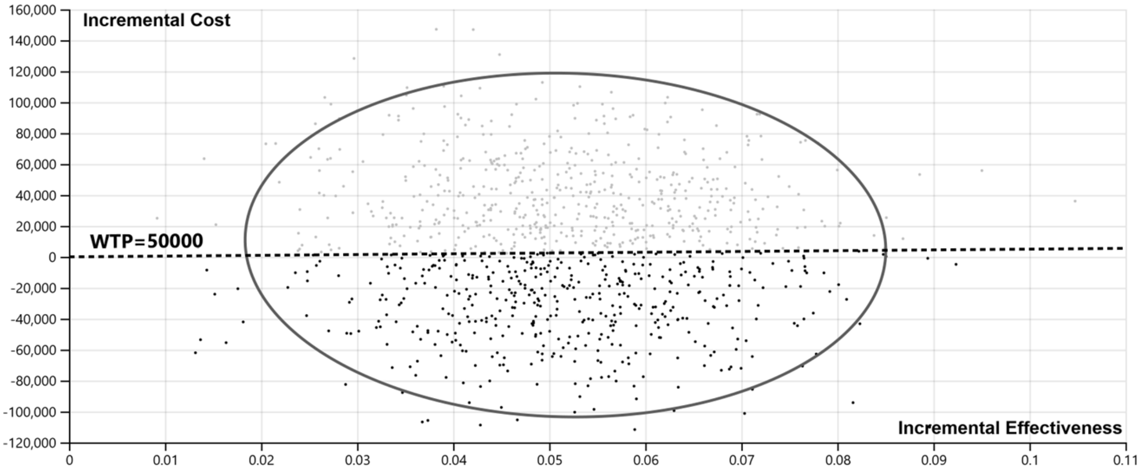


Sources: CLS-HASI data linkage, NSW Ministry of Health program cost data.
Notes: Costs and outcomes (QALY) based on 1-year timeframe. QALYs based on K10 bridging algorithm.

This single year timeframe shows a further decrease in the proportion of point estimates being below the $50,000 per QALY cost effective threshold. The proportion of PSA estimates within the 95% confidence interval and below the willingness to pay threshold indicate the CLS-HASI program is less likely to be cost effective over 1 year with a probability of 43%.

4 Summary cost effectiveness figures

The further highly conservative 1-year model scenario indicates that the CLS-HASI program is not likely to be cost effective within a single year timeframe, Table 1. Reflecting the substantial variation in consumer outcomes the first year following entry indicates an increased cost of around $11,500, although still with a marginally improved QALY outcome. This result is not surprising as the return on CLS-HASI program investment will reflect the improved mental health over subsequent years despite inherent uncertainty in consumer recovery pathways.

The cost effectiveness modelling scenarios provide an estimate of the increasing likelihood the CLS-HASI program is cost effective over multiple year timeframes, Figure 7. The results indicate a low probability of around 43% the program is cost effective over 1 year. But as the initial cost investment continues to provide a level of sustained consumer outcomes the probability the program is cost effective increases to 67% over 2 years and is estimated at 95.3% in the 5-year base case.

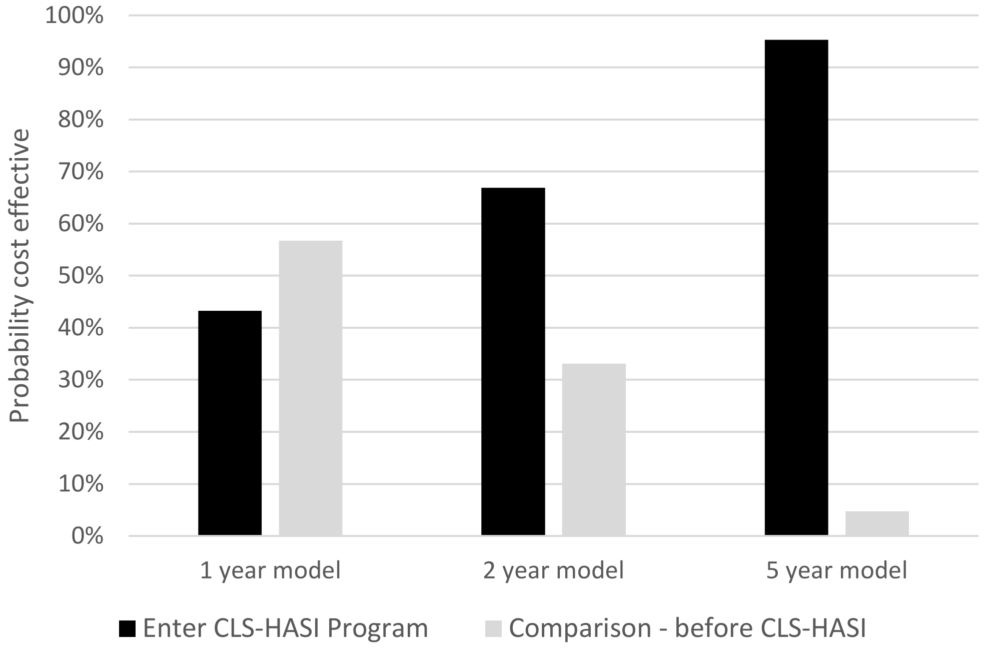
Table 1 CLS-HASI Program cost effectiveness results

	Cost		Effectiveness		Cost per QALY
Base case and potential benefits	Total Cost	Additional cost	QALYs	Additional QALYs	
Base case – 1 year					
Comparison: Before program	$32,179		0.46		
CLS-HASI Program 1 year	$43,701	$11,522	0.51	0.05	$220,572
2-year model timeframe					
Comparison: Before program	$ 72,553		0.90		
CLS-HASI Program 2 years	$58,901	- $13,652	1.00	0.10	Cost saving
5-year model timeframe					
Comparison: Before program	$185,820		2.13		
CLS-HASI Program 5 years	$99,645	- $86,175	2.38	0.25	Cost saving

Source: NSW Ministry of Health: program data linkage. CLS-HASI Program cost data.
Notes: Cost effectiveness is the estimated costs per QALY. Estimated over a 1, 2 and 5 year timeframe following entry to the program.

The scale of model results across multiple years indicates the CLS-HASI program continues to be highly cost effective. The results incorporate the substantial variation in consumer outcomes and test the joint uncertainty of all model parameters through the probabilistic sensitivity analyses and related 95% confidence intervals. In the case that confounding factors such as regression to the mean are partially influencing outcomes, this could potentially mean the program is cost saving in year 3 rather than year 2. This provides perspective to show that even if additional sources of model uncertainty are discounted, the CLS-HASI program remains highly cost effective.

Figure 7 CLS-HASI Program cost effectiveness – by model timeframe



Source: NSW Ministry of Health: program data linkage. CLS-HASI Program cost data.
Notes: Cost effectiveness is the estimated costs per QALY. Estimated over 1, 2 and 5 year timeframes.

5 Economic evaluation summary

Program cost analysis

- Program cost data was analysed based on audited annual acquittal reports from each CMO. The total CLS-HASI program cost for 2018-19 was $70.0 million, predominantly (99%) for support services provided by CMOs.
    - Project management (Ministry costs) and partner agency costs accounted for an estimated $410,000 (0.6%).
- Around 65% of CMO costs are employee expenses, operational costs account for around 14% and almost 9% are administration expenses. Motor vehicles accounted for around 5% and ‘other’ expenses made up around 4%.
- From the CLS-HASI MDS data there was a total of 890,610 hours of consumer support provided in 2018-19 indicating an average cost per hour of $78.60.
- The average cost per consumer was $35,622 in 2018-19 ranging from around $10,800 for low support consumer, around $43,000 for medium level support and around $205,000 per consumer for high level support at times over 8 hours per day.

Cost effectiveness analysis

- The economic evaluation developed a Markov model framework which integrated program costs with the significantly positive outcomes from the data linkage.
- This provided the basis to include cost offsets across hospital inpatient rates of admission and lengths of stay, community mental health, emergency department presentations, contact with corrective services and community corrections.
- The economic modelling results for a 5-year timeframe base case show a net cost saving of around $86,000 and a positive outcome of around 0.25 QALYs.
- To examine the characteristic uncertainty in longer term outcomes additional model scenarios were developed for 1- and 2-year timeframes.
    - The results indicate a low probability of around 43% the program is cost effective over 1 year.
    - As the initial cost investment continues to provide sustained consumer outcomes the probability the program is cost effective increases to 67% over 2 years and is estimated at 95.3% in the 5 year base case.

- The CLS-HASI program cost effectiveness results are consistent with the previous HASI evaluation which reported the program was likely to be self funding over 2 years when healthcare cost offsets were included.
- The economic modelling results are also consistent with the recent Productivity Commission Inquiry into mental health which indicated that service expansion is likely to be highly cost-effective including community-based programs.
- The scale of model results across multiple years indicates the CLS-HASI program continues to be highly cost effective.

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Mental Health
Commission
of New South Wales

Insights Report: The role of Peer Navigators

Final Report

August 2023

Acknowledgement of Country

The Mental Health Commission of NSW acknowledges the Traditional Custodians of the lands where we work and live. We celebrate the diversity of Aboriginal peoples and their ongoing cultures and connections to the lands and waters of NSW.

We pay our respects to Elders past, present and emerging and acknowledge the Aboriginal and Torres Strait Islander people that contributed to the development of this report.

We advise this resource may contain images, or names of deceased persons in photographs or historical content.

Lived Experience Acknowledgement

The Mental Health Commission of NSW also acknowledge people who have lived experience of mental health issues and distress, and the lived experience of their carers, families and kinship groups. The Commission is committed to amplifying the voices of all those with lived experience. We value and respect their wisdom and expertise, and the bravery it can take to speak up. Together we will work to ensure people's right to live meaningful, healthy lives, free from stigma and discrimination.

Insights Report: The role of Peer Navigators

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Contents

1

Overview and purpose of report

1. Overview and purpose of report

The Mental Health Commission of NSW (the Commission) extends its thanks to members of the Peer Navigation Project Advisory Group for their valuable guidance. Importantly, the Commission also recognises and appreciates the contribution of those involved in the project pilot sites; peer navigators, consumers, carers, staff and service providers.

1.1 Background

Between 2021-2023 the Mental Health Commission of NSW (the Commission) undertook the Peer Navigation Project. The project developed from consultations for Action 14 of the *Living Well in Focus 2020-2024: A strategic plan for community recovery, wellbeing and mental health in NSW*, which identified the need to improve referral pathways to connect individuals with the right services and supports to improve their outcomes.

The purpose of this project was to examine the potential role of peer navigators, who can draw upon their personal lived experience of mental health issues and connection to communities and familiarity with local services, to help individuals access the right care and supports. To explore, test and evaluate the concept of peer navigation, the Commission collaborated with individuals who have personal lived experience of mental health issues, their families, carers and kin, as well as representatives from the mental health and human services sectors.

The primary objective of the first phase of the project was to explore the value of peer navigation to strengthen connection at the intersections between mental and physical health and other human services with a mix of informal, community, social service, cultural and clinical supports. An Insights Report, available on the Commission's website, documents the extensive discussions and workshops held with participants, and outlines the preliminary findings of the first phase of this project.

Exploring the value of peer navigation demonstrated its importance in:

- Building capacity to navigate service systems and advocate for coordinated and integrated care and supports for individuals
- Having a peer worker provide non-clinical support to people experiencing mental health issues and supporting them to navigate the service system
- Integrating social connection within mental health care
- Addressing the broader social determinants of health and factors that could contribute to mental ill health (such as homelessness or not having a regular general practitioner), and
- Supporting service systems where there is a workforce shortage and/or high workload of mental health clinical staff, such as regional and rural areas of NSW.

The main objective of the project's second phase was to examine the potential role of peer navigators and test the model with several communities and organisations across NSW. This report summarises the findings from the four pilot sites that trialled the peer navigation model between 2021-2023.

1.2 Overview of phase two

The core components of phase two of the Peer Navigation Project were to:

1. Develop and test peer navigation roles for priority population groups through four pilot sites (see table below), and
2. Develop specific training for peer workers around system navigation through the addition of a peer navigation unit for the Certificate IV in Mental Health Peer Work.

Table 1. The four peer navigation pilot sites.

Organisation/agency	Focus
Western NSW Local Health District (Western NSW LHD)	Individuals living in rural and isolated communities in NSW
Marathon Health	Young Aboriginal women in rural NSW
ACON	Transgender people in NSW
South Eastern Sydney Local Health District (SESLHD)	People experiencing complex mental health issues in tertiary hospital settings

Findings from the four pilot sites show the adaptability and effectiveness of the peer navigator model within the mental health and related service systems. They also highlight the value of lived experience as fundamental to the success of the model.

For consumers, key benefits of peer navigators included feeling supported and empowered to understand and navigate a complex system, increased engagement and willingness to reach out for help, timely access to services that reflect their diversity and needs, and improved mental health and recovery outcomes.

For staff and providers, the visibility of the peer navigators, who were embedded in services, was central to understanding and valuing the peer navigator model. Education and training, including for peer navigators, was also essential. Other findings show that staff improved their knowledge of mental health and related services, and that peer navigators filled a gap in support and service provision, particularly in areas with limited clinical staff.

A challenge for pilot implementation was the short pilot timeframes, which affected onboarding and upskilling of peer navigators, and their capacity to build rapport with consumers prior to engaging in navigation work. Timeframes were further impacted by prolonged flooding in some of the pilot areas.

Role delineation and scope of practice was also a challenge, including where the level of support required by a consumer surpassed the role and ability of the peer navigator. At times, lack of services and resources available for referral created a barrier, particularly when consumers required immediate assistance such as with housing.

This report also summarises the second core component of the project to develop a nationally recognised unit on peer navigation for the mental health peer workforce undertaken by the Mental Health Coordinating Council (MHCC).

#2

Key outcomes of phase two

2. Key outcomes of phase two

Key outcomes of the four pilot sites are summarised below.

Table 2. Key outcomes of the project.

Improvement in referral pathways and consumers and staff knowing how to navigate the service system	— Consumers felt supported and empowered in navigating the often complicated mental health and related service system — Consumers were more likely to engage with services with a peer worker walking alongside them and offering warm handovers and active follow up — Timely access to support was improved — Unsuitable referrals and missed appointments were reduced, leading to shorter waiting lists
Improved mental health and recovery outcomes, reduction in distress and willingness to seek help	— Many consumers reported feeling less alone, better understood and listened to — Many consumers reported a reduction in distress and use of alcohol or other drugs — Others reported a beneficial change in their attitude toward the mental health system and willingness to reach out for help — Consumers felt more empowered to take steps towards their personal recovery and healing
Improvement to the system and staff practice	— Staff and providers improved their knowledge of mental health and related services, particularly non-mental health staff — Peer navigators filled a gap in support and service provision, particularly in areas where clinical staff are limited (e.g. rural communities)
Improved understanding of, and access to, peer workers	— Embedding peer navigators into settings that may not traditionally employ peer workers (e.g. Emergency Departments) improved access to peer-led support — Visibility of peer navigators improved understanding and valuing of peer work to staff and communities, particularly in non-traditional settings — Training and support for staff, including the peer navigator, was crucial to embedding the role
Consumers saw increased access to services that reflected their diversity and needs	— Lived experience is an essential component of the success of the programs — Knowing the peer navigators have lived experience is helpful for consumer engagement and provides a unique depth of understanding, particularly where peer navigators are a member of the community they are supporting — The peer navigator model is adaptable for different services and can incorporate diverse experiences and intersectionality

3

Peer Navigation Pilot Site Evaluation Summaries

3. Peer Navigation Pilot Site Evaluation Summaries

Each pilot program was evaluated to determine the outcomes, opportunities and challenges of program implementation. Overall, the pilot programs had positive outcomes for consumers, carers and staff (including the peer navigators and their colleagues). Importantly, the pilot sites showed that the peer navigator roles filled a gap in service provision, particularly regarding navigating and connecting people with services, advocacy, mental health education, and peer support and recovery planning.

This proved beneficial in busy settings like emergency departments in Sydney as well as isolated communities in rural NSW. Additionally, gaps in culturally responsive and trauma-informed care were filled through the employment of Aboriginal Peer Navigators and Trans and Gender Diverse Peer Navigators.

Several of the pilot sites have explored ongoing employment opportunities for the peer navigators or have embedded peer navigation into mental health peer work roles and new services. Embedding peer navigation into mental health peer work roles will be supported by the Peer Navigation Unit being developed by the MHCC (due for completion in 2024).

Evaluations of each pilot site are summarised below.

3.1 Western NSW Peer Navigation Pilot Project

The Western NSW Peer Navigation Pilot Project aimed to support equitable access to mental health treatment and care for people in isolated rural communities via a peer navigation model. The project supported navigation of, and access to, mental health services with a peer navigator position established in each town (Warren and Coonabarabran).

The peer navigators supported people to navigate referral processes for timely engagement, by establishing links and rapport with service providers. Moreover, the peer navigators' familiarity with local services and processes contributed to supporting access to services. For example, a person was assisted to visit a bulk billing general practitioner (GP) in a neighbouring town, providing a solution that had both a fiscal benefit and was more suited to the person's needs.

The peer navigators established strong links with Western NSW LHD Mental Health Drug and Alcohol Services, ambulatory and inpatient services, community services, non-government psychosocial service providers and humanitarian services such as Rotary and the Warren Health Action Group.

3.1.1 Scope of the program

The Peer Navigation Project was established and implemented using co-design methodology with both peer navigators establishing strong links and a visible presence in the community.

In Coonabarabran, the Peer Navigator was based in the community health team and worked closely with the visiting Mental Health Clinician, Drug and Alcohol Worker and Aboriginal Health Worker.

The Peer Navigator provided in-reach to the emergency department and the hospital as needed. In Warren, the Peer Navigator worked closely with the Aboriginal Health Worker, GPs and the Warren Youth Group. The Peer Navigator was based at the Multi-Purpose Service (MPS) and also worked out of the GP surgery, Warren Youth Centre and the Residential Aged Care Unit.

The strength and success of the pilot project was the co-design approach, with each peer navigator working within their role to respond to the unique needs of the community. The visibility of the peer navigators in their communities allowed for referral processes to occur informally. Peer navigators reported receiving referrals from all areas of the community, as well as from colleagues and service providers.

3.1.2 Evaluation overview

A formal evaluation (Beck, Coote, Raftery, Sng, & Kelly, 2022) was prepared by researchers at the University of Wollongong, Western NSW LHD and The Peregrine Centre and is expected to be published. The evaluation was funded as part of The Peregrine Centre's Rural Mental Health Partnership with NSW Health. The qualitative study was designed to explore consumer, provider and peer navigator experiences of the pilot program. A sample of consumers (n=11), providers (n=5) and peer navigators (n=2) were interviewed.

A summary of the evaluation from the formal evaluation report is included below.

3.1.3 Client demographics and sessions provided

A total of 96 peer navigation sessions were provided during the 3 month evaluation, with 61.5% of these being unique presentations. Approximately 44% of participants identified as Aboriginal or Torres Strait Islander and just under 60% of participants identified as female. Most participants were aged 26-40 years with the next most prevalent age groups being 41-65 years and 18-25 years.

The majority of support provided was 1:1 peer support, with just under 10% of sessions primarily focusing on advocacy. Participants were supported to access psychologists and social supports most frequently, with GPs, community mental health teams and drug and alcohol services also common.

3.1.4 What were the outcomes and challenges?

Service providers, consumers, carers and community members reported easier and more streamlined access to services with support from the peer navigators. Additionally, it was reported that the peer navigators were able to motivate and encourage people to link with services or provide assistance to manage anxiety when accessing, or planning to access, support.

Participant feedback

Consumers, providers and peer navigators commonly reported that knowing the peer navigators had lived experience was helpful for consumer engagement and provided a unique depth of understanding (Beck, Coote, Raftery, Sng, & Kelly, 2022).

> *“I think she understands me a lot better.”*
> *- Tyler (20-29), Site 2*

The evaluation found “this experience of ‘mutual understanding’ meant that consumers felt better able to share their experience without fear of being judged or dismissed. This was often contrasted with the challenge of talking to providers who did not have lived experience" (Beck, Coote, Raftery, Sng, & Kelly, 2022, p. 9).

> *"They've been through it. They've lived it. And people warm to that. They seem to warm to that. And they know that they're not going to be judged."*
> *- Vanessa, 50-59, Provider*

The collaborative and flexible nature of the relationship was highlighted as a positive by providers and consumers alike, and consumers appreciated having the option of meeting in a more 'casual' setting like a café or at home (Beck, Coote, Raftery, Sng, & Kelly, 2022).

Consumers and providers both described how an active approach to contacting consumers helped overcome emotional and attitudinal barriers to accessing support. Consumers often contrasted the active follow-up demonstrated by the peer navigators with prior unhelpful experiences characterised by extended periods of waiting and uncertainty (Beck, Coote, Raftery, Sng, & Kelly, 2022, p. 11).

> *"It was a little bit difficult because even though I had gone to my GP and told them what was going on with myself, inside my own head, and stuff like that, they contacted and got referrals done for a counsellor. But then nothing really major happened. So, it took a while. And then when I got in contact with [navigator], yes, she speeded things along a lot quicker."*
> *- Camila, 20-29, Site 2*

The ease with which the peer navigators could be contacted was frequently raised by consumers and providers. Within the context of long wait lists, limited clinical services and time-poor clinicians, the availability of navigators meant that referrals could be made, and support offered sooner than would otherwise occur through traditional channels (Beck, Coote, Raftery, Sng, & Kelly, 2022, p. 12).

> *"It just might be that the community knows that [navigator] is at the library on a Tuesday at such-and-such. Do you know what I mean? It's easy. They're visible to the community."*
> *- Maria, 50-59, Provider*

Providers also commented on how the number of inappropriate referrals had reduced, thereby reducing waitlists and administrative load (Beck, Coote, Raftery, Sng, & Kelly, 2022, p. 13).

> *"…been able to do referrals, have support with people that are linked with us. So that's stopped them reaching out through the triage, which means more paperwork, puts more of a load on us. It takes a load off us that way… It might not seem like it's much, but just the support that the people have been getting from them… They're taking a lot of the workload off us. And they're being a good support over there."*
> *- Amanda, 40-49, Provider*

The evaluation found “many consumers also derived comfort from knowing that they could reach the peer navigators should they need to. Providers described how for some consumers, this brief contact with a navigator was enough to ‘hold them over’ to the next appointment, for others it afforded an opportunity to seek a referral or advice around appropriate services” (Beck, Coote, Raftery, Sng, & Kelly, 2022, p. 13).

> *“And if I want to talk, I can talk to her. It’s just nice knowing that she’s there when I need her.”*
> *- Kimberly, 40-49, Site 1*

> *“…there’s also this huge gap out here of psychologists and therapists, that are just either not available, long waiting lists, unaffordable. And sometimes all people need is just a bit of supportive therapeutic contact which people are able to get from a Peer Navigator.”*
> *- Amanda, 40-49, Provider*

The emotional and practical support offered by peer navigators within the context of service utilisation was also raised. For example, some people found it helpful to have someone to talk to while waiting at the emergency department, while others appreciated having someone to walk them to and/or attend appointments with them (Beck, Coote, Raftery, Sng, & Kelly, 2022, p. 15). Providers noted a reduction in the number of missed appointments since the pilot began and benefits of having a peer navigator attend appointments with clients.

> *“…they're waiting for a mental health assessment from the video team in Orange, or whatever that is, they've been able to sit there with them and support them through that. That's invaluable…”*
> *- Rachel, 20-29, Provider*

Peer navigators played a crucial role in linking people to services, including mental health and other services like housing or employment. Many consumers did not know where to seek community-based mental health support while others had received referrals that had yet to be actioned or could not afford the providers and needed an alternative (Beck, Coote, Raftery, Sng, & Kelly, 2022). Similarly, providers appreciated having a local point of contact with extensive knowledge of the local service system to seek advice or make a referral.

All consumers reported that contact with the peer navigators contributed to improvements in their mental health and motivation to manage their mental health, with many reporting a reduction in distress and use of alcohol or other drugs. Others reported a beneficial change in their attitude toward the mental health system and willingness to reach out for help and talk about their experiences (Beck, Coote, Raftery, Sng, & Kelly, 2022).

Peer Navigator experience

A structure of support was established to ensure the Peer Navigators were connected to clinical teams and supports although working remotely and often independently. Weekly check-in meetings were held with the Peer Workforce Coordinator, monthly review meetings with the Team Leader and regular clinical support from the Mental Health Drug and Alcohol Clinical team. The provision of a structure of professional development, support and supervision with the aim to grow the rural workforce was applied, with both peer navigators extending their contracts for another six months.

Both peer navigators described the importance of ensuring that the scope and boundaries of the role were made explicit to consumers and services. In some instances, uncertainty about the role scope led to consumers and providers making requests of the peer navigators that were 'out of scope'. Although both were comfortable and willing to assert their boundaries, this was often experienced as 'tricky' within the context of limited access to clinical support (Beck, Coote, Raftery, Sng, & Kelly, 2022, p. 21).

> *"It can be tricky at times, but I've just learnt that I don't overstep my boundaries, and I make it clear where my boundaries lie in that first initial meeting."*
> *- Laura, Peer Navigator*

The importance of ongoing training and support was raised, and some providers spoke of the potential to 'upskill' the peer navigators.

> *"I think making sure that they've got an opportunity to access education, and maybe then upskilling. I mean a lot of them have very valuable skills but just not had opportunity, maybe to sort of look for more training."*
> *- Amanda, 40-49, Provider*

Opportunities and challenges with implementation

Local and prolonged flooding impacted on service provision in both towns, with Warren at times completely and repeatedly isolated. The presence of the Peer Navigator in the town supported ongoing connection to services who visit the town from major centres.

Rural communities cited the loss of services and supports and a reluctance or inability to travel to larger towns to seek support. The presence of the Peer Navigator regularly supported access to remote services, in particular mental health clinical services, when the clinician was prohibited from travelling due to environmental factors.

Challenges and considerations pertained to the positioning of the navigators within the broader health care system, their scope of practice, the impermanence of this valued source of support and suggestions for improvement (Beck, Coote, Raftery, Sng, & Kelly, 2022).

One consideration consistently raised by providers was the importance of embedding navigators within a service. This meant that peer navigators had access to the infrastructure and support required to perform their role. Embedding the peer navigators also increased their visibility to providers (Beck, Coote, Raftery, Sng, & Kelly, 2022).

> *"And they've got the clinical governance if they need it. They've got escalation pathways. They've got all that stuff in place."*
> *- Eric, >60, Provider*

Suggestions for improvement typically focused on expanding the service. Both consumers and providers wanted more promotion of the service and more peer navigators to be available. Some consumers suggested expanding the role to provide group programs or outings would improve community connection and opportunities for peer support.

> *"I think there need to be a lot more peer workers. I understand that job wouldn't be easy, but they do help. And, like I said, it's been one of the best things that's helped me, is to have that extra support."*
> *- Camila, 20-29, Site 2*

> *"I think it's a resource we could use more of. I think it'd be good to have one in every town."*
> *- Eric, >60, Provider*

The evaluation highlighted considerations for team-based implementation using a co-design approach: "Importantly, aligned with the flexible, needs-driven approach adopted in the current evaluation, the study sites differed in their approach to team-based implementation. For one navigator, this meant spending part of her time co-located within a clinical team. For another navigator, remote access to a clinical team and relationship building within the local community were more strongly emphasised. The co-design of peer navigator programs is central to ensuring alignment between the structure of the program and the needs and infrastructure of the local community. It does however complicate evaluation and dissemination" (Beck, Coote, Raftery, Sng, & Kelly, 2022, p. 26).

Similarly, concordance between central features of these roles with other peer worker positions was found, although clear role delineation was complicated by the flexible and co-designed nature of the pilot programs in each community.

The evaluation found peer navigators provided continuity of care between appointments with clinicians and could be utilised in lieu of clinical staff as the first point of contact within rural communities. This could partially address resourcing challenges experienced by remote communities and may help with the economic viability of the initiative (Beck, Coote, Raftery, Sng, & Kelly, 2022).

Training and ongoing professional development are essential to support implementation. Services that are considering employing a peer navigator need to ensure that policies and procedures support ongoing mentoring and development. Integration of the peer navigator into multidisciplinary teams is improved through preparing the organisation for the new role and staff training (Beck, Coote, Raftery, Sng, & Kelly, 2022).

Conclusion

The pilot has been successful in establishing peer navigator roles in two rural communities. In addition to identifying how peer navigators can contribute to the overall wellbeing of the community through navigating and supporting access to care, the Peer Navigation pilot has identified how a service gap of employing and retaining clinical staff can be ameliorated.

Feedback from consumers, providers and peer navigators highlighted the benefits of peer navigators for enhancing consumer engagement through an active approach, facilitating timely access to support and empowering consumers: "Peer navigators may offer a dynamic, engaging solution for helping to address the many health disparities faced by people living in rural communities." (Beck, Coote, Raftery, Sng, & Kelly, 2022, p. 30).

The Peer Navigation Pilot Project in Western NSW was extended until June 2023 and Western NSW LHD has since funded the program permanently.

3.2 Marathon Health Peer Navigation Pilot Project

The program operated from March-December 2022 in Condobolin, NSW. Warrugarra (Wiradjuri language for *Home*) aimed to support disadvantaged girls and young First Nations women aged 16 to 35 to access mental health and wellbeing programs and community-based social supports. An Aboriginal Peer Navigator was employed to ensure culturally appropriate services and provide relatable support and mentoring – building people's self-confidence and knowledge and removing barriers hampering their recovery journey.

3.2.1 Scope of the program

The scope of Warrugarra was to support up to 20 women within the program's funded period. There was also a focus on determining the benefits of the peer navigation program and its ability to support the Aboriginal Peer Navigator to develop their leadership skills and confidence. For this program, the Aboriginal Peer Navigator was:

- A paid employee of Marathon Health
- Employed on a part-time contract at 53 hours per fortnight
- A local resident of Condobolin with no formal training prior to being employed in this position
- Identified as having a lived experience of mental health issues
- A past client of the Condobolin Wiradjuri Wellness Project.

This position and pilot program, although a stand-alone service, was embedded in the existing Condobolin Wiradjuri Wellness Project and co-located at the Condobolin Marathon Health office.

3.2.2 Evaluation overview

Support was provided to program staff to evaluate the program during and after delivery – with the aim to understand how Warrugarra impacted both participants and the Peer Navigator.

The evaluation used a mixed quantitative and qualitative design. Four outcome measures were used to collect data on participants' wellbeing, goal setting and progress towards goals, and overall satisfaction through the pilot period.

Measures included Goal Attainment Scaling (GAS), the Modified K5 for Aboriginal and Torres Strait Islander peoples, Personal Wellbeing index and consumer satisfaction surveying. These were applied at regular intervals, including initial and in three-month intervals or on exit from the program. Qualitative data was also obtained from the staff and participants through semi-structured interviews and staff reflective journaling.

3.2.3 Client demographics and sessions provided

There were 15 First Nations young women supported through the pilot period. The average age was 24.7 years which included six participants in the 16-18 aged cohort, and nine ranging from 20-29.

Six participants (40%) were supported through most of the pilot program, with a successful and planned transition to another service. Support included goal planning, engagement in service navigation and relevant referrals.

Four participants (27%) were supported with initial meetings with the Peer Navigator and guided with navigation to relevant services and education, before exiting to appropriate pathways.

Five participants (33%) accessed group-based events and education sessions. The Peer Navigator provided mental health and social and emotional wellbeing resources and information on available services.

Overall, there were 80 individual occasions of service with participants, including the facilitation of 30 referrals to external services. This translated to an average of 7.5 occasions of service, with an average of 2.2 referrals for program participants. This reflects pleasing engagement and interest in the program.

3.2.4 What were the outcomes and challenges?

Participant feedback

Feedback surveys were provided to all participants and eight surveys were completed. Levels of satisfaction were high and 100% of respondents agreed with the following statements:

- I felt listened to and my needs were understood
- I was supported in making choices about the service I received
- I was helped with issues that were important to me
- I was helped to build my self-esteem and confidence
- I would be happy to recommend the service to others.

Participant improvements were high, with 100% agreeing or strongly agreeing that their ability to understand and better manage their mental health and wellbeing had improved.

Goal Attainment Scaling

Goal Attainment Scaling (GAS) was used throughout the program to measure success in achieving participants' identified goals. Goals were divided into the categories of:

- Vocation and education
- Linking to social and emotional wellbeing/mental health services
- Self-confidence and empowerment
- Social skill development
- Housing.

Six of the 15 program participants provided data on this measure on entering and review/exit of the program. All had links to relevant services included as a goal within their personal support plan with the Peer Navigator. Service linkages included connections to:

- Acute mental health services
- Community mental health services (both locally and outside of Condobolin)
- Local group-based cultural programs
- Services to support with birth certificates and license documents
- Generalist counselling
- Social and emotional wellbeing programs.

On average there was an improvement score across this data set meaning, on average, participants felt they had achieved their set goals at a rate 16.7% higher than they had expected.

Every participant who completed initial and exit GAS achieved their goals with higher-than-expected improvements to social isolation, their sense of community wellbeing, and overall self-confidence.

> *"This program helped me to build social skills."*
> *- Participant*

Modified K5 (MK-K5)

Six of 15 (40%) program participants completed initial and follow-up screenings with the modified K5 which measured for depression and anxiety. If a participant had a score which indicated they may be experiencing depression and anxiety, they were referred for further support from a clinician in addition to peer navigation.

Almost all participants (5 out of 6) who completed the MK-K5 required further mental health support from a clinician. On repeat application of the MK-K5, three participants self-reported improvements, two stayed the same, and one increased in need for further mental health investigation.

Personal Wellbeing Index

Six of 15 (40%) program participants completed an initial and final Personal Wellbeing Index (PWI) screening. The PWI measures seven core domains to assess participant satisfaction and wellbeing. Domains include relationships, achieving in life, standard of living, health, community connectedness, personal safety and future security.

There were no significant changes in wellbeing from initial to secondary screening. Overall, the mean of the initial and follow up values out of 100 was 50.48. This is considerably lower than the NSW average in 2021 of 75.10.

Peer Navigator experience and feedback

This pilot considered the support and professional development needs of the Peer Navigator. The Peer Navigator is a local Condobolin-based First Nations woman who had been a participant of the Condobolin Wiradjuri Wellness Project, and particularly the SHINE Women's Group.

The Peer Navigator experienced positive outcomes from their time in the role. There was a significant increase in confidence, leadership and understanding of the role as a Peer Navigator. This role was embedded with numerous support mechanisms including operational support, extensive training and mentoring from a peer leader (over 20 hours) that optimised opportunities for success.

More than 60 hours of training was provided, including training tailored for peer workers as well as organisational and governance training, DV Alert, De-Escalation, Safeguarding and Child Protection, Calm Care and Suicide Awareness training.

> *"My time started by learning the Marathon Health system and completing Peer Work training. I was lucky enough to meet fellow Peer Workers and develop a connection. Marathon Health offered ongoing professional development internally, which was awesome. I really took a lot out of all the training, and this played a massive part in my growth... Reflecting on these highlights along the journey has made me realise how much I have grown. From someone with lived experience in mental health and recovery, who had little to no confidence, I have grown immensely, learning the power of using your lived experience to support others who are on their own recovery journey has been so empowering for me... I will be forever grateful for the opportunity I was given by Marathon Health, as my time here has been life changing."*
>
> *– Peer Navigator*

Mentoring for the Peer Navigator was seen as an important component of the success of the program. The Peer Navigator stressed the importance of having someone external to the team to reflect with, and connect to, as they learned the role and built confidence. Mentorship also allowed for access to a broader peer worker team and community. This was important to reduce isolation, especially for a Peer Navigator who was operating alone and was geographically disconnected to other peer workers.

Since completion of the pilot, the Peer Navigator has continued to study the Cert IV in Community Services with plans to continue employment in the local community. Ongoing employment options are being considered by Marathon Health.

Strengths and challenges of implementation

Timeframes were highlighted as a challenge for the program, particularly the short-term nature of the pilot (12 months). Marathon Health staff felt that increased time to connect and engage in culturally appropriate ways was essential before diving into outcome-based deliverable work. It was noted that the short pilot timeframe was detrimental to a community such as Condobolin, where services may be seen to “come and go”.

> *“This program has helped me to express my feelings and to help me relax, I wish the program was for longer.”*
> *- Participant*

Unfortunately, this was further impacted by the Condobolin community experiencing flooding during the pilot. This affected both service delivery and face-to-face mentoring sessions for the Peer Navigator.

Through the pilot, the cohort of participants that connected with the Peer Navigator were often determined to be in a state of crisis. The Peer Navigator highlighted that she felt mental health navigation was “not high on their list,” and at times she felt that they needed help that was beyond “the scope of her role”.

A clear theme within this cohort of participants was that the level of support required at times surpassed the role and ability of the Peer Navigator. As predicted, it was favourable that this role was embedded within existing services, as it allowed for successful referral pathways and escalation of support needs to other team members.

> *“The Peer Navigator helped me feel welcome and comfortable. I felt heard and listened to and I got regular check ins and phone calls, it felt relaxed. I was also supported by my case worker at Marathon Health and attended the women’s group SHINE. I was referred to NewAccess, a phone service within Marathon Health, and they were great and really supportive. They allowed me to talk and listened to me which helped a lot. They also called regularly to check in on me, which really made me think they cared and listened to me.”*
> *- Participant*

The team environment was seen as pivotal and played a large role in the Peer Navigator’s experience. Therefore, key factors for success include a team with a willingness to learn and understand the role of the Peer Navigator, communication, compassion and strong leadership.

Given that the concept of a Peer Navigator was new in the community, opportunities for increased education and communication with the community about the role and function of peer navigation would have been advantageous. There was also a push for increased focus on group activities and community engagement, and the ability to gain more organic referrals was highlighted as being connected to issues with the program timeframe.

> *“I would recommend this program to others, and I have already… There needs to be more programs like this, and it needs to be for longer.”*
> *- Participant*

This approach would support a culturally appropriate pathway, and one that requires more time and resourcing. A peer navigation participant highlighted the importance of this approach being non-clinical:

> *“It supported me to make changes and was different than other services, more relaxed, not so clinical and more about me and my needs.”*
> *- Participant*

As previously mentioned, mentoring and connecting with other peer workers was seen as an important component of this program. The mentor highlighted that based on the context of the position and the team, more mentoring (e.g. fortnightly) and more face-to-face contact with the Peer Navigator would have been favourable.

The Peer Navigator’s lived experience was important in this model and their experiences and skills also benefitted from additional training. A staged approach to support the Peer Navigator to step into the role would be a consideration for future programs. Prior training or exposure to peer work would have been ideal, especially in pilot projects where there are limited timeframes for service delivery. There was extensive initial training, and this combined with starting a new role was at times overwhelming for the Peer Navigator.

A challenge with the program was engaging the 16-18yr old age group without withdrawing them from school and impacting their attendance. Through consultation with the high school, the Peer Navigator was able to deliver a wellbeing program inside the school with young girls who were identified by school staff as needing the support. This was a wonderful achievement for the program and was a creative and successful approach.

> *“I really like it; it has helped me both in and out of school. It would be good to have more of it.” – Participant*

Conclusion

The pilot successfully enabled access to needed ongoing support for young Aboriginal women, facilitating over 30 referrals to services such as acute mental health, psychosocial supports and mental health coaching. This program successfully allowed the delivery of integrated support with other service provisions within the Condobolin community.

The Peer Navigator was able to identify and resolve barriers to service access, and to improve health and help seeking behaviours. The Peer Navigator enabled participants to access support in navigating a highly complex mental health and community services system, in ways that were culturally safe and empowering.

Culture plays a crucial role in resilience and mental wellbeing, especially for First Nations communities. Timeframes that enable a deeper connection with community and an opportunity to build trust and rapport and support larger evaluation data sets are recommended.

3.3 P4T Trans Peer Navigator Pilot Program - ACON

P4T was a pilot trans peer navigation program designed to provide peer support to trans and gender diverse (henceforth trans) adults living in NSW. The program centred trans self-determination, autonomy, and agency.

ACON ran the pilot from May 2021 to October 2022. The service was peer-led and community co-designed over six months. This included extensive consultations and research by a team of three part-time trans staff. In December 2021, four additional staff were hired, bringing the team to six peer navigators and one project coordinator. All staff were peers, including trans women, trans men, and non-binary people, with two Aboriginal trans staff members.

3.3.1 What is a Trans Peer Navigator?

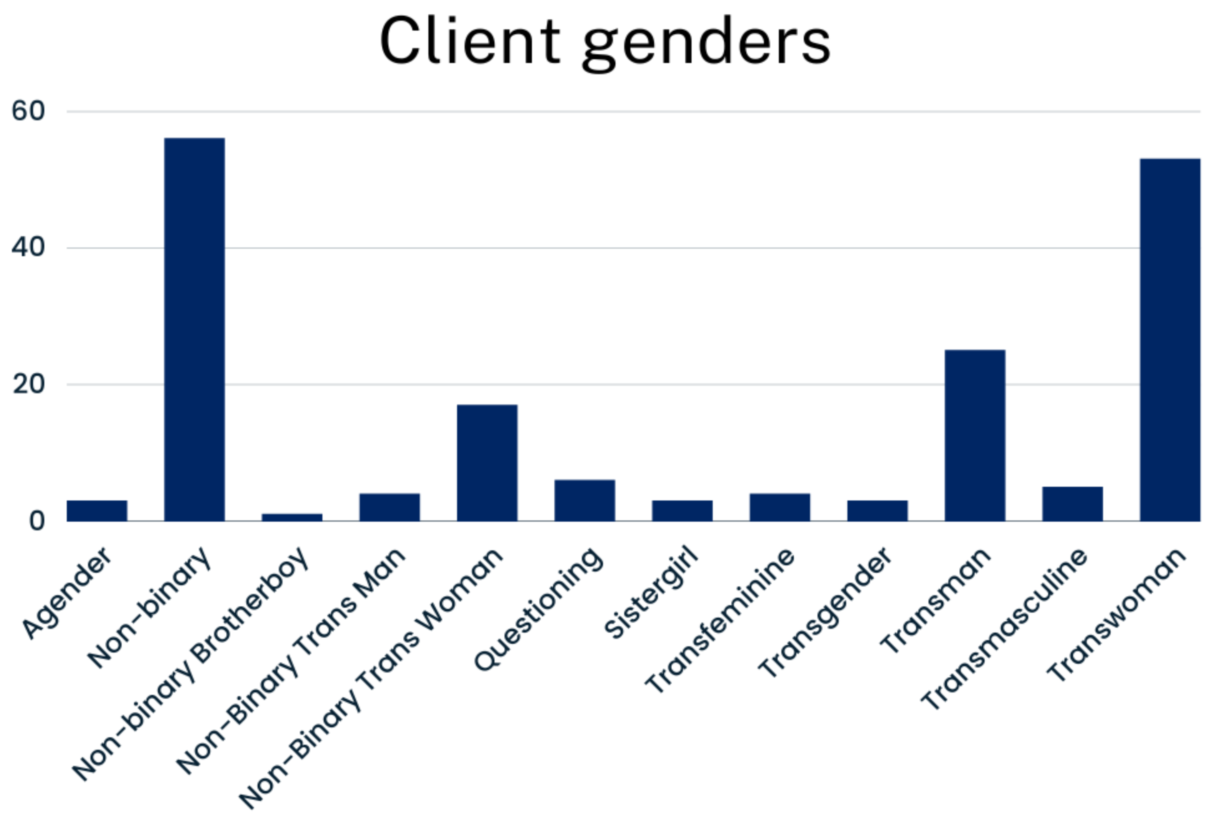
Trans peer navigation is a role bridging advocacy, referral and informal support between people with a trans lived experience. All of the peer navigators in this pilot also had a lived experience of mental health issues.

The role is focused on supporting trans people to improve access to resources and information for a wide range of health and personal needs including medical, legal and social gender affirmation support, and housing and employment. Trans peer navigation is person-centred and peer navigators provide support to trans people using their lived experience. This role builds on the success of peer work roles in mental health and HIV+ communities, in addition to research that shows peer support constitutes a significant protective factor for trans health and other aspects of trans life (ACON, 2022).

3.3.2 Client demographics and sessions provided

Clients of P4T (including those who applied but were referred on) ranged in age from 18 to 65, with over a third (40.2%) being 18-25 and another third (35.5%) aged 26-35. 9.8% of clients were of Aboriginal and/or Torres Strait Islander descent, and over a quarter (27.2%) were living regionally at the time they participated in the program. The program provided services to people across the gender spectrum, with trans women and non-binary people being the most prominent genders represented.

Figure 1. Client genders



*Clients who listed any non-binary gender categories (e.g. genderqueer) were all listed as non-binary for clarity. Clients who ticked both categories such as “man” or “woman” as well as non-binary categories are listed as non-binary man/woman respectively.

Across the evaluation period of January-September 2022, the service saw 99 unique clients, with nearly one-third utilising all four allotted hourly sessions and some requiring further support. The sessions were provided online with a peer navigator which further assisted regional and rural participation in the program.

The most common presenting issues were medical affirmation, identity, mental health and wellbeing, connecting with trans communities, social affirmation and relationships. Housing, legal gender affirmation and domestic and family violence were also areas of significant concern.

Referrals to other services was a key role of the peer navigators, often requiring multiple referrals to support each participant holistically. The most common services referred to were GPs, psychologists and counsellors, and other ACON services like care coordination or HIV+ Peer Support.

3.3.3 Workplace structures to support implementation

Fortnightly external professional supervision was provided as an essential component of professional development. The project coordinator was also available during the service operation hours for support or advice after a session. If a particular issue or difficulty arose, the peer navigators found time to meet and work out a solution together. It was noted by the peer navigators that having a coordinator who they could debrief with and seek advice from was an important aspect of the workday.

Complexity of presenting issues meant the peer navigators were required to develop competency across many fields. Although some of the peer navigators had previously worked in community services, many were new to the sector and therefore had to significantly upskill in order to best support the clients. Peer navigators upskilled in a variety of ways, but several stated that their most important tool in upskilling was by consulting with the other peer navigators. Sharing skills and information played a pivotal role in P4T's success.

3.3.4 What were the outcomes and challenges?

Of the clients who completed the post-service evaluation, feedback was largely positive, and showed a strong increase in ability to access support and gender-affirming services. Of the clients who completed the post-service evaluation, 80% rated the service 5 stars (the highest rating).

> *"Incredibly good service, made me feel comfortable and heard, not judged which is very uncommon. Feels great to be heard and understood by some[one] else."*
> *- Participant*

The service also significantly improved clients' confidence around navigating the service system. In the pre-service survey, 50.6% of clients said they agreed or strongly agreed with the statement "I am confident that I can access services I need", compared to 89.7% of clients in the post-service survey.

> *"Great at creating a safe, welcoming, and affirming environment. My peer mentor actively listened to me and made me feel supported, I felt like I could be completely honest with who I am and what I need because they got it too. They did their best to provide me with links and resources."*
> *- Participant*

Some clients also had little to no contact with other trans people prior to attending P4T and named the lived experience aspect of the program as vital to the service. The clients interviewed stated that they found the peer navigators to be knowledgeable, hands-on and enthusiastic. The P4T's unique position as a peer-led service was both what attracted them to the service and what helped them to achieve their goals.

The peer navigators were required to share their lived experience in purposeful ways as part of their role. Though this was a complex position to uphold and maintain, several peer navigators stated that disclosing information at the right moment was a great way to build rapport, provide clients with new information or context, or to simply make a client feel like they are not alone in their experiences.

Some of the challenges and considerations identified in the evaluation included:

- A cap on available sessions per client meant that peer navigators commenced referral processes quite quickly when it may have been preferable for some clients to build more rapport first.
- Lack of services and resources available for referral, particularly long waiting lists. This was additionally challenging when clients required immediate assistance such as with housing.
- Peer navigators who worked remotely felt more isolated than peer navigators who worked alongside each other in an ACON office. This brought regional and rural perspectives to the peer team, however meant that some peer navigators had less opportunity to connect with fellow peer workers.

- Trans community members who have other intersectional or marginalised identities and experiences require further consideration before and during program implementation. The experience of peer workers from diverse backgrounds was integral to the success of the program with the organisation working to ensure appropriate structures were in place to support staff.

The lessons of this pilot were included in the development of ACON’s new trans mental health service, comprising trans peer workers and trans care coordinator counsellors through ACON’s Client Services. This service includes workers at ACON offices in the Hunter, Sydney and Lismore regions.

3.4 South Eastern Sydney Local Health District (SESLHD) Peer Navigator Pilot Program

This pilot involved recruiting a full-time mental health peer worker to provide support to consumers experiencing mental health concerns as they navigated the tertiary health system in SESLHD and discharge to primary health and community support services. The position was seen as a critical link for providing improved support navigating the system for consumers and their supporters at St George Hospital.

3.4.1 Scope of the program

The Peer Navigator worked alongside staff in the Emergency Department (ED), Psychiatric Emergency Care Centre (PECC) and Consultant Liaison Psychiatry (CLP) team, and on general wards, to provide information, education and support to people experiencing mental health concerns. The role also educated members of the multidisciplinary team about peer work, mental health and trauma-informed and recovery-oriented approaches to build their capacity to educate and support consumers.

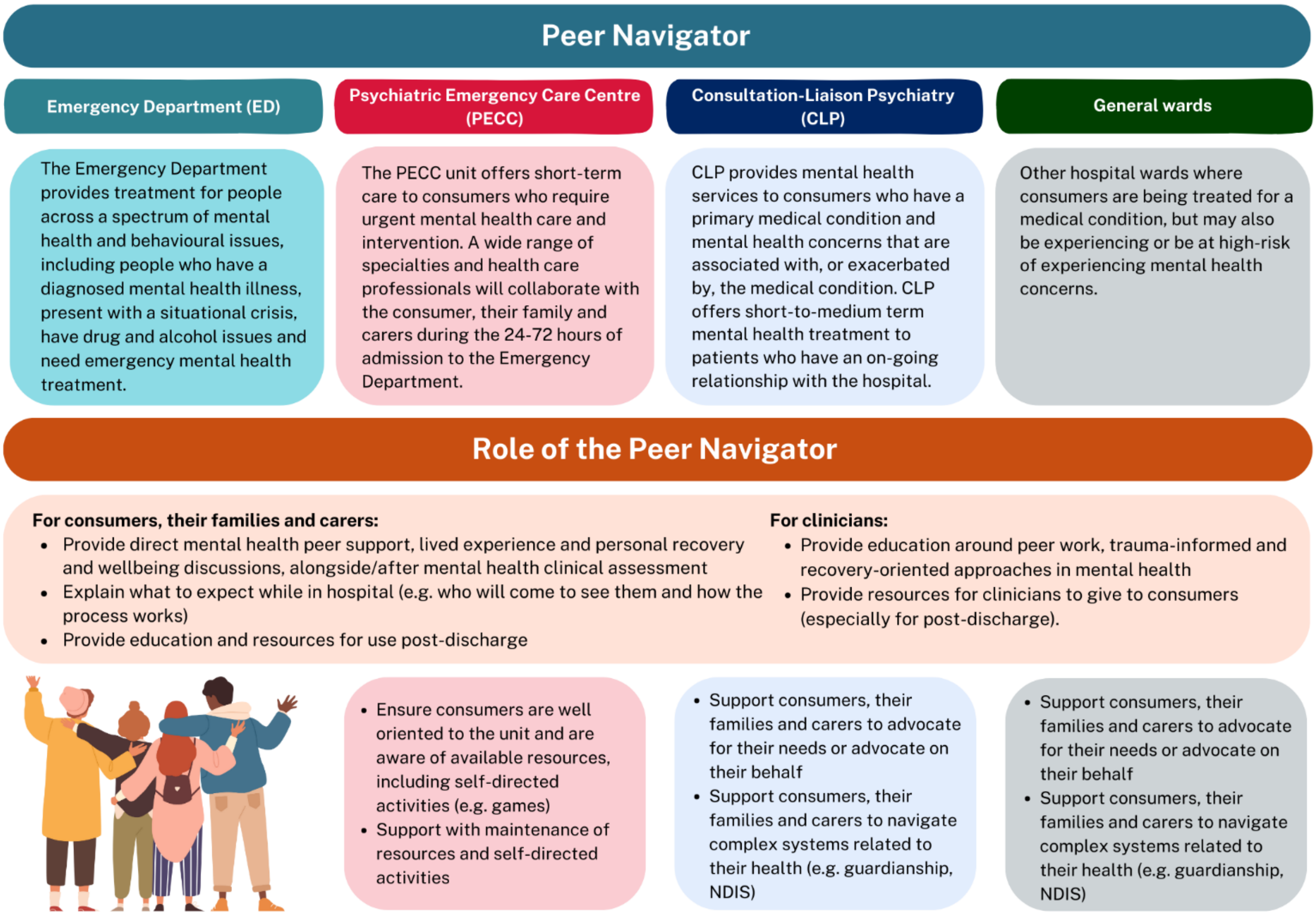
The Peer Navigator did this through direct mental health peer support and personal recovery and wellbeing discussions, support to orient people to the various hospital settings they were admitted to, and the provision of resources and education. The Peer Navigator also supported consumers to advocate for their needs or navigate complex systems related to their health (e.g. the NDIS). See Figure 3 below. Due to clinical governance structures, workload and large scope of the role, the Peer Navigator was unable to provide significant post discharge support.

The project aimed to create new insights into the viability and utility of a peer navigator role in settings where peer workers are less likely to be employed such as the ED, PECC and general wards of major tertiary hospitals.

The Peer Navigator interacted with the multi-disciplinary team in a variety of ways, including:

- providing resources
- updating other staff about the mental health status of consumers
- supporting staff to conduct initial assessments of consumers
- and clarifying and streamlining processes such as internal referrals.

Figure 1. Peer Navigator Model



Peer Navigator

Emergency Department (ED)

The Emergency Department provides treatment for people across a spectrum of mental health and behavioural issues, including people who have a diagnosed mental health illness, present with a situational crisis, have drug and alcohol issues and need emergency mental health treatment.

Psychiatric Emergency Care Centre (PECC)

The PECC unit offers short-term care to consumers who require urgent mental health care and intervention. A wide range of specialties and health care professionals will collaborate with the consumer, their family and carers during the 24-72 hours of admission to the Emergency Department.

Consultation-Liaison Psychiatry (CLP)

CLP provides mental health services to consumers who have a primary medical condition and mental health concerns that are associated with, or exacerbated by, the medical condition. CLP offers short-to-medium term mental health treatment to patients who have an on-going relationship with the hospital.

General wards

Other hospital wards where consumers are being treated for a medical condition, but may also be experiencing or be at high-risk of experiencing mental health concerns.

Role of the Peer Navigator

For consumers, their families and carers:

- Provide direct mental health peer support, lived experience and personal recovery and wellbeing discussions, alongside/after mental health clinical assessment
- Explain what to expect while in hospital (e.g. who will come to see them and how the process works)
- Provide education and resources for use post-discharge

For clinicians:

- Provide education around peer work, trauma-informed and recovery-oriented approaches in mental health
- Provide resources for clinicians to give to consumers (especially for post-discharge).

- Ensure consumers are well oriented to the unit and are aware of available resources, including self-directed activities (e.g. games)
- Support with maintenance of resources and self-directed activities

- Support consumers, their families and carers to advocate for their needs or advocate on their behalf
- Support consumers, their families and carers to navigate complex systems related to their health (e.g. guardianship, NDIS)

- Support consumers, their families and carers to advocate for their needs or advocate on their behalf
- Support consumers, their families and carers to navigate complex systems related to their health (e.g. guardianship, NDIS)

3.4.2 Evaluation overview

The evaluation, conducted from February to December 2022 by ARTD Consultants, sought to:

- assess the implementation and reach of the Peer Navigator Pilot Project,
- understand the experiences of consumers and their support people accessing the Peer Navigator and the multidisciplinary team,
- and assess the extent to which the project was able to achieve its intended outcomes.

It draws on several data sources:

- administrative data about people supported by the service,
- a survey of, and interviews with, consumers supported by the Peer Navigator and members of the multidisciplinary team, and
- an interview with the Peer Navigator.

Overall, there was sufficient data to report on program implementation, reach, staff experiences, outcomes and key learnings. However, low response numbers from the consumer and carer survey mean findings should be seen as indicative rather than representative of people supported by the Peer Navigator. A summary of the evaluation from ARTD Consultants is provided below.

3.4.3 Client demographics and sessions provided

The Peer Navigator reached a total of 88 consumers experiencing mental health concerns through 207 sessions from 22 April to 31 October 2022. The Peer Navigator saw similar numbers of consumers across the various settings in which they worked – 29 in the PECC unit, 26 in the ED and 34 on other wards.

The Peer Navigator supported a similar proportion of males (53%) and females (46%). Most (58%) ranged from 25 to 54 years of age, with the average consumer being 42 years of age. Consumers were predominantly born in Australia (73%).

3.4.4 What were the outcomes and challenges?

Consumer outcomes

Data suggests consumers and their support people who were connected to the Peer Navigator were highly satisfied with the information and support they received and had positive experiences. Almost all consumer survey respondents agreed that they were able to access the support in an easy and timely manner. Almost all were satisfied with the amount, accessibility and tailoring of the information and agreed they had received caring and compassionate support that made them feel respected, understood, listened to and like they could trust the Peer Navigator.

Data, while limited, suggests the Peer Navigator position is having positive outcomes for consumers and their support people. Most consumer survey respondents agreed that they:

- felt more empowered to take steps towards their personal recovery and healing
- had a better understanding of mental health services and supports and were more aware of how to access them
- felt less alone because of the support and information they received from the Peer Navigator.

Staff outcomes

Data suggests the Peer Navigator position achieved its intended outcomes and had positive impacts for the multidisciplinary team. Most staff survey respondents felt they:

- were more knowledgeable about mental health services and supports in the community
- were better able to support people experiencing mental health concerns
- better understood the value and scope of mental health peer workers.

Most staff felt it was easy to work with the Peer Navigator, that they understood the Peer Navigator’s role and how they’re meant to work together, and that care was well coordinated for people. The role developed connections with, and raised awareness of, community supports and services and referred people to other programs such as the local Safe Haven.

According to all staff, the resources developed and distributed by the Peer Navigator, and time taken to talk through them, have been one of the most effective components of the project for both consumers and staff. The resources enabled consumers, their families and carers to understand supports and services that were available in the hospital and community, and were effective for educating non-mental health staff. In particular, they are:

- developed from a lived experience perspective
- accessible – simple information, structured logically, available in multiple formats (hard copy and electronic with QR codes linking to more information)
- categorised into topics so they can be tailored to individual needs
- developed in response to consumer needs.

Additional resources were developed as part of the program for use by staff to ensure the positive outcomes for staff and consumers continued if the role was not funded on an ongoing basis.

"I guess the focus [with peer workers], predominantly, it's been about how to support the consumer, which is 100% the right way to go. But what we found in this role, it's about empowering and educating and resourcing the clinicians, which I think [the Peer Navigator] has had such a strong focus because I guess when you work in a clinical environment for so long you almost get kind of like tunnel vision. You're not aware of what's outside your own space. [The role] has just brought so many resources, so much knowledge, so much awareness to everybody, and I guess everyone's been so grateful because it's really enhanced our capacity to give more to consumers, which is really important."

- Staff interviewee

Improving knowledge of peer work and closing gaps in support

The Peer Navigator role was effective at filling key gaps in support:

- for people experiencing mental health concerns in fast-paced settings (e.g. the ED) where staff are time-poor
- for people who are experiencing mental health concerns on the wards, but haven't been admitted for mental health issues
- from a peer lens in settings where this had previously not been available
- to understand and connect to community services post discharge.

"She's really been able to assist us in managing the person in the emergency department because obviously the emergency department's a busy place for somebody who's experiencing mental health distress. Having somebody that we can call on and say, "I really don't have the time to sit with this person. They're very distressed. I've done what I needed to do. Are you able to come and support them?" And she's always been able to come and do that."

- Staff interviewee

"Because they've got lived experience with mental health conditions, and they have that extra training as well and know how to navigate that process, having them come in and do that work so that I'm not stepping outside the bounds of my role has been really useful."

- Staff interviewee

Staff also saw the nature of the support provided by the Peer Navigator – that is, the lived experience, holistic approach to mental health and wellbeing – as unique and complementary to the clinical support they provided, and highly effective for consumers. They indicated that the peer lens allowed the Peer Navigator to build stronger connections with consumers through shared experience and overcome some consumers' reservations with staff. Some also reported it enabled staff to better understand consumers' needs and experiences.

According to staff, understanding of and connections to community mental health services is a big gap for many consumers once they leave hospital. The Peer Navigator played an important role in discharge planning by supporting consumers to understand and connect to community mental health supports, and by working with consumers to identify their goals and provide strategies for managing their mental health post discharge.

By proactively reaching out to key staff in the ED, PECC unit, CLP team and general wards, and sharing resources with departments at Sutherland Hospital, the Peer Navigator was able to build strong relationships and understanding of peer work and mental health throughout the hospital within a short timeframe. This was evidenced by all staff in relevant units knowing of the Peer Navigator, starting to embed the role in their teams and regularly calling on the Peer Navigator to support consumers they were caring for. According to staff, this was one of the most effective elements of the role and highlighted the lack of awareness of peer work and mental health among clinicians. As a consequence, their appetite to know more to better support consumers increased.

Implementation considerations and workplace supports

The embedding of the Peer Navigator was supported through the following practical strategies:

- daily handover meetings with other mental health staff
- providing the Peer Navigator with a pager so they could be notified if they were needed in the ED
- the Peer Navigator completing progress notes in the medical file to record support and resources provided to the consumer. This was critical to educating staff about resources and role-modelling recovery-oriented language, as well as increasing the visibility of the role to staff.

> *“When I've been providing support to people who are post ED or post admission, being able to read through the notes that the Peer Navigator has written about what resources have been provided and what the main issues were for that particular person is a really great snapshot for us knowing that somebody has already had those resources provided to them and we can then refer back to those and say, “Oh, you remember these resources that you were provided, how are you going with that stuff?"*
>
> *– Staff interviewee*

Challenges and learnings

Some of the challenges of the program included the short timeframe for the pilot which meant there was a limited amount of time to:

- scope the role and onboard the Peer Navigator
- establish relationships with the multidisciplinary team, and build their knowledge and awareness of peer work and mental health
- develop resources and determine referral pathways
- collect feedback from, and see outcomes for, consumers.

Being a new position in new clinical environments meant the Peer Navigator had to teach herself the clinical terminology (e.g. acronyms in progress notes) and processes for each hospital setting as the position rolled out. This proved to be a substantial amount of additional work on top of the role.

Supporting people post discharge was one of the more challenging components of the role. This is because a consumer must be connected to the Acute Care or Community Mental Health Teams (i.e. teams of clinicians whose remit is to provide post discharge support) for the Peer Navigator to support them post discharge in an effort to minimise the risk assumed by one person. This posed challenges because only consumers discharged from PECC or those who had a mental health assessment in the ED are referred to the Acute Care Team. Implementation of this component of the peer navigator role is being further explored with the Acute Care Team.

Table 3: Enablers to Implementation

Enablers	
Qualities and qualifications of the Peer Navigator	The Peer Navigator was proactive, committed, had good communication skills and was resilient enough to cope if she was 'brushed off' by staff, which enabled her to reach key staff throughout the hospital and in community services to form relationships in the limited timeframe. She also had health-related qualifications, which meant she had existing knowledge and skills related to supporting people and was able to adapt faster to the hospital setting.
Mechanisms to coordinate care	Daily handover meetings, a pager for the Peer Navigator and case notes enabled the Peer Navigator to provide timely care that was well coordinated with consumers' clinical care. The case notes have also helped staff better understand what the person is experiencing, what they discussed with the Peer Navigator, and helped them provide recommendations for ongoing interactions with the consumer.
The resources	Enabled consumers and staff to learn about mental health and available supports and services both in the hospital and the community; assisted the Peer Navigator to empower staff to have conversations around mental health with consumers and provide consumers with resources – which was important for maximising reach and ensuring sustainability.
Staff attitudes	Staff embraced the role – they were open to working with the Peer Navigator and eager to learn more.
Support for the Peer Navigator	Management (some of whom had an existing relationship with the Peer Navigator) who were supportive of peer work and the role, and access to supervision, were essential for supporting the Peer Navigator in the role – particularly given it was a newly formed role. However, some staff indicated management needed to be more involved in introducing and explaining the role to the various units, wards and departments.
Filling gaps in support	By filling gaps in support, the role was widely embraced and seen as valuable.
Lived experience	The Peer Navigator was able to connect in a different way to consumers and provide support that complemented the clinical care they were receiving.

Table 4: Barriers to Implementation

Barriers	
Timeframe for pilot	Limited time to onboard the Peer Navigator, scope the role, build relationships and knowledge of the multidisciplinary team and develop resources. This potentially limits the sustainability of the role because more time is required to embed the knowledge and skills into the practice of clinicians.
Number of people in the role	Having only one person in the role limited its scope as it meant the Peer Navigator had to prioritise some settings and consumers over others.

Barriers	
Fast-paced nature of some settings	This can limit the amount and nature of support that can be provided because it limits the time available.
Lack of privacy in some settings	This can limit the nature of the support that can be provided because the Peer Navigator can only discuss what consumers are comfortable with others hearing.
Consumer readiness	Not all consumers who meet the criteria to be connected to the Peer Navigator are ready to talk about their mental health, therefore some are less likely to engage with the information and support provided by the Peer Navigator.
Clinical governance	Consumers must be connected to the Acute Care or Community Mental Health Teams (i.e. teams of clinicians whose remit is to provide post discharge support) for the Peer Navigator to connect with them post discharge in an effort to minimise the risk assumed by one person. This limits the number of consumers the Peer Navigator can connect with post discharge.

This evaluation identified several key learnings about the role of the Peer Navigator and other peer workers in mental health for SESLHD:

- The Peer Navigator is an important role that has positive outcomes for staff, and there is some evidence of its positive outcomes for consumers
- The role facilitates connections between staff within and between hospitals, consumers, families and carers, and community services
- There is a distinct lack of knowledge and awareness of peer work and approaches to supporting people experiencing mental health concerns among non-mental health hospital staff
- The role supports the development of the peer workforce
- The peer navigator role benefits from being filled by an experienced peer worker
- The ability to support people post discharge may strengthen outcomes for consumers experiencing mental health concerns and their support people
- Elements of the role could be embedded in the practice of clinicians and integrated into existing peer worker roles in a variety of settings.

4

Peer Navigation Unit Development

Peer Navigation Unit development

A Peer Navigation Unit of Competency is being developed by the Mental Health Coordinating Council (MHCC), in partnership with the Mental Health Commission of NSW, for inclusion in the CHC43515 Certificate IV in Mental Health Peer Work qualification.

The MHCC has worked closely with the NSW Community Services and Health Industry Training Advisory Body (CSH ITAB) and a range of stakeholders to gain a better understanding of peer navigation and the skills and knowledge that are required to perform this role. Key stakeholders included existing peer workers, peer navigators, peer managers and supervisors, community and public mental health services, and educators.

The information collected was used to form an initial outline of the skills and knowledge that exists, what role(s) are currently performed in peer navigation and by what types of workers. This helped to develop a focus group and advisory committee to further steer the unit development.

A Peer Navigation unit overview was developed between May 2022 and May 2023 and reviewed by the focus group and key stakeholders. The unit overview was finalised and submitted for approval to the Australian Skills Quality Authority (ASQA), with initial approval received. Final endorsement on the National Register of Vocational Education and Training (VET) is pending at time of publication.

The MHCC, in collaboration with the Mental Health Commission of NSW, will develop resources and training materials for Registered Training Organisations (RTOs) to rollout the nationally recognised Peer Navigation Unit in 2024.

References

ACON. (2022). *An Evaluation of the P4T Trans Peer Navigator Pilot* program *[unpublished]*. ACON Health Ltd.

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Insights Report: The role of peer navigation in a joined-up wellbeing and mental health support model

REPORT

October 2021

Executive summary

This report details the process and outcomes of a project undertaken in 2020-2021 in response to *Living Well in Focus 2020 – 2024: A strategic plan for community recovery, wellbeing and mental health in NSW*:

Action 14: The Commission will lead the co-design of joined-up wellbeing and mental health support with key stakeholders by June 2021.

In accordance with the Commission's commitment to co-design and co-production the work to develop joined-up wellbeing and mental health support has been undertaken with the participation of people with lived experience of mental health issues and their families, carers, friends as well as representatives from the mental health and broader human services sectors.

Following the findings from early workshops in 2020, the project focused on the area of 'peer navigation' and the service system changes/supports that may need to be developed to embed this function. In 2021 a combination of interviews with key advisors; written feedback from Deputy Commissioners, Community Advisory Council members and focus groups examined this in more detail, seeking to both articulate the peer navigation role and to identify what is required to support the workforce to perform the function.

Key insights were gathered and are summarized in the report. These insights are grouped under the following broad service system areas;

- Describing the role of the peer navigator
- Governance and accountability arrangements to support the role
- Access to peer navigation support
- The role of service providers in developing/embedding peer navigation
- The intersection between peer navigation and informal supports
- Workforce development
- Funding and contracting arrangements
- Evaluation and Monitoring

While the report captures the rich and diverse conversations throughout the project work it does not seek to articulate an implementation plan for embedding peer navigation in the system. This recognises two important points drawn from these conversations:

- There is still scope to more fully articulate the peer navigation function and its place in the system
- Any work to implement the function should also include co-production at a local level, recognising that joined-up wellbeing and mental health supports and peer navigation will need to respond to local need in each community.

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1. Background

The proposed focus on joined up wellbeing and mental health support aligns with recent significant strategic statements and consumer conversations held recently. These are noted briefly below for context.

Living Well mid-term review (2019)[1]

The Commission undertook a mid-term review of *Living Well: A Strategic Plan for Mental Health in NSW 2014-2024*, the 10-year plan for mental health reform in NSW. As part of this review, the Commission consulted with a broad range of stakeholders around NSW to consider the progress that has been made against *Living Well* over the first five years and to identify priorities and opportunities for the remaining five years of the strategy.

The Commission heard from 3,000 people across NSW through a variety of consultation activities over an 18-month period. People shared with the Commission their views on what was working well in mental health, their challenges and what they hoped reform efforts to achieve in the next five years.

Thematic analysis (Australian Institute of Health and Welfare)[2] of these conversations identified common themes:

- Access to services, for example: services available where people are, easy navigation of the system, community hubs
- Funding security and challenges, for example: availability, financial barriers, competitive tendering, and short-term funding cycles

In addition, in seven out of ten regions people identified strong themes:

- Peer Workforce, for example: peer-led services, lived experience peer workers, increasing number of peer workers
- Staffing/Workforce, for example: availability and training, education for staff, professional development, and recruitment

Roundtables on workforce matters, and with people with lived experience and agencies involving about 200 people, reinforced the consultation and survey messages around the need for improved service access, coordination and for finding better ways of assisting people to navigate the service/system, including mental health, health and social support services.

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[1] https://www.nswmentalhealthcommission.com.au/content/living-well-mid-term-review

[2] https://nswmentalhealthcommission.com.au/sites/default/files/living_well_qualitative_analysis_-_nsw_mental_health_commission.pdf

Living Well in Focus 2020 - 2024[3] (2020)

Living Well in Focus 2020 – 2024 identifies three whole-of-government priorities that inform the direction of mental health reform over the next five years. These strategic priorities, which are underpinned by seven focus areas, will provide the best opportunity for good mental health and wellbeing of all people in NSW. The strategic priorities set out in this plan will:

1. Strengthen community recovery and wellbeing
2. Strategically invest in community wellbeing and mental health
3. Ensure the right workforce for the future.

Living Well in Focus 2020 – 2024 aligns with the NSW Premier's Priorities and directions of the Strategic Framework for Suicide Prevention in NSW 2018–2023. It also assists NSW to deliver on its commitments under the Fifth National Mental Health and Suicide Prevention Plan and the National Mental Health and Wellbeing Pandemic Response Plan (Pandemic Response Plan).

Productivity Commission[4] (2020)

Actions arising from the Productivity Commission Inquiry support the focus on joined up wellbeing and mental health supports, including peer work:

> ***Action 16.5 — Strengthen the peer workforce. Peer workers are a valuable but under-utilised part of the mental health workforce.***
>
> - *The Australian Government should provide once-off seed funding to create a professional association for peer workers.*
> - *The Australian, State and Territory Governments should, in consultation with stakeholders, develop a program to educate health professionals about the role and value of peer workers in improving outcomes for consumers.*

Co-Design workshops (2020)

During late 2020 the Mental Health Commission conducted workshops with diverse groups of people with lived experience of mental health issues; community members; community managed organisations representatives; and government to identify how best to provide joined-up wellbeing and mental health support. Seven early designs evolved and were explored. All included Peer Practitioners as a core contributor to a more streamlined experience for consumers.

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[3] https://www.parliament.nsw.gov.au/tp/files/78652/Living%20Well%20in%20Focus%20%202020%20-%202024.pdf

[4] https://www.pc.gov.au/inquiries/completed/mental-health/report

Consequently, this is the core of the suggested system response. This report illustrates how this in turn could be used as a strategy to build out Peer Practitioner involvement in services to provide support, mentoring, education, system navigation and transitions. These roles would be active at each of the existing and proposed new access points for consumers and patients. During the co-design conversations the existing points were discussed and are represented at Figure 1 (Page 11). Further work will be required to map the current situation and consider any additional access point which may be required. The Primary Health model and the One Stop Centres model are both integrated in recognising these as key consumer access points and the proposition for Peer Practitioners to be engaged in existing and new versions of these access points. The proposed design also acknowledges the important and extensive role defined for Peer Practitioners and covers the training and support that would be required to enable Peer Practitioners to undertake these roles and help to drive the required culture changes.

The report also recognises, supports and services existing and evolving consumer access points. It also defines a couple of new access points. A key part of the role of the Peer Practitioner is to facilitate culture change and attitudes in relation to Mental Health & Wellbeing, including the recognition and support of whole person health.

The insights and analysis which follows synthesises these inputs to provide guidance about how the objective of joined-up wellbeing and mental health support might be realised.

Evidence – Desktop literature review (2021)

A desktop literature review by the Commission found that peer navigation as a distinct role within peer work is a relatively new concept, with the evidence base growing since 2010. The literature includes systemic reviews and some random controlled trials that demonstrate the approach can improve service access and engagement, promote recovery, reduce readmission to hospital and lead to higher satisfaction with services.

The review shows that peer navigation combines the benefits of lived experience in the peer workforce, with the need to assist people as they navigate in and around health and support systems that are not well coordinated or integrated. The review also shows that there are presently peer worker positions being recruited to in various sectors that mention navigation and related concepts such as warm or supported referral.

Australian academic literature is limited, with most studies identified coming from the USA, Canada and the United Kingdom.

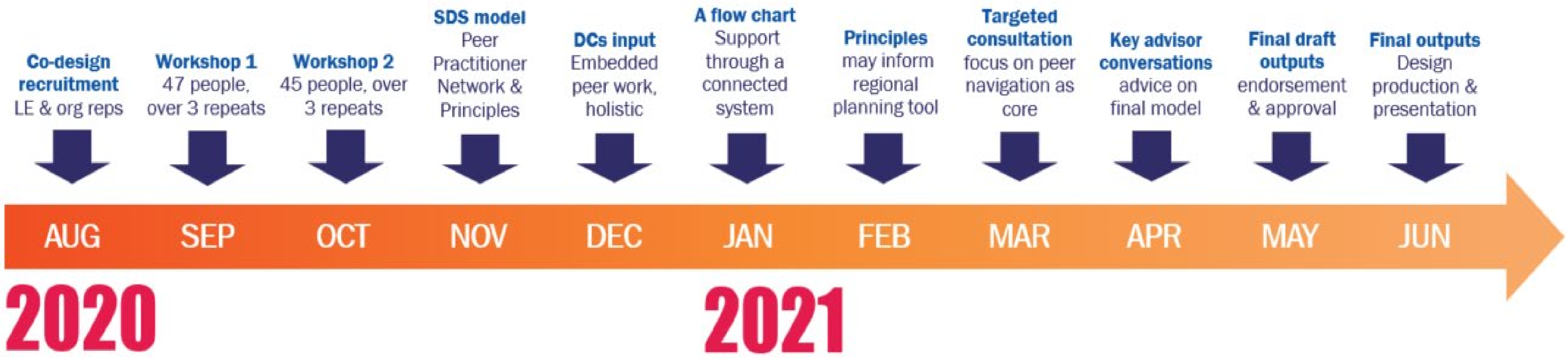
Fields in which peer navigation has been shown to be effective include in mental health, primary care, cancer support, people affected by HIV/AIDS, and in the interface between physical and mental health services.

2. Objective – Joined-up wellbeing and mental health support

Living Well in Focus 2020-24 Action 14 states that:

The Commission will lead the co-design of joined-up wellbeing and mental health support with key stakeholders by June 2021. The design will inform the development of a cross-sector regional planning tool to improve referral pathways and connect individuals with the right services to improve their outcomes.

An overview of the project activity is below. (Figure 1)



This document describes the following final project outputs:

1. Design – Peer Navigation
    a. elements – role and function peer navigation
    b. enablers/building blocks

3. Co-design and community conversations inform the design elements

Co-design work was conducted in 2020

Key co-design activity included:

- The Mental Health Commission invited participants with Mental Health lived experience who had responded to their previous expression of interest, as well as participants from different organisations (i.e. participants who work in the Mental Health sector).
- Participants completed the prework activities. This data was synthesised to create some inputs for the first workshops.
- Three x 0.75-day workshops were held where participants discussed their challenges and how a joined up Mental Health System might work. Seven models (concepts) were collaboratively generated by the groups in these sessions.
- This data was synthesised to create 7 Model Posters reflecting the ideas and inputs from the initial workshop series as well as a set of draft principles to reflect qualities of the model and guidelines for broader quality improvements in the system.
- Workshop series 2 consisted of three x 3-hour workshops focusing on facilitated discussions about the models. In 2 smaller groups, participants further iterated on one of the 3 categories of models they felt would have the most impact. There was also a short discussion about the draft principles.
- Project outputs included a final co-design report, draft model elements and principles, and some early high level conceptual mock-ups for how these might be translatable to the proposed tool.
- Workshop outputs and draft models were reviewed in January 2021.Draft models had concentrated on entry points and not movement or flow and connection through the whole system.
- A new diagram revisited the key elements of joined up support generated during Living Well Mid-term Review and this flow chart model outlines ways of integrating peer navigation into the desired model to better support people to access different services depending on their needs and / or to provide ongoing peer support. This is detailed at 4. below.

Co-design participants identified priority areas to be included in service design

Based on evidence and community feedback are the following elements with peer workers and Aboriginal mental health workers as a critical component of the workforce in each element:

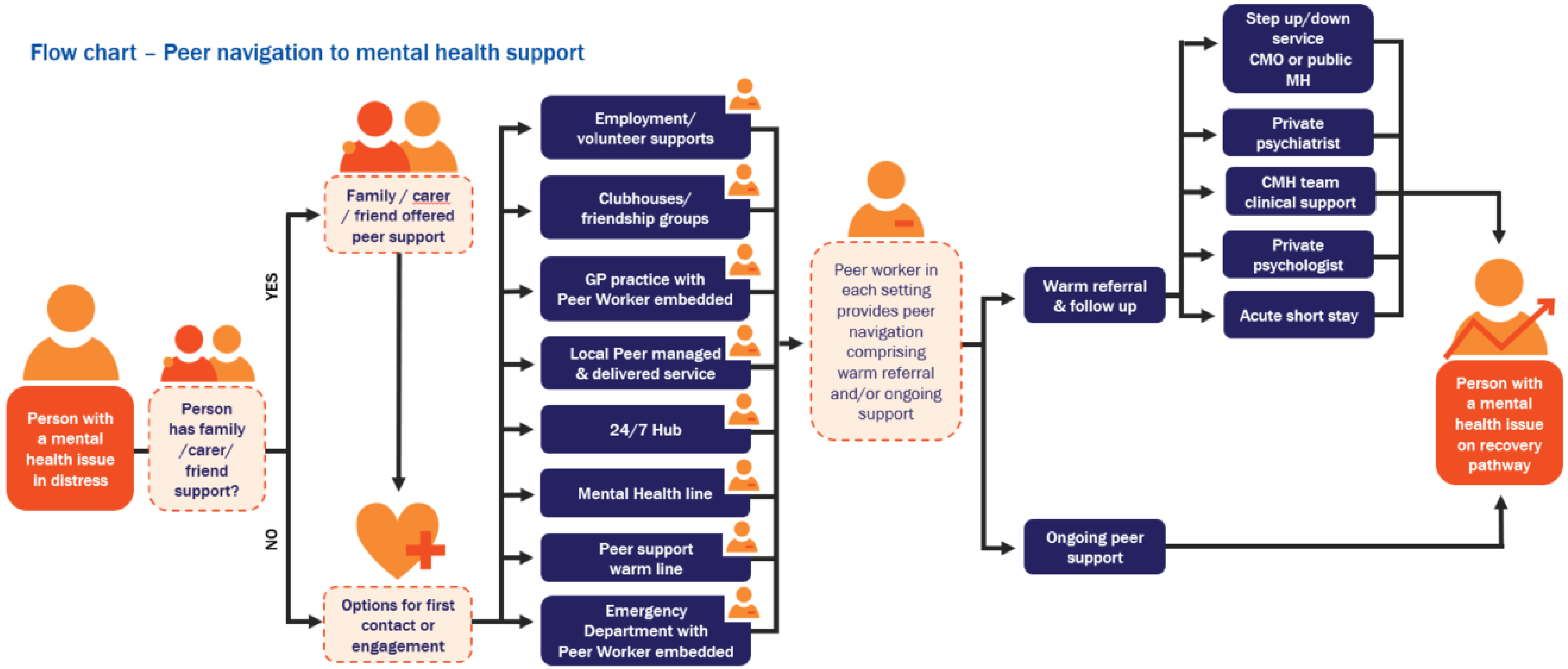
- 24-hour community supports: Warm 24-hour telephone lines (where local support services provide compassionate responses to people in distress and appropriate local referrals)
- 24-hour community safe spaces / alternatives for people in distress
- “Mental Health Ambulances” where mental health workers attend mental health-related call-outs in the community with paramedics reducing reliance on Police Officers (except where public safety is of concern)

- Hospital services: Small, short stay acute units in public hospitals providing intensive recovery support and clinical services and family inclusive practice
- Peer workers in all emergency departments
- Integrated care across physical and mental health (e.g. clinical liaison to other units)
- Effective discharge planning
- Pathways into and out of community services: Step up, step down services in the community providing alternatives to hospital and longer-term recovery options
- Integrated drug and alcohol services
- Peer worker navigators in communities to help people find the right pathway and access to care and to provide support during that journey
- Primary care: Consultant liaison psychiatry support for general practices
- Clear mechanisms and protocols with private practitioners and private sector providers including discharge planning
- Mental health practice nurses and Nurse Practitioners
- Aboriginal Medical Services recognised as deliverers of mental health services
- All elements of the model should be delivered by workforces who are culturally competent and apply family inclusive, trauma informed and recovery-oriented supports. This also enables hospital and residential services to provide specialist treatment for people who need more intensive support within a therapeutic inpatient environment.

4. What is joined-up wellbeing and mental health support – Peer Navigation?

Drawing on the Co-design work, specifically the common elements noted above, ‘peer navigation’ was the service element identified by participants as most critical to realising joined-up wellbeing and mental health support for people living with mental health issues.

A visual representation of the 2020 conversations about the role/responsibilities of peer navigation in the system context is below. (Figure 2)



Flow chart – Peer navigation to mental health support

What are the principles underpinning peer navigation?

We heard that the following principles should guide peer navigation. The text reflects conversations from the 2020 workshops:

Principles

	Lived experience empowered	**Trauma informed and actioned**	**Needs-based and person-centred**	**Accessible and inclusive**	**Mental health and wellbeing educating**
How the principles can support the design	Lived Experience Peer Practitioners are the foundation. Their experiences and skills are supplemented with additional training to enable them to operate alongside multi - disciplinary teams. By being associated with a body/ organisation specifically designed to train, support and raise the voices of Lived Experience Peer Practitioners, there is more chance to drive culture change across the system. Using the description 'Peer Practitioner' also helps to influence the valuing of these people.	Trauma Informed and Actioned is applied at a variety of levels. Additional Consumer access points have been added, for example Community Based Crisis Centres which are staffed by Peer Practitioner employees and other professionals skilled in modern trauma treatment and care approaches. Education, promotion and online content will be written with trauma informed sensitivities. Note that more work should be done to refine and define this principle in practice.	Peer navigation requires collaboration with each community, to ensure implementations is needs based and person-centred. The design proposes training and coaching in human-centred co-design, eco-system design and strength-based approaches. Within services, Consumer directed step up and step-down options are more available and visible, Consumers have access to choices of Peer Practitioners to enable supported navigation and	The access points, services and range of Peer Practitioner trainees and employees are representative of the demographics and diverse needs of local consumers. Educational, promotional and online materials are highly visual and represent that diversity. Peer Practitioners Support Consumers across the range of mental health and wellbeing needs. People with Lived Experience from a variety of backgrounds and ethnicities will be encouraged to take up Peer Practitioner roles.	Education about mental health and wellbeing and supports available is key to this model. Peer Practitioners will provide education directly to Consumers and service providers that they work with. There will also be efforts made to identify and partner with existing services providing Mental Health & Wellbeing education. The partnering will include offers for Peer Practitioners to participate in educational activities and events alongside existing stakeholders

Comments on the Principles

Notwithstanding that the principles above were drawn from earlier co-design conversations the focus group participants made several comments about them including

- Consider including recovery-focused and consumer-led as a principle. Lived experience empowerment seems to focus on the peer workers as employees and not the people accessing the service. Recommend expanding this principle out to include consumers or including recovery-oriented, hope, consumer-led/choice etc. somewhere. mentoring by peers that have experience working on other committees for peers that maybe new to committees.
- The term ‘co-design’ is problematic – it should be about ‘co-production’ – not having a fixed idea at the start. Build from the ground up with lived experience involvement. Instead of time-limited pilots, we should be trying it out, adjusting with learnings – prototyping – with continuity of funding.
- Several members of the focus groups concurred that ‘Trauma – informed’ is a ‘buzz-word’ and that the term should be replaced by ‘Trauma Care’. The larger group reported that the term implies that ‘do not add further trauma’ but that ‘no action is taken to deal with the trauma’ that has already occurred. Many noted that there seems to be limited understanding of the term and no application. There is a clear need to stabilise any crisis and at the same time deal with the trauma.
- The importance of advocacy at all levels is not emphasised sufficiently. The feedback around this issue note the central role of advocacy in bringing about system change, including empowering users, workplaces and communities to advocate for the rights of people with lived experience.

5. Overview of Proposed System Elements and Building Blocks/Enablers

Enablers develop the service delivery principles, providing guidance on how to implement the Model elements in a practical and meaningful way for local people, providers and community.

The themes and enabler examples[5] listed below reflect the conversations held in the Workshops (Sep/Oct 2020), the key advisor interviews (Apr 2021) and meetings of the Mental Health Commission Deputy Commissioners and Community Advisor Council (Mar/Apr 2020). The Description and Notes reflect common understandings of these enablers and the Notes are drawn from the Productivity Commission's Actions (2021).

Themes	System Element	Enabler (examples)	Description/Notes
Co-ordinating activity, stakeholders and resources to support service delivery and accountability	Governance and Accountability	▪ Peer-Led Service Governance ▪ Peer Work Hub (UPDATE)	Governance supports the implementation and delivery of the model by co- ordinating activity and stakeholders. It ensures effective stewardship of resources and transparency by monitoring and reporting outcomes to community and other stakeholders.
Understanding demand, need, and priorities	Eligibility and Targeting	▪ New Peer Work roles focused on the 'missing middle' ▪ Identified Peer Navigation Service	This element describes how to estimate demand, assess need, criteria for eligibility and prioritisation of referrals. 'Providing a formal coordination service to link up care services for people with severe and complex mental illness (action 15.4) and implementing single care plans for people with moderate to severe mental illness who receive services from multiple providers (action 15.3). (PC) 'State and Territory Governments should take sole responsibility for commissioning psychosocial supports outside of the National Disability Insurance Scheme, supported by additional Australian Government funding (action 23.2)' (PC)
Supporting flexible access and warm referral	Access and Referral	▪ Multi-agency Flexible Access Pathways ▪ Warm Referral ▪ After hours Service ▪ Peer Warm Line/Telehealth ▪ Co-location of PW	This element describes how consumers will find out about services and supports and how they will make informed decisions about connecting with and using services. This will occur in a way that easily understood and supports person-centred care. 'Governments providing more alternatives to emergency care for people with mental illness, including peer- and clinician- led after hours services and mobile crisis services (action 13.1). (PC) 'Local-level planning for what services are required, better use of technology, and strategies to grow the workforce are key factors in improving access for people, especially in regional and remote Australia (PC)

Clarifying the work and obligations of agencies, professionals and community	Roles and Responsibilities	• Draft Role Description • Functions mapped against consumer journey	This element ensures that consumers understand who is available to provide support; what can be provided by each professional and/or agency in their local area; and the service delivery obligations of services/providers to consumers and to each other.
Describing and ensuring quality service provision	Practice Guidance and Support	▪ Peer Work Professional Assoc. ▪ Workforce Education for Health and Social Care professionals (stigma)	This element will describe principles of practice; operational guidelines for quality service delivery; and components of a supportive community of practice that builds the capability of its members who are drawn together by a common purpose of assisting consumers. 'The Australian Government should provide once-off seed funding to create a professional association for peer workers (action 16.5) (PC)'
A local workforce to support local consumers	Workforce Development	▪ Cert 1V UPDATE ▪ IPS Update ▪ Part-time roles	This element describes an approach to proactive recruitment, support and sustainability of a local workforce to provide services to consumers. It will include local training and development strategies to ensure that wherever possible, positions are filled by local people.
Flexible funding and contracts which support local service development	Funding and Contracts	▪ Local MOUs/Protocols – CW/State – GPs/PHNs ▪ Consortia funding bids	This element describes flexible funding arrangements to support collaborative working. Contracting arrangements support the growth and development of the local service system. 'The Australian, State and Territory Governments should extend the funding cycle length for psychosocial supports from a one-year term to a minimum of five years and ensure that the outcome for each subsequent funding cycle is known by providers at least six months prior to the end of the previous cycle. The Australian Government should require Primary Health Networks to enter into longer term contracts when commissioning psychosocial services, in line with the longer funding cycles that have been introduced more generally for Primary Health Networks (action 17.1)'
Activity, outcomes and process monitoring to ensure the model delivers	Evaluation and Monitoring	▪ Program Logic ▪ Minimum Data Set ▪ Reporting Dashboard	This element includes a logic model, process and outcomes measures to support formative evaluation. It will include data collection and reporting mechanisms embedded in routine service delivery. Activity data and outcomes reported regularly to consumers and the community. 'Psychosocial support services help people live within their communities — publishing information about the regional funding shortfall for psychosocial supports and increasing the amount of funding over time to meet this shortfall to make sure that people who need these supports can receive them (action 17.3).'

The focus groups helped us to understand these enablers in more detail from both consumer and operations points of view and provide us with guidance about the priorities for implementation.

They provided an opportunity to fine-tune our insights to provide guidance around how agencies/provider may act to embed peer navigation across the system by answering the following questions:

- What are the governance and accountability arrangements?
- Who will the peer navigators serve?
- How will consumers access Peer Navigators?
- How will service providers facilitate the work of peer navigators?
- What training, practice guidance and support is required for peer navigators?
- How will we build the peer navigation workforce?
- How can funding and contracts support collaborative and sustainable service delivery?
- Evaluation and Monitoring – How will we measure outcomes?

6. Summary of Insights – System Elements/Enablers and Consumer Journey

6.1 Introduction

The summary below reflects conversations and feedback from Deputy Commissioners, Community Advisory Council members and focus group participants in May 2021.

These conversations were focused on developing the understanding of the specific role, responsibilities and essence of peer navigation as it might be undertaken within the broader system of mental health and social supports. The conversations further considered what system elements might need to be introduced, reviewed, adapted or expanded to support the development and functioning of the peer navigation role. The user journey was also discussed with a view to understanding the navigation function at each point.

The brief was purposely broad in scope to support wide-ranging discussion of as many of the intersecting parts of the system as possible, going beyond service delivery to consider overarching strategic elements such as governance and funding. Our conversations were intended to draw out information about opportunities and possibilities which might be developed as a response to the shortcomings, gaps and inequities of the mental health and social supports service system which are well known to people with lived experience of mental health issues.

The summary below is by no means an exhaustive review of the possibilities, nor is it intended as one-size-fits-all guidance. It is acknowledged that there is diversity of aspirations, priorities and needs across groups of consumers, communities and locations.

The peer navigation role was discussed with a view to articulating the essential functions associated with navigation, as distinct from other functions of peer work more generally. There was strong support for the notion that the navigation' role is very much place-based, with lived experience and deep knowledge of local service systems as well as the broader system context. There was also the concept off 'step-up/step-down' access to this role to help users to have timely access to varying levels of support throughout their recovery journey. Broad eligibility criteria were proposed for a peer navigation service. It was noted that programs can quite easily exclude consumers leaving significant gaps in the system. In relation to the intersection between the navigation function and other elements it was identified that there is a need to consider how peer navigators in an identified service may link up with, and work with, peer workers in services funded through NDIS, CMOs and public-sector.

It was suggested that linking the proposed role for peer navigators to the NSW Peer Workforce Framework (in development) and the National Guidelines (in development) will be important.

There was strong support for peer work generally with the view that well-resourced peer workers should be supported to assist a person across time, to support relapse prevention, being available as they transition across services and, where possible, across geographical locations. Peer work can be beneficial across the spectrum of support needs and should not be limited to one group if possible. It was also noted that peer-led services which deliver particular models of care (such as Open Dialogue) should be considered.

The expansion of Peer Navigators and Indigenous Health Workers will enable consumers and potential consumers to find their way through a highly complex mental and physical health system, in ways that are culturally safe, and trauma informed, less anxiety-provoking, and more empowering. Peer navigators have the potential to increase consumer health literacy and self-advocacy skills and support continuing engagement with mental health services and promote hope and recovery.

There was a strong concern raised about the concept of 'peer drift' as peer workers may become enculturated into the existing paradigm having the potential to further entrench the many harmful practices that already exist. One participant noted that the peer worker 'is supportive of the client [sic] NOT necessarily the organisation's purpose'.

Strong examples of peer services were noted:

- Humane Clinic: https://www.humaneclinic.com.au/
- Just listening community: https://www.justlistening.com.au/
- Flourish Australia's Resolve Program
- Central Coast Local Health District and Primary Health Network Partnership – Intellectual Disability Mental Health.

6.2 What are the governance and accountability arrangements required?

There was strong support for governance by an independent body that recognises the value and role of peer work. This was frequently articulated as being best facilitated by peer-led, peer run and staffed services with one attendee suggesting that the service should focus on the navigation function alone. Independent governance was described as a Board or committee to oversee governance – led by peers, including peers from different backgrounds LGBTIQ, Aboriginal and Torres Strait Islander communities etc. It was noted that independent governance may assist with the strengthening and consistency in the ways in which peer-workers are supported to perform their roles.

It was noted that in practice, this may require service level agreements across sectors; pooled funding; and other structural elements to support intersectoral collaboration, independence and accountability.

6.3 How will consumers access support?

Respondents were almost unanimous in their support for flexible access across the continuum of need and in a variety of format. These included multiple access points; after-hours and online access; soft access points through Safe Havens Cafes/Recovery Colleges/community spaces; extended hours peer warm line as well as through more formal psychosocial support services (GPs and other clinicians (psychologist, social worker, OT). It was also noted that provision of multiple pathways, by integrating PHNs, private practitioners and public mental health services will provide choice, reduce stigma, and enable the physical health needs of people living with mental distress to be addressed more effectively. Co-location of peer workers at other points in the system was also suggested, specifically emergency departments and community health centres.

Discussion of the user journey drew the following insights about access: there need to be a diversity of peer workers accessible for users so that they can be supported by someone from their own community if this is what they would like; access points should include non-Health services including Police; Corrections; Education and Employment support services to ensure that access is available to people not currently in contact with mental health and/or social services. There were conflicting views about whether/how people described as ‘the missing middle’ might access peer workers.

6.4 How will service providers facilitate the work of peer navigators?

Many participants referred to the impact of culture and stigma on the integration of and value accorded to peer workers. There were several suggestions made about what is required to address these concerns. These include: addressing discriminatory language about peer work; workforce education for social and health care professionals about the role and value of peer work; and pro-active work to ensure that peer work is an integral part of any service system response to users.

There was a perception that CMO’s more actively integrate and enable peer work into their services. It will be important to explore this perceived difference in any implementation work.

6.5 What is the role of family/friends/carers who provide informal support?

The role of family, carers and others who support people with lived experience of mental health issues has been discussed throughout the project. There is strong support for the consideration of the contribution and impact of this role on outcomes for service users. In this most recent phase of the work the following insights were noted: Safe havens and small local short stay inpatient units will provide respite, maintain family and community connection and reduce stigma; service models such as Open Dialogue should include peer-led options; and noting that it is important that informal supports should be included/bolstered in the peer work response – ‘we don’t want to further negate or marginalise those informal supports’.

It was noted by participants that the inclusion of informal supports may require:

- Deeper exploration at intake to identify the full range of informal supports that may be available to the person
- a clear articulation of ‘family inclusive practice’ in service design so that all workers (peer and non-peer) understand what is required
- A parallel system of Carer Peer Practitioners be included in the service design to support the viability of family relationships along the lines proposed for Consumer Peer Workers

6.6 What training and practice guidance is required to support peer navigation?

Participants provide substantial feedback in this area. There was support for the professionalisation of peer work while some participants also cautioning that ‘peer workers need to remain peer workers – not try to be clinicians’. There was broad agreement that the existing training and practice guidance could be updated to explicitly describe and include the navigation function more prominently.

There was also discussion about additional training which may be useful including the Certificate IV in Community Services. Some participants note that peer worker roles are not entry level positions due to the experience required to carry out the role effectively while others noted that completion of qualifications should be required prior to commencing in an identified role or undertaking a placement in a peer work role. There was a recognition that trainees should be supported to develop practical skills.

Many participants expressed support for access to supervision and support from a more experienced peer worker rather than from health professionals.

6.7 What is required to build the peer navigation workforce?

There was strong support for the professionalisation and networking structure for Peer practitioners to contribute to the recognition, understanding and status of peer work as a discipline and a legitimate career pathway. Key points are:

- The Productivity Commission's recommendation that a peer work professional association be established was well supported, including the establishment of a peer work Community of Practice (CoP), noting that the CoP should reflect and support workforce diversity
- There needs to be an industrial award established to support peer work at various levels and to assist with mapping of career pathways for this profession
- Flexible roles are supported including part-time and job-share options with workplans that include reasonable adjustments for medication and hours of work
- Wider advertising and promotion of job opportunities available required to ensure that candidates are aware of the roles
- A diversity of roles is required so that support is available to a wide range of people including people with previous negative health service contact, people who have had contact with the criminal justice system, people who are in group home or supported living facilities, people that are neuro-diverse or members of the LGBTIQ+ community.
- A strong connection between the peer workforce and the mental health consumer movement was noted as pivotal to embedding a social justice framework in peer work.

6.8 How can funding/contracts support collaborative and sustainable services?

Discussion about funding and contracts centred on the need for longer-term funding arrangements to support service development; collaborative approaches to funding designed to ensure that services work remain independent; joint funding of a peer navigator service may support collaborative approaches at all levels; and consideration should be given to Commonwealth-State funded services joining together to provide services.

Funding sustainability was also discussed with strong agreement that the current prevalence of short and/or fixed term contracts constrains the development of new service types/models and where these are funded as 'pilots' there is often insufficient time for the service to establish what outcomes are being achieved. Activity-based funding was also noted as problematic as it can create perverse incentives related to throughput of users rather than a focus on outcomes, which may involve longer service times. It was noted that the service goal and timeframe may be different for each client.

It was also noted that it would be important when establishing resource allocation for peer navigation that an accurate and comprehensive assessment of the costs of providing the service would need to be developed to ensure that resourcing is sufficient to provide the service in the way which best meets the service user needs.

6.9 Evaluation and Monitoring – How will we measure outcomes?

There was limited discussion about this element, however broad agreement was expressed that outcomes measured should be clearly related to client goals rather than the current preference for activity-based measures.

Mental Health Commission
of New South Wales

Peer navigation: Desktop review

Prepared by Richard Schweizer (PhD) for the Mental Health Commission of NSW

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Contents

1. The Mental Health Commission of NSW

The Mental Health Commission of New South Wales (the Commission) was established in July 2012. The Commission's purpose is to monitor, review and improve the mental health and wellbeing of the community by undertaking strategic planning, systemic reviews and advocacy - all guided by the lived experience of people with mental health issues and caring, families and kinship groups.

The vision of the Commission is:

That the people of NSW have the best opportunity for good mental health and wellbeing and to live well in the community, on their own terms, having the services and supports they need to live a full life.

2. Purpose and scope this review

The Mental Health Commission of NSW has undertaken this desktop review to inform the project to codesign a joined-up wellbeing and mental health supports in NSW, which may include peer navigation as a key feature.

This literature review sought to find current academic literature describing and investigating the "peer navigator" role. Key search terms were "peer navigator", "peer navigation", "patient navigator". As there was not a great deal of research into peer navigation in Australia, global research was included. The section of this review on peer navigation and primary health care also contained a relatively small amount of information on peer navigation; as such, wider terms including "patient navigator" and "lay navigator" were used. This review is not exhaustive; it seeks to represent the more outstanding research around peer navigators and peer navigation, from 1995-2020.

The review shows that peer navigation is a relatively new position or job description. The review particularly shows that peer navigation combines the benefits of lived experience in the peer workforce with the need to navigate in and around health and mental health systems that are not well coordinated. The review also shows that there are presently peer navigation positions open in health and mental health organisations.

3. Peer navigation and mental health

A wide array of research into peer navigation and mental health exists. This research is generally very positive about the impact peer navigators can have on people with moderate-to-serious mental illness, although not all the research is of very high scientific rigour. The literature tends to show that people with a lived experience of a mental health issue or of caring appreciated the shared experience of living with a mental health challenge and benefited from the peer navigator's acquired knowledge of systems and services.

Cabassa et al. (2017) offer a wide review of literature evaluating peer-based health interventions for people with serious mental illness. They find that evidence generated by most of the studies was limited by methodological limitations. Mixed and limited intervention effects were reported for most health outcomes. However, the authors recognise that the most promising interventions based on the evidence were self-management and peer-navigator interventions.

Corrigan et al. (2014) offer a review of research into supporting people of colour with serious mental illness who develop physical illness. Their research indicates that peer navigators can improve integrated care by linking to or providing effective psychiatric services to people with mental illness, amongst other benefits. They observe that many illnesses had social causes that could be addressed by peer navigators; causes such as poverty and unemployment, homelessness, criminal justice experience and substance abuse.

Corrigan et al. (2015) focus on supporting African Americans with mental illness who are homeless and facing significant health risks and illness, leading to high mortality and morbidity rates. The article is based on a qualitative study to begin to investigate these problems and possible solutions. Peer navigators were mentioned frequently in focus groups. The authors observe that peer navigators are committed to time and relationships and can aid with such tasks as helping people get to appointments and engagement with providers; accompanying people into the examining room; helping people access entitlements and prescriptions; and connecting health problems to issues of shelter, nutrition, and personal safety.

Corrigan et al. (2017a) examine the impact of a peer navigator program developed by a community-based participatory research team and used with a group of African Americans with serious mental illness who were homeless. Peer navigators provide instrumental assistance and interpersonal support. With people of shared ethnicity, peer navigators provide emotional presence and listening skills. The study shows improvement in self-reported indices of physical and mental health for those in the Peer Navigator Program, compared with treatment as usual, suggesting that peer navigators had a positive impact on the health of program participants beyond results from improved housing and insurance.

Corrigan et al. (2017b) offer a more focused study into whether the Peer Navigator Programs improved scheduling and achieving healthcare appointments for homeless African American people with serious mental illness. Improvements were found at six months and twelve months. This research suggests peer navigators may offer a promising solution to barriers in utilizing the healthcare system for people with severe mental illness, especially those who may be homeless or from minority racial groups.

Corrigan et al. (2017c) examine the physical and mental health of Latino populations in the United States of America (USA) with serious mental illness. Focus group feedback yielded information about perceived costs and benefits of peer navigators leading to recommendations for a peer navigator training program. Participants believed navigators who were not only Latino but in recovery from serious mental illness would have a special empathy for program participants. They would have a consumer’s knowledge of the service system which could be helpful in navigating the health system. The study also made recommendations for peer navigator training, including:

- communication skills,
- knowledge of the healthcare system, and
- care coordination skills

Druss et al. (2010) address possible service gaps in health literacy and cognitive limitations of people with serious mental illness with physical health concerns. The research showed that people who received a Chronic Disease Self-Management Program delivered by peers had significantly more primary care visits at six-month follow-up. The intervention group also had better physical activity, medication adherence, and physical health-related quality of life.

Godoy et al. (2019) identify peer navigation amongst professional and paraprofessional navigation for children with mental illness. Children with mental illness are an important cohort of study as many mental health problems can be minimized when identified and treated early. Peer navigation is highlighted as a promising intervention to improve engagement in mental health services. It is suggested that the peer relationship with patients can foster rapport and build trust. The authors identify five types of supports that can be provided by a peer navigator:

- informational and/or educational
- instructional and/or skill development
- emotional and/or affirmational
- instrumental and
- advocacy.

They also argue that defining navigator roles clearly and providing adequate training and supervision are vital to their success.

Griswold et al. (2005) observe that patients presenting with a psychiatric emergency at hospitals face a unique set of challenges in connecting to primary care. The authors focus on the role that community case managers can play creating connections to primary care. Note, however, that this study focuses on community case managers – a role similar to but distinct from a peer case managers of peer navigator.

Griswold et al. (2010) report on a randomized control trial of primary care navigators versus usual care for people accessing primary care after a psychiatric crisis. The study found that patients who worked with mental health peers were statistically more likely to follow through with primary care. This study also makes a connection between the use of mental health peers and the movement from an institutionally based mental health system to one organized around recovery-based values.

Happell et al. (2016) focus on the inclusion of mental health consumers as co-investigators in research likely to enhance service reform; a process the authors observe emerging in the academic literature in 2015. In this study, the authors also identify key health/mental health problems such as difficulties accessing resources important to health care, the accumulation of vulnerabilities during homelessness and the role of communities and governments in meeting needs. The findings point to the need for individual health management, suggesting peer navigators would be valuable. Participants also indicated that they thought peer navigators would have essential competencies and orientations beneficial to working with other consumers.

Kelly et al. (2014) report on pilot trial of a peer health navigation intervention for improving health and healthcare utilization called the Bridge. Twenty-four individuals with serious mental illness were randomly assigned to either peer navigation or treatment as usual. The results of the trial suggested a number of positive outcomes from peer health navigation. These included outcomes related to health status and healthcare utilization; participation in the intervention was associated with improved health status and declines in pain severity.

In a report about a randomized control trial of a peer navigator intervention aimed at increasing the health of people with serious mental illness, Kelly et al. (2017) report that the group receiving the interventions showed significant improvement in access and use of primary care health services, higher quality of the consumer-physician relationship, decreased preference for emergency, urgent care, or avoiding health services and increased preference for primary care clinics, improved detection of chronic health conditions, reductions in pain, and increased confidence in consumer self-management of healthcare. Consumers were also taught skills by peer navigators to access and manage their healthcare effectively.

O'Donnell et al. (1999) present results of a study of a client-focused case management and consumer advocacy program, with one group of people with serious mental illness receiving the intervention, and one not. They report that qualitative measures of satisfaction with services and advocacy increased in the group receiving client-focused case management.

Portillo et al. (2017) examine a peer navigation project for people returning from prison diagnosed with a mental illness. Multiple roles were played by peer navigators; three main roles were identified:

- role model
- legitimizer and
- resource broker.

Peer navigators were shown to have positive effects. The project showed that peer navigators play multiple roles that extend beyond the client level by influencing the organization and its interaction with the community.

Simpson and House (2002) seek to identify evidence from comparative studies in the UK on the effects of involving consumers in the delivery and evaluation of mental health services. The study focused on a systematic review of randomized control trials. Unfortunately, the study found insufficient rigourous evidence to show benefits of a peer-navigator-like role.

Sledge et al. (2011) report on an intervention that joined people with serious mental illness who had had two or more psychiatric hospitalisations during the last 18 months to weekly support of peer mentors. Results showed those receiving peer mentoring had significantly fewer rehospitalizations and inpatient days during the nine months of the study.

Solomon et al. (1995) describe results of a randomised control trial where mental health consumers were randomly provided case consumer case managers [similar to peer navigators] and non-consumer case managers. Perhaps surprisingly, the data obtained at two years after the initiation of the service did not show a stronger therapeutic alliance with consumer case managers. The study did find a positive relationship between the strength of the alliance and beneficial outcomes for those in both the experimental and control interventions including quality of life, symptomatology, attitudes toward medication compliance, and satisfaction with overall mental health treatment.

4. Peer Navigation and primary health care

Peer navigators have been used in the field of physical health and primary care. However, the literature around peer navigation and primary care is not extensive. If we include studies that looked at navigators who are not peers – such as "patient navigators" or "lay navigators" – we find a richer vein of research that complements work done on peer navigators.

Carter et al. (2018) offer a scoping literature review into navigation delivery models and roles of navigators in primary care. Their focus is on the emergence of patient navigator models in North America; not on peer navigator models. Nevertheless, some of their insights are relevant to the task at hand. There is a focus on the need for navigators to help patients be directed through a complex and badly integrated health care system. Service design and target population is also emphasized – populations defined by race, gender, age, socioeconomic status, geographic location or disease group. The role for "lay navigators" is also noted.

Carter et al. (2018) offer a scoping literature review into navigation delivery models and roles of navigators in primary care. They identify a number of navigator models, delivered by lay persons, nurses and teams of health professionals; note, they do not deal with peer navigators explicitly, although many of the functions are the same between models. These functions may include systems navigation in primary care for complex clients with health and social support needs.

Casillas et al. (2019) examine in a randomized control trial two modalities of young adult cancer survivorship care: text messaging and use of a peer navigator. The authors find that the peer navigation group had significant increases in all self-efficacy measurements from pre- to post-test when compared to the control group. People receiving peer navigation had greater confidence in their ability to plan their survivorship care and seek continuous health insurance coverage post-intervention. Peer navigators were also able to provide culturally appropriate care.

Dohan and Schrag (2005) identify logistic, cultural, educational and other barriers that can impede the delivery of high-quality cancer care to underserved patients. They argue that patient navigators represent an innovation that can help overcome perceived barriers to care. Navigation services have been implemented at all stages of cancer care: prevention, screening, treatment and survival.

Donovan et al. 2018 identify ethical principles to guide the practice and management of "service navigators" in the health system. The authors recognize indications that navigator services can help to reduce healthcare disparities and can have a positive impact on health outcomes. They identify four components of ethical navigation:

- the reinforcement of ethical practices
- fostering self-determination
- supporting transitions and wellbeing and
- mobilizing service systems.

They also recognize that "service user-led" models of navigation [ie, peer navigators] can offer particular benefit to people navigating the health system.

Ferrante et al. (2010) write about translating the role of patient navigator into a primary care context. They observe that navigation in community primary care practices is useful for patients who have complex needs. They also observe that integrating patient navigator services into primary care settings will require new practice and payment models to be effective and canvas a number of barriers and facilitators to the implementation of a patient navigator role. These include:

- co-location and interaction of the patient navigator with other practice members
- onsite space for in-person visits and
- prospectively planning for optimal activities in the local environment.

They also make recommendations for setting up a patient navigator model. These recommendations include:

- having a clear consensus of what patient navigation means to all participants
- determining which patients should be a priority, such as the most vulnerable, the most expensive, those with the most to gain, or those who consume the majority of the clinician's time and
- Providing adequate workspace for new personnel. Typically, the patient navigator should be located in the health service office facilities.

Freund et al. (2011) report on the results of a study into cancer screening processes and a patient navigation program in America. Their key relevant finding is that cancer patients receiving navigator support were more likely to reach resolution after an abnormal test in 13 of the 15 cancer sites, (that is, 89 to 99% resolved).

Lorhan et al. (2013) examine volunteer and peer navigation approaches in the context of cancer patient health system navigation in Canada. The article highlights pilot programs in British Columbia, Ontario, and Newfoundland, where volunteers were engaged as lay or peer providers of cancer patient navigation services. They find the role of lay or peer navigator can help resolve systemic challenges for cancer patients and can be adapted to different communities.

McMurray and Cooper (2017) investigate the evolving model of the "nurse navigator" in Australia. They argue:

> "As the pivot person in the interdisciplinary team, the nurse navigator can make a significant contribution to health reform by working towards patient-centred care wherein patients receive timely, seamless, culturally appropriate guidance and support for developing health literacy. Having patients empowered by a level of health literacy that enables them to better navigate through the services they need has an important impact on their ability for shared decision-making. It also contributes to health system improvement by improving access, equity, efficiency, effectiveness and sustainability of health services." (P 2).

The authors also recognize the value of peer-to-peer counselling.

Meade et al. (2014) offer observations around experiences, challenges and lessons learned when implementing a lay patient navigator program to improve cancer care among medically underserved patients who presented in a primary care clinic with a breast or colorectal cancer abnormality, in Florida, USA. They distinguish "lay navigators" as a subset of navigator models. Lay navigators are close to what we have been dealing with as "peer navigators" in this review, although they may not necessarily have lived experience of the patient's illness. Nevertheless, Meade et al. justify the lay navigator approach as the navigator may have cultural knowledge or sensibility when dealing with non-dominant ethnic and cultural groups; part of the value of lay navigators may benefit from their personal characteristics (a common justification for peer navigators). The authors conclude that "a lay model of navigation is well suited to assist patients through complex healthcare systems; however, a stepped care model that includes both lay and professional navigation may be optimal to help patients across the entire continuum." (p 449). This appears to be an important point of difference compared with some other articles.

Mollica et al. (2014) examine the role of peer navigation in African American breast cancer survivors. They find that peer navigator intervention was acceptable to both peer navigators and breast cancer survivors and peer navigation offered support, knowledge and motivation. Peer navigation was feasible in terms of recruitment, cost and time requirements. Improvements in symptom distress, perceived support from God, and preparedness for recovery outcomes were observed over time.

Peart et al. (2018) offer a scoping review into patient navigators facilitating access to primary care. They find that patient navigators may help connecting people to appropriate primary care providers and extend the concept of patient-centred care across different healthcare settings. They find that typical activities of patient navigators included:

- facilitating access to health-related programmes
- promoting and facilitating continuity of care
- identifying and removing barriers to care and
- effective and efficient use of the health system.

They also argue that a key aspect of the patient navigator is a relationship-based approach, informing and involving patients in connecting them to care.

Valaitis et al. (2017) offer a scoping literature review into navigation delivery models and roles of navigators in primary care, mostly in the United States. They find that various positive outcomes were reported for patients, providers and navigators, as well as the health and social care system, although noted that many of the cites studies were not of a high scientific rigour. They also argue that key roles of navigators are to:

- link patients and families to primary care services, specialist care, and community-based health and social services
- provide more holistic patient-centred care and,
- identify and resolve patient barriers to care.

Walkinshaw (2011) discusses the regulation of patient navigators in Canada. Role responsibilities typically included connecting patients who have cancer with the right doctors and ensuring that they have access to the host of available therapies and resources. Navigators were also there to ensure continuity of care and to get answers to questions that patients have about their diagnosis. The author also canvasses the creation of peer navigators for culturally sensitive cohorts. The author gives the example of the Odette centre, which has a peer navigation program for patients in Cantonese or Mandarin.

5. Peer Navigation and human immunodeficiency virus

A rich literature deals with peer navigation for people living with Human Immunodeficiency Virus (HIV), particularly in South Africa. Peers are recognized as having key skills, knowledge and personal positioning for empathetic response to patients[1].

Bauman et al. (2013) report on barriers and facilitators to connection to HIV primary care in New York, USA. Barriers included:

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[1] NB, there are a number of HIV support services in the USA that use peer navigation. A selection of these services are described in **Appendix A** of this document.

- health care system factors (long wait for provider appointments, requirement of a positive confirmatory test before scheduling an appointment, system navigation, disrespectful to patients)
- social factors (HIV stigma) and
- characteristics of risk populations (e.g., mental illness, homelessness, substance use, being an immigrant).

Facilitators were also recognized, including:

- networking among community organizations
- individualized care plans
- team approach
- comprehensive and coordinated care services and (importantly for this review)
- patient peer navigation.

They observe that peer navigators' life experience can help overcome patient reluctance to enter care.

Cunningham et al (2018) examine the effectiveness of peer navigation to sustain viral suppression among HIV-positive men and transgender women released from jail in the USA. In their study, trained peer navigators counselled participants on goal setting and problem solving around barriers to HIV care and adherence. The study finds that viral suppression was significantly higher at certain timepoints after release from jail for people receiving peer navigation.

Higa et al. (2012) offer a systematic review of US studies into interventions to improve retention in HIV primary care. Strengths-based case management and multiple retention strategies are identified as key methods to improve retention in primary care. However, other interventions are also recognized; amongst them, peer navigation and including peers as part of a health care team.

Lama et al. (2019) examine the integration of gender-affirming primary care and peer navigation for HIV to improve the health of transgender women. The study took place in Lima, Peru, and was aimed at people with a positive HIV status assigned a male sex at birth, who identified themselves as transgender women. Peer health navigation was observed to facilitate retention in care by visiting participants at home, work, or socialization venues, or by contacting them by social media and phone.

Lippman et al. (2016) focus on interventions aimed at improving engagement in HIV care in South Africa. The research outlines a prospective study in the form of a three-arm cluster randomized control trial, focusing on an SMS (text message) intervention and a peer navigation intervention. It is suggested that the peer navigation intervention could offer more flexibility in terms of the patient barriers to care that it can address than other interventions.

Pagkas-Bather et al. (2020) focus on peer navigator acceptability amongst minority men who have sex with men in Washington. The study aimed to create awareness of "pre-exposure prophylaxis", which can prevent sexual HIV transmission. Forty-eight per cent of the target group were interested in peer navigation around pre-exposure prophylaxis. The authors also find peer navigation interventions to reach minority men should address stigma, focus on lower-income men, and try to match peers to clients to the extent possible.

Remien et al. (2015) examine barriers and facilitators to engagement of vulnerable populations in HIV primary care in New York. Peer navigators were used to engage with vulnerable population and encourage HIV care to maximise viral suppression. Peer navigation was seen as a vital part of this process. A positive role was also identified for peer educators. Benefits were seen to accrue to people take up the role of peer educator; benefits included:

- building a sense of community
- cultivating a support system and
- becoming positive role models for their peers.

Steward et al. (2018) examine the acceptability and mechanisms of action of a peer navigation program in South Africa engaging HIV-positive clients. They focus on the use of anti-retroviral therapy to curtail the HIV epidemic and reported on a peer navigation program to enhance engagement in HIV care, anti-retroviral therapy adherence, and behavioral prevention. They find that:

> "Clients expressed near universal approval for the peer navigator program and were satisfied with the frequency of contact with navigators. HIV stigma emerged as a primary driver of barriers to care. Navigators helped clients overcome feelings of shame through education and by modeling how to live successfully with HIV. They addressed discrimination fears by helping clients disclose to trusted individuals. These actions, in turn, facilitated clients' care engagement, ART adherence, and HIV prevention efforts. " (P 330).

Treloar et al. (2015) report on the evaluation of two community-controlled peer support services for assessment and treatment of hepatitis C virus infection in opioid substitution treatment clinics. They found that there was a very strong positive response to the peer worker services reported by staff and clients who had and had not interacted with a peer worker. The authors also found that peer workers were trusted sources of information and acted as mediators between client and staff. The role of peer worker was compare to the role of "patient navigator" in the United States.

6. Models of peer navigation

A variety of models of peer navigation are in use across different industries and fields. These models tend to share the feature of someone with lived experience drawing on their experience to help someone else coordinate access to some service or good. Beyond that, there are several issues that distinguish different models.

These issues include:

- Whether the peer navigator is paid or unpaid.
- Whether the peer navigator is a lay person or has received some training.
- What service the peer worker is attached to. This may include being part of a home care model, attached to community health centre, attached to a clinic or attached to a mobile vehicle.
- The process is for referring and transitioning a client to a case manager or peer navigator.
- What field they work in. This may include:
  - people with HIV
  - people with substance use issues

    - sex workers
    - people with mental health challenges or
    - people experienced homelessness/unstable housing at one point in their lives.
- What role they play, with common roles including:
    - outreach to target populations
    - support services
    - health navigation and accompaniment services to medical appointments
    - appointment reminders and counseling
    - assistance with transitional health care after hospitalization
    - linkage to onsite primary care
    - linkage to behavioral health, recovery programs or pharmacy services or
    - linkage to supportive housing services.
    - other tasks, including:
        - reminder phone calls, phone check-ins to ascertain reasons for missing an appointment, and appointment accompaniment (e.g. for medical care, legal services, social services, and Supplemental Security Income (SSI)-related appointments)

7. Peer navigation roles examples in Australia

This section of the review identifies some of the more outstanding roles that incorporate peer navigation in Australia. The section contains information on two programs that use, or have used, positions that could be described as peer navigation. The section also includes information on currently available job position descriptions for roles that are described as, or could be described as, peer navigation.

Peer Supported Transfer of Care Peer Worker

The Peer Supported Transfer of Care (Peer-STOC) initiative connects people leaving acute mental health care with peer workers who have lived experience of recovery and managing their wellbeing. Peer-STOC workers draw on this lived experience to support the personal recovery of people with mental health issues. Peer-STOC workers provide assertive support during transfer of care from inpatient hospital stays through to the community, helping people to connect to the information, knowledge, resources and services they need to live well in the community.

More information on Peer-STOC can be found here:

https://nswmentalhealthcommission.com.au/peer-supported-transfer-of-care-initiative

Partners in Recovery: Support Facilitator

This national program was targeted at better coordination between services such as medical care, housing, income support, employment, education and rehabilitation services that support people with mental health and complex needs. Typically, this coordination was done by a "support facilitator", who might or might not have lived experience of a mental health issue. The support facilitator position is very similar to that of peer navigator.

More information on Partners In Recovery can be found here:
https://www.mhcc.org.au/project/partners-in-recovery/

The program ceased in mid-2019 with funding redirected to other programs of support.

Peer Work Hub: Peer Worker

The Peer Work Hub describes the roles and functions a peer worker may undertake.

These roles and functions include coordinating service delivery, managing budgets and other resources, and supervising peer workers and other staff. For example, managing businesses or private services, or working in management and coordination positions in public, private or non-government organisations.

More information on Peer Work Hub peer worker roles and responsibilities can be found here:

https://peerworkhub.com.au/the-case-for-peer-work/peer-work-unpacked-roles-and-functions/

Living Positive Victoria Peer Navigator Program: Peer Navigator

The goal of the Peer Navigator Program is to promote the health and well-being of all people living with HIV in order to build an individual's capacity to self-manage their HIV, build their resilience and enjoy optimal health and wellbeing.

The primary role of the Peer Navigator is to provide individualised client-centred support for people living with HIV who are newly diagnosed, re-engaging in care or have complex needs. This requires the delivery of interventions that promote treatment readiness, treatment adherence, retention in care and improved individual health outcomes. A further aim is to foster personal resilience, improved health literacy and emotional wellbeing.

More information on the Living Positive Victoria Peer Navigator Program peer navigator role can be found here:

https://livingpositivevictoria.org.au/wp-content/uploads/2016/09/Peer-Navigator-Position-Description-April-2021.pdf

See also:

https://livingpositivevictoria.org.au/programs-and-services/one-on-one-support/

Trans and Gender Diverse in Community Health Initiative: Peer Navigator

The Peer Navigator role involves:

- Developing and implementing effective peer navigation approaches that are evidence informed and relevant to trans, gender diverse and non-binary (TGD&NB) communities
- Engaging with the community to promote awareness of the services available to TGD&NB communities
- Providing a point of contact for TGD&NB people accessing or seeking to access services
- Providing advice and support as required for initial needs identification for TGD&NB clients accessing services both internally and externally, and provide links to external services as required
- Providing advice and support for intake, assessment and referral processes with TGD&NB clients.

More information about the Trans and Gender Diverse in Community Health Initiative peer navigator position can be found here:
https://www.ethicaljobs.com.au/members/Darebin_Community/peer-navigator---trans-and-gender-diverse-in-community-health-initiative

Children's Health Queensland: Nurse Navigator (Aboriginal and/or Torres Strait Islander identified)

The role of Nurse Navigator (Aboriginal and/or Torres Strait Islander identified) is to provide advanced clinical and professional practice, facilitating a safe and efficient patient journey across the continuum of care to support children and young people from both Child Safety and Youth Justice pathways. This will be facilitated through applying the Nurse Navigator principles of coordinating patient centred care, creating partnerships, improving patient outcomes and facilitating systems improvement. The role will improve complex patient care, increase system efficiencies, and reduce costs by streamlining and coordinating care. The Nurse Navigator must identify as Aboriginal and/or Torres Strait Islander.

More information on the Children's Health Queensland Aboriginal and/or Torres Strait Islander nurse navigator position can be found here:

https://www.seek.com.au/job/51906692?type=standard#searchRequestToken=504e841a-c672-41af-9cda-d8bc42d1a24a

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9. Appendix A

The following as a short list of peer navigator programs providing support to people living with HIV in the United States.

Boom!Health's Bronx Health Connect (BHC)

This program is an innovative harm reduction approach designed to maximize effectiveness along key points in the HIV care continuum/treatment cascade. To better engage and retain PLWHA in ongoing medical care, the BHC program implemented several strategies including a Peer health navigation approach. Trained Peers' responsibilities include:

outreach to target populations;

support services;

health navigation and accompaniment services to medical appointments;

appointment reminders and counseling;

assistance with transitional health care after hospitalization; and

linkage to onsite primary care, behavioral health, recovery programs, pharmacy services, and supportive housing services. (p 6)

Mazzoni centre

The Mazzoni Center, a nonprofit community-based organization that serves the Greater Philadelphia region, saw the need and vast health disparities among the transgender population, particularly transgender women and girls. In response, the Mazzoni Center created the Trans Wellness Project. The project established a Community Advisory Board comprised of transgender women who provide critical direction and input for the program and in the hiring and training of transgender women as Peer Navigators. Peer Navigators have successfully engaged this hard-to-reach population and decreased barriers to care. To address the need for culturally competent health care, the Mazzoni Center initiated a collaboration between the Peer program and their primary care practice to provide a regular, drop-in health service specifically tailored to serve the needs of transgender people. (p 9)

The Open Door, Inc

The Open Door, Inc. recognizes the importance of supporting not only their clients, but also their Peers with medical and treatment adherence. Peers should be able to prioritize their own health while helping others do the same. The Open Door, Inc. Peers receive paid time off incentives for attending their HIV-related medical appointments as well as monthly therapy appointments. At these appointments, Peers can advocate for themselves, problem solve, identify coping skills to prevent burn-out, and deal with compassion fatigue. (p 12)

AIDS Alabama

Since the development of Living Well, AIDS Alabama has built a meaningful collaborative relationship with the University of Alabama 1917 Clinic to ensure medical adherence and full engagement of clients. AIDS Alabama social workers and the Living Well Retention in Care team met with the Clinic's lead social worker to discuss new policy changes to the AIDS Drug Assistance Program (ADAP) and opportunities for Peers to assist with enrolling participants. AIDS Alabama is partnering with the Clinic to locate and enroll clients in the new health insurance program, HealthPLUS Alabama. This partnership will prevent interruption of client service—and also make sure clients receive the additional medical benefits associated with the program. This is an example of the developing clinic/ community partnership approach to addressing the comprehensive health needs of those living with HIV/AIDS in Greater Birmingham.

Christie's Place

Christie's Place was founded and operates on the belief that Peer-based support for women living with HIV is integral to good health outcomes and quality of life. As Christie's Place moved to a mobile/home-based model of Peer navigation in 2010, an expanded level of team assimilation was needed with their new Coordinated HIV Assistance and Navigation for Growth and Empowerment (CHANGE) for women program. With increased Peer Navigator responsibility, agency staff and partner clinics/agencies were educated and trained on the broadened position. Part of Christie's Place support for Peer Navigators is ongoing training, such as trainings on trauma informed care, self care, motivational interviewing, crisis management, and more. Peers were meaningfully integrated into the broader interdisciplinary teams at clinics, and the agency strategically aided this by building strong rapport and communication among partner organizations. Peer Navigators are included in all levels of programming and clinic activities, whether it's the agency's retreats, clinical meetings, or their role in making meaningful referrals to mental health services. Peer Navigators are trusted members of the team.

AIDS Action Committee of Massachusetts

To support Peer advocates' ability to effectively do their work and communicate with medical case managers, AIDS Action Committee of Massachusetts has ensured that their Peer advocates have access to an electronic database to collect service utilization data and write notes. Peer advocates are trained in issues around confidentiality, data collection, and in writing progress notes. The Peer supervisor meets with Peer advocates in both individual and team meetings to discuss and review data collection. Moreover, Peer advocates are expected to be prepared to discuss clients on their caseloads on a weekly basis, including the goals they're specifically working with clients on to help connect and retain them in HIV care.

AIDS Foundation of Chicago

The AIDS Foundation of Chicago (AFC) has created a model of Peer navigation that incorporates separate and distinct roles for both Peer Navigators and case managers. Peer Navigators are expected to focus on emotional barriers that prevent people living with HIV from engaging and/or remaining in HIV primary care. When resource or insurance-related barriers present themselves, Peers provide an active referral to case managers. At any point in the provision of Peer services, client interactions may be tracked through a shared client-level data system. All clients who wish to receive case management services must sign releases that facilitate client-level data (ie. de-duplication of their record) in the database system. Clients must also confirm whether or not they are active within the data system. This authorization allows AFC to prevent duplication not only of records, but also of effort thereby facilitating higher quality case management and Peer navigation. Peers are expected to attend a minimum number of professional development sessions coordinated by the AFC; these meetings also offer the opportunities to share any dual enrollment information, which they may be aware of.

Mental Health
Commission
of New South Wales