## CONTENTS

<table>
<thead>
<tr>
<th></th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>i.</td>
<td>Acknowledgements</td>
</tr>
<tr>
<td>ii.</td>
<td>Abbreviations</td>
</tr>
<tr>
<td>iii.</td>
<td>A note about language</td>
</tr>
<tr>
<td>iv</td>
<td>List of tables</td>
</tr>
<tr>
<td>1.</td>
<td>EXECUTIVE SUMMARY</td>
</tr>
<tr>
<td>2.</td>
<td>INTRODUCTION</td>
</tr>
<tr>
<td>3.</td>
<td>THE EVALUATION</td>
</tr>
<tr>
<td>4.</td>
<td>FINDINGS</td>
</tr>
<tr>
<td></td>
<td>Key Evaluation Question 1: To what extent does the Program provide clinical and non-clinical services appropriate to residents’ needs and aspirations?</td>
</tr>
<tr>
<td></td>
<td>Key Evaluation Question 2: To what extent are the partnerships between service providers and Area Health Services effective in delivering coordinated services?</td>
</tr>
<tr>
<td></td>
<td>Key Evaluation Question 3: To what extent do governance arrangements and management processes facilitate achievement of Program objectives?</td>
</tr>
<tr>
<td></td>
<td>Key Evaluation Question 4: To what extent does the Program increase residents’ independence, participation, quality of life and wellbeing?</td>
</tr>
<tr>
<td>5.</td>
<td>CONCLUSIONS</td>
</tr>
<tr>
<td>6.</td>
<td>APPENDICES</td>
</tr>
<tr>
<td>1.</td>
<td>Services and organisations included in the evaluation</td>
</tr>
<tr>
<td>2.</td>
<td>Evaluation framework</td>
</tr>
<tr>
<td>3.</td>
<td>Membership of Stakeholder Reference Group</td>
</tr>
<tr>
<td>4.</td>
<td>Membership of Internal Management Group</td>
</tr>
<tr>
<td>5.</td>
<td>Evaluation rubrics</td>
</tr>
<tr>
<td>6.</td>
<td>Most Significant Change process</td>
</tr>
</tbody>
</table>
i. Acknowledgements

We appreciate the cooperation and assistance of service providers at the 20 Services involved in this evaluation together with the contribution made by community mental health services and other stakeholders. Our thanks go to the residents and families who shared their stories and personal experiences and, in doing so, have contributed to improving services for people experiencing severe and persistent mental illness in Western Australia.

Mary Sankey and Carina Calzoni
October 2012

ii. Abbreviations

AHS       Area Health Service
CSRU      Community Supported Residential Units
GP        General Practitioner
KEQ       Key Evaluation Question
MHS       Mental Health Service
MOU       Memorandum of Understanding
NGO       Non-government Organisation
SLA       Service Level Agreement

iii. A note about language

Different terms are used by Services across the Program. For clarity, this report uses the term ‘recovery worker’ for staff at NGOs and ‘case manager’ for clinicians at Mental Health Services.

‘Family’ has been used in preference to the word ‘carer’ to indicate family members and distinguish these from paid or voluntary carers/care workers.

‘Recovery’

From the perspective of the individual with mental illness, recovery means gaining and retaining hope, understanding one’s abilities and disabilities, engagement in an active life, personal autonomy, social identity, meaning and purpose in life, and a positive sense of self. It is important to remember that recovery is not synonymous with cure. Recovery refers to both internal conditions experienced by persons who describe themselves as being in recovery – hope, healing, empowerment and connection and
external conditions that facilitate recovery – implementation of human rights, a positive culture of healing, and recovery-oriented services\(^1\).

### iv List of tables

<table>
<thead>
<tr>
<th>Table</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Table 1:</td>
<td>Service Models and Types</td>
</tr>
<tr>
<td>Table 2:</td>
<td>Residents’ Reasons for Leaving Previous Accommodation</td>
</tr>
<tr>
<td>Table 3:</td>
<td>Residents’ Rating of Program Effects</td>
</tr>
<tr>
<td>Table 4:</td>
<td>Families’ Rating of Program Effects</td>
</tr>
</tbody>
</table>

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1. EXECUTIVE SUMMARY

The Supported Accommodation Program (the Program) provides supported accommodation for people experiencing severe and persistent mental illness, who are homeless, at risk of homelessness, living in unsuitable accommodation or residing for long periods in inpatient units. The aim of the Program is to maintain and/or improve residents’ quality of life by providing housing and access to support services that address each individual’s whole of life needs and personal goals.

The evaluation covers 20 Services, operated by nine non-government organisations and one public sector organisation, delivering ten service models. Some of the Services were established over a decade ago. Newer Services, established in the last five years, were developed to meet defined needs. These include two long term accommodation models (Community Supported Residential Units and Community Options) and two transitional models (for Homeless Adults and Homeless Youths).

A participatory approach was used to develop the evaluation framework, with input from a Stakeholder Reference Group and a Mental Health Commission Internal Management Group. The framework is based on four key evaluation questions (KEQ). Rubrics, a scale used to make a value based judgement about how successful a program is, were developed for three of these KEQs where standard criteria could be established to fairly assess the success of the Program.

The methodology included face to face consultation with service providers at the 20 Services, case managers and other contacts at ten community mental health services, the Office of the Chief Psychiatrist, Council of Official Visitors, the Licensing and Accreditation Regulatory Unit, Department of Housing, Department for Child Protection and the Department of Health’s Strategic Business Unit. Priority was placed on obtaining input from residents and families to understand their experience of the Program and identify the changes it was making in their lives. Face to face interviews were conducted with 37 residents and 15 families. Two paper-based surveys received responses from 126 residents and 47 families respectively, representing a 66 percent response rate in total.

Findings

The findings provide evidence, gathered through the evaluation, against the four KEQs. General findings about the Program and its beneficiaries are described first in order to provide a deeper appreciation of the Program objectives and to contextualise the findings against the evaluation questions.
Who the Program serves

Most of the Services focus on men and women aged 18-65 years. The evaluation found that for many people, the move into the Program marked the end of an ordeal in which they had needed to leave previous accommodation because of problems such as abuse or trouble with other residents, neighbours or police. Half of the respondents reported leaving because of loneliness.

KEQ 1: To what extent does the Program provide clinical and non-clinical services appropriate to residents’ needs and aspirations?

Based on the rubric developed for KEQ 1, the Program overall was rated ‘good’ at understanding and meeting residents’ clinical and non-clinical needs and hopes for the future. Residents reported receiving good clinical and non-clinical care and feeling comfortable and well supported at their accommodation. Feeling safe was one of the aspects they most liked about their Service.

The evaluation found that generally NGOs are fully aligned with the values and principles of person-centred care and the recovery approach, both in terms of philosophy and stated values, and operationally.

The evaluation concludes that there is essentially just one service model. Specialist Residential Services is not a model but, rather, funding for extra staff to manage extreme behaviours associated with mental illness. The other nine ‘models’ address needs that can be remediated – provision of a home and developing or restoring functional capacity in an enabling environment – and take a recovery approach, recognising that both medical treatment and psychosocial support are important. Differences between these service models, however, are simply those of intensity, reflected in hours of support per day and length of stay.

Two limitations were identified, affecting the extent to which the Program could be successfully implemented. One concerned inappropriate or incomplete referrals, in which critical information, such as recent forensic history, is not disclosed by the hospital, MHS, GP or other person making the referral. This is of considerable concern to NGOs and community mental health services as it may expose other residents, recovery workers and clinical staff to unacceptable risk and, if a resident has to leave through eviction or return to hospital, this disrupts the person’s recovery and potentially heightens their mental distress. The second limitation, said by NGOs to be the biggest single problem they face, is that a lack of affordable housing is preventing residents from transitioning to more independent living when they are ready to do so.

Including service providers in designing and planning supported accommodation infrastructure is likely to result in building designs that better support achievement of Program aims.
**KEQ 2: To what extent are partnerships between service providers and Area Health Services effective in delivering coordinated services?**

Based on the rubric developed for KEQ 2, the Program overall was rated ‘poor’ at delivering coordinated services.

The evaluation identified a number of good partnerships between NGOs and community mental health services, marked by mutual respect, ease of communication and a focus on joint care of residents. The evidence suggests that partnerships between some NGOs and mental health services are still to be established and there are many issues to be resolved before fully productive ways of working together are achieved.

Differences in the organisational cultures of NGOs and mental health services are a barrier to the delivery of coordinated services. In some Services there are no formal mechanisms to clarify and underpin the working relationship.

While case managers based at mental health services coordinate mental health multidisciplinary teams, generally there is no integration of mental and physical health care. Any coordination (such as with private psychiatrists, GPs or other health professionals) is undertaken by the NGO or the resident’s family. Some NGOs and families expressed concern about poor communication between health professionals and the effects of this on residents.

There is a widespread view among community mental health clinicians and other stakeholders that patients with serious mental illness are being discharged from hospital too early and that this is straining the resources of community mental health services. This has implications for the Program as some mental health services report having to ration resources by limiting case loads and case work.

**KEQ 3: To what extent do governance arrangements and management processes facilitate achievement of Program objectives?**

A rubric was not developed for KEQ 3 because variations between the Services made it difficult to develop standard criteria against which to assess governance arrangements and management processes.

For historical reasons, contract arrangements are input-focused and there are inconsistencies in funding levels for Services delivering similar models of care. A new funding model is required, both to take account of the Mental Health Commission’s move towards outcomes focused purchasing and to fund Services on an equitable basis.
NGOs are heavily regulated and are required to spend a large amount of time reporting on relatively small numbers of residents. There is scope to reduce this administrative burden.

Staff turnover has been an issue for most of the Services, but seems to have stabilised. Contributing factors are a 15% increase in funding resulting from the Component 1 funding (targeted at not for profit organisations delivering community services) that was part of the 2011-12 WA Government Budget, together with the maturing of newer Services. There are clearer understandings about how best to manage residents’ issues and a more developed capacity to support and train staff.

Factors affecting occupancy are largely beyond the control of NGOs and include gate-keeping by mental health services in order to manage case loads and case work.

**KEQ 4: To what extent does the Program increase residents’ independence, participation, quality of life and wellbeing?**

Based on the rubric developed for KEQ 4, the Program overall was rated ‘excellent’ and is delivering outcomes valued by residents and families.

The evaluation collected stories concerning the most significant change that has occurred as a result of Program participation. Four of these were selected by the Stakeholder Reference Group to be included in the report and their reasons for selecting the stories have been documented.

The Program has enabled many residents to obtain employment, including those whose families did not consider this possible. Residents reported significant improvements relating to engaging in meaningful activity, being more independent, managing everyday life, ability to socialise, ability to lead a good life and overall wellbeing.

Clinical and non-clinical service providers agree that knowing residents well is fundamental to moving them towards recovery.

Reports from NGOs, mental health services, residents and families indicate the Program is effective in reducing hospital re-admissions. It was beyond the scope of the evaluation to obtain objective data substantiating this finding.

There are currently no mechanisms for recording and reporting on outcomes at a Service or Program level however there are plans for this to be addressed part of the new outcomes focused purchasing arrangements which will take effect from July 2013.
Conclusions

This is valuable Program delivering tangible benefits to people experiencing severe and persistent mental illness. As well as being provided with a good home, residents receive good clinical and non-clinical care and feel comfortable, safe and well supported. Many residents are pleased with the changes they have made in their lives and are optimistic about things continuing to go well for them. The Program is achieving good outcomes even in circumstances where families had previously held few expectations of improvement in the lives of their partners, adult children or siblings. Families are grateful and relieved that their family member is safe, well and happy. There are indications that the Program reduces preventable re-admissions to hospital.

There are two major issues affecting this Program and the future development of other programs or services. The first is a lack of affordable accommodation. Some people entering the Program have experienced severe hardship, struggling with homelessness and their mental illness. Residents ready to move out of the Program to continue their recovery all too often have nowhere suitable to go.

A second issue relates to aspects of an organisational culture clash between NGOs and mental health services that is a barrier to coordinated service delivery. Achieving change will require a strategic approach including identification of some ‘change champions’. The strategy should also identify how physical and mental health care can be better integrated for people experiencing severe and persistent mental illness.

Service providers do not see themselves as part of a Program and there is little or no networking taking place. With the ongoing development and establishment of services for people experiencing mental illness this seems to be a missed opportunity. More forums for clinical and non-clinical service providers to share knowledge and experience could be encouraged and are likely to be welcomed. For instance, members of the Stakeholder Reference Group established to provide input to this evaluation, including NGO and public sector service providers, have expressed a desire to continue working together in some capacity.

The energy, commitment and skill of NGOs and community mental health services is producing real change in the lives of residents of supported accommodation and their families. These clinical and non-clinical service providers are eager for change in the mental health system in WA that will further improve the lives of people experiencing severe and persistent mental illness.
2. INTRODUCTION

The Mental Health Commission was established in March 2010 to provide leadership and support in a new approach to the delivery of mental health services in Western Australia. Key objectives driving the reform are to provide:

- Person-centred services that support recovery
- Connected, whole of government and community approaches
- A balanced investment in new priorities.

The Commission’s ten year strategy for achieving these objectives is set out in ‘Mental Health 2020: Making it personal and everybody’s business’\(^2\). The strategy identifies a number of priorities for action, one of which (Action Area 3: A good home) is to expand the range of accommodation options to support people with mental health problems and/or mental illness after they leave hospital, when they are homeless or when they need an alternative place to live.

One new development involves establishing independent homes for people who are homeless or at risk of homelessness. This enables individuals with severe and persistent mental illness to live in their own home with a range of suitable personalised supports accessed through community based organisations. Strong links with community based clinical supports are also facilitated. As at June 2012, 70 properties had been acquired in locations according to individual choice, taking into consideration connections to the community and any existing informal and formal supports. Each person’s home is complemented by an individualised support package enabling planning, coordination and funding to create a mix of informal and formal supports, including the clinical services needed to establish long-term recovery.

In addition to this, the Commission is committed to improving services provided at existing accommodation options. The Commission funds 15 public sector operated residential beds, 531 places in supervised hostels, 910 places in community housing with in-reach services and 369 places in supported accommodation.

The focus of this evaluation is on components of supported accommodation.

The Supported Accommodation Program

The Supported Accommodation Program (the Program) provides supported accommodation for people:

\(^2\) Mental Health Commission, 2010. ‘Mental Health 2020: Making it personal and everybody’s business’, Perth, Western Australia
• Experiencing severe and persistent mental illness
• Who are homeless, at risk of homelessness, in unsuitable accommodation or residing for long periods of time in inpatient units.

This group may be at risk of extended inpatient admission and readmission, frequent visits to Emergency Departments and high usage of community mental health and other health services.

People living in supported accommodation have been assessed by hospitals, community mental health services, private psychiatrists or General Practitioners (GPs) as having a mental illness that is severe and persistent. Consistent with Mental Health Commission (the Commission) Service Definitions\(^3\), this means they will experience a level of functional impairment that is associated with having a diagnosed mental illness that interferes with their ability to live independently, to the extent that:

• They require support with the activities of daily living, and/or
• Support is not available and the essential activity does not occur.

The person’s impairment will have been in existence for over six months and they are likely to have had one or more admissions to an acute hospital in the two years before referral to the Program and to have risk factors which may exacerbate their condition such as:

• Existence of co-occurring issues (intellectual, physical and/or substance abuse)
• Lack of effective environmental support
• Social isolation
• Unstable accommodation.

The Program is for individuals aged from 17 to 75+ years and does not cater for families with children. It aims to:

1. Maintain and/or improve residents’ quality of life by providing housing and access to support services that address residents’ whole of life needs and personal goals. An emphasis on recovery, psychosocial rehabilitation and support assists residents to attain optimal mental and physical health, social competence and family connectedness.

2. Improve resident outcomes through coordinated service delivery of a two-way partnership between the non-government organisation (NGO) providing 24 hour

\(^3\) Service Agreement Schedules C04794, 2008-2011
non-clinical support and rehabilitation, and the Area Health Service providing clinical care and support\(^4\).

The original scope of the evaluation covered 18 Services. This was subsequently extended to cover a total of 20 Services operated by ten organisations (nine non-government and one public sector) delivering ten models of care. Together, these Services provide 228 beds. Five Services are located in regional areas (Albany, Bunbury and Geraldton) and 15 in the Perth metropolitan area (Appendix 1, list of Services and operators). Services in scope for the evaluation were selected by the Commission to capture the full range of service providers and models of care.

**Service models and types**

Length of stay in transitional services is time-limited, from three months in Crisis Accommodation and Subacute Step Down to 12 months in Intermediate Care and Supported Accommodation for the Homeless, and aims to develop residents’ capacity to live with less support and more independence. Long-term or permanent accommodation provides a home for residents for as long as they require it.

<table>
<thead>
<tr>
<th>Model</th>
<th>Type</th>
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<tbody>
<tr>
<td>Crisis Accommodation</td>
<td>Transitional</td>
</tr>
<tr>
<td>Intermediate Care Accommodation</td>
<td>Transitional</td>
</tr>
<tr>
<td>Community Supported Residential Units (CSRUs)</td>
<td>Long-term/permanent</td>
</tr>
<tr>
<td>Supported Accommodation for the Homeless</td>
<td>Transitional</td>
</tr>
<tr>
<td>Community Options</td>
<td>Long-term/permanent</td>
</tr>
<tr>
<td>Long Term Supported Accommodation</td>
<td>Long-term</td>
</tr>
<tr>
<td>Specialist Residential Services</td>
<td>Long-term/permanent</td>
</tr>
<tr>
<td>Hostel Accommodation</td>
<td>Long-term/permanent</td>
</tr>
<tr>
<td>Subacute Step-down (publicly operated)</td>
<td>Transitional</td>
</tr>
<tr>
<td>Permanent Accommodation (publicly operated)</td>
<td>Permanent</td>
</tr>
</tbody>
</table>

Table 1: Service models and types

Some Services were established ten or more years ago and the service models have evolved during that time. These older models include Crisis Accommodation, Intermediate Care Accommodation and Long Term Supported Accommodation. As a key initiative of the WA Mental Health Strategy 2004-07, the Program was expanded to provide a greater range of supported accommodation options and newer models, such as those for Homeless Adults and Homeless Youth, Community Supported Residential Units (CSRUs) and Community Options, were developed to meet defined needs. For

\(^4\) Under their Service Agreements, NGOs are required to formalise the partnership arrangements between their organizations and their Area Health Service. Clinical mental health services are delivered by community mental health services (MHSs)
instance, Community Options was designed for long term residents of Graylands Hospital who could live in a community setting with a high level of support.

Two publicly operated services were in scope for the evaluation: Hampton Road Service, a subacute step-down facility, and Jacaranda House, established to provide a permanent home for former residents of Whitby Falls psychiatric hostel.

The purpose of the evaluation was to assess:

- The impact of the Program on the independence, participation, quality of life and wellbeing of residents
- Implementation and ongoing management processes of the Services
- Effectiveness of the partnerships between service providers and Area Health Services.

3. THE EVALUATION

A participatory approach was used to develop an evaluation framework (Appendix 2) to focus the evaluation and drive data collection, with input from a Stakeholder Reference Group (Appendix 3). The evaluation framework, including criteria against which assessments of impact and effectiveness were made, was developed with input from an Internal Management Group at the Commission. The Internal Management Group (Appendix 4) also contributed to development of the rubrics, scales used to make evaluative judgements about how successful a project or program has been in relation to particular questions or outcomes.

The evaluation framework was based on four key evaluation questions (KEQ) around which this report is structured:

- KEQ 1: To what extent does the Program provide clinical and non-clinical services appropriate to residents’ needs and aspirations?
- KEQ 2: To what extent are the partnerships between service providers and Area Health Services effective in delivering coordinated services?
- KEQ 3: To what extent do governance arrangements and management processes facilitate achievement of Program objectives?
- KEQ 4: To what extent does the Program increase residents’ independence, participation, quality of life and wellbeing?

In this evaluation, the rubrics comprised a set of specific components that, when combined created a global score for the overall Program against the specific KEQ.
Rubrics were developed for KEQ 1, KEQ 2 and KEQ 4 (Appendix 5). For these KEQs, background documentation and literature were available to sufficiently describe the evaluative criteria and the merit criteria (e.g. excellent, good, adequate, poor or detrimental) prior to data collection. A rubric was not developed for KEQ 3 as variations between the different Services made it difficult to develop standard criteria to fairly assess the governance arrangement and management processes across the Program. The rubrics guided data collection and analysis and were used in order to make value-based judgements of quality or effectiveness of the Program.

**Methodology**

A high priority was placed on giving a voice to those whom the Program serves, that is, the residents themselves and their families. Two methods were used to elicit the perceptions and experiences of these intended beneficiaries: face-to-face, semi-structured interviews and structured, paper-based questionnaires.

Semi-structured interviews with residents centred on developing an understanding of their experience of the Program and capturing their ‘story’ of the most significant change they had experienced since living in supported accommodation, using the Most Significant Change Process (Appendix 6).

Resident interviews were conducted with 37 men and women, from 18 to 63 years of age, at eight Services including three in regional areas. The majority of the interviews were audio recorded. A thematic analysis was undertaken and ‘most significant change’ stories were documented.

The purpose of the semi-structured interviews with families (parents, siblings, partners or adult children) was to develop an understanding of their experience of having a relative who was participating in the Program and to capture their story of the most significant change they had observed in their relative since he/she has lived in supported accommodation. In the majority of cases the 15 families taking part in interviews were not relatives of the residents who were interviewed. The interviews were audio recorded. A thematic analysis was undertaken and ‘most significant change’ stories were documented.

Two surveys were conducted using paper-based questionnaires. Residents were surveyed at only 18 Services as those living in the two Specialist Residential Services, located in aged care facilities, did not have the cognitive capacity to participate. Families of residents at only 19 Services were surveyed as, at one Service, none of the residents had granted the NGO concerned permission for their family to be contacted. Completed questionnaires were received from 126 residents and 47 families. The combined total of 173 represents a 66 percent response rate.
In addition, the evaluation involved:

- A literature scan to inform the development of the rubrics and qualitative and quantitative tools
- Consultation with key informants including:
  - Management and recovery workers at 20 Services;
  - case managers and other relevant contacts at ten Mental Health Services (MHSs);
  - other stakeholders including Office of the Chief Psychiatrist, Council of Official Visitors, Licensing and Accreditation Regulatory Unit, Department of Housing, Department for Child Protection and the Department of Health’s Strategic Business Unit
- Review of secondary data provided by service providers and the Commission.

All except two of the consultations were conducted face to face.

The majority of the interviews and consultations were conducted between March and May 2012.

**Limitations**

The broad scope of the evaluation (20 Services operated by ten organisations delivering ten models of care), together with an initial five month timeframe for its conduct, imposed limitations. Data collection was restricted to current residents: it did not include the views and experiences of people who met admission criteria but were not referred to the Program, or those who had been referred but were not offered a place. Exit interviews were not conducted. Other limitations included:

- Availability of secondary data to inform the evaluation: activity reports and other records were often incomplete or combined data from several Services, only some of which were in scope for the evaluation
- Measures of demand were not available
- Data captured in the Department of Health information system was not in scope for the evaluation.
4. FINDINGS

The next section of this report discusses the evidence gathered through the evaluation methods outlined above. The findings first describe who the Program serves, including an indication of experiences residents have had prior to coming into the Program. Findings in relation to the four key evaluation questions are then addressed.

Who the Program Serves

Most of the Services focus on men and women aged 18-65 years. The two exceptions are:

- The Homeless Youth Service, designed for young men and women, between the ages of 17 and 23 years
- Specialist Residential Services, located within aged care settings, for residents whose behaviour associated with their mental illness makes them unsuitable for mainstream dementia units or nursing homes and are typically aged from 50 to 75+ years.

There is no clear and consistent reporting on demographics across the Program however, from available information including responses to the evaluation surveys, it appears that residents may be predominantly male and that people who identify as Aboriginal may be under-represented. Seventy-two percent of residents responding to the survey were male. Several MHSs were of the view that the Program does not provide an adequate number of places for women. Seven percent of residents responding to the survey identified themselves as being of Aboriginal or Torres Strait Islander (ATSI) descent. This figure is higher than the proportion of the WA population identifying as ATSI (3.5% according to Australian Bureau of Statistics 2006 Census data), however there are indications in literature that the prevalence rate of diagnosed mental disorders in ATSI peoples is two or three times that of the corresponding general population and that even this may be an under-estimate\(^5\). There are difficulties in defining and measuring mental illness in ATSI peoples, discussed in some detail in ‘Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice’\(^6\).

Evaluation survey findings and interviews with residents and families indicate that, for many people, the move into the Program was the culmination of an ordeal. A significant

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\(^6\) Purdie, N, Dudgeon P and Walker R, Eds, Commonwealth of Australia, 2010, developed by the Australian Council for Educational Research, the Kalunga Research Network and Telethon Institute for Child Health Research
proportion of respondents reported that ‘sometimes’ or ‘often’ they had to leave previous accommodation because of problems such as abuse, or trouble with other residents, neighbours or police. Half of respondents reported leaving because of loneliness.

The table, below, indicates the percentage of respondents who reported that ‘sometimes’ or ‘often’ they had to leave previous accommodation because of problems.

<table>
<thead>
<tr>
<th>Reason for leaving</th>
<th>‘sometimes’ / ‘often’</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feeling lonely</td>
<td>50%</td>
</tr>
<tr>
<td>Emotional abuse</td>
<td>38%</td>
</tr>
<tr>
<td>Trouble with other residents</td>
<td>36%</td>
</tr>
<tr>
<td>Physical abuse</td>
<td>23%</td>
</tr>
<tr>
<td>Problems with cleaning or general housekeeping</td>
<td>22%</td>
</tr>
<tr>
<td>Trouble with neighbours</td>
<td>20%</td>
</tr>
<tr>
<td>Trouble with landlord</td>
<td>17%</td>
</tr>
<tr>
<td>Trouble with police</td>
<td>14%</td>
</tr>
<tr>
<td>Problems paying rent</td>
<td>10%</td>
</tr>
</tbody>
</table>

Table 2: Reason for leaving previous accommodation

Interviews with residents and families support this finding. Some residents had been homeless or were living in unsafe or otherwise inappropriate accommodation without support:

“I was homeless…it’s like my life began when I started staying here. I’ve had a terrible time before I came here. It’s been a relief” (resident)

“And the Care Awaiting Placement was horrific...so my mum went from being fairly independent, to being put in a locked-up situation in a psychiatric ward, to being plonked in front of a television 24/7. So you can imagine, by the time my mum came here, I was ecstatic. I must have gone to nearly a dozen places...some of them you wouldn’t put your worst enemy in them. I always liked this place and I felt very grateful that my mum came here. It is very welcoming and it’s really the people that make it, apart from the fact that it’s got a nice, homely feel” (family)
KEQ 1: To what extent does the Program provide clinical and non-clinical services appropriate to residents’ needs and aspirations?

Based on the evaluation rubric developed for this question (Appendix 5) judgements were made on a five point scale: excellent, good, adequate, poor or detrimental. Overall, the Program was rated ‘good’ at providing clinical and non-clinical services appropriate to residents’ needs and aspirations, as the following statement from the rubric generally holds true, based on the evidence from the evaluation:

<table>
<thead>
<tr>
<th>Evaluation Rubric</th>
<th>Description of ‘Good’ Rating</th>
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<tr>
<td></td>
<td>Clinical and non-clinical service providers understand residents’ aspirations and life goals and are supportive of them. Residents feel comfortable and safe in their supported accommodation facility. Residents and their families feel they are treated with respect and are informed of their care and recovery options. Residents are encouraged to engage in a range of activities. Residents have access to clinical services but there may be some delays in accessing these services. Clinical and non-clinical services are mostly responsive to residents’ changing needs.</td>
</tr>
</tbody>
</table>

The findings that support this statement are described below. In addition, there were a number of constraints and context issues identified during the evaluation that impact on the extent to which the Program is responsive to residents’ needs and aspirations.

**Understanding residents’ needs and aspirations**

There was evidence that there are systems in place for clinical and non-clinical service providers to understand residents’ aspirations and needs.

The needs assessment process starts before entry to the Program when a referral to a Service is made. Many residents enter the Program from hospital, although sometimes referrals are made by a MHS, private psychiatrist or GP. Having been assessed as meeting the criteria for a particular Service, and been offered and accepting a place, assessment information is used to plan how the resident’s clinical and non-clinical service needs can be met. In many Services, a resident will have two plans:

1. Needs from a clinical perspective are identified by a MHS in a Care Plan, sometimes also called a Management Plan, recorded on the WA Health Department’s Mental Health Clinical Information System (PSOLIS). Care Plans are reviewed regularly, sometimes in a process involving the NGO and resident.
2. Non-clinical needs and hopes for the future are identified by the NGO, using tools such as Outcome Star, Journey to Recovery and Recovery Markers Questionnaire, in discussion with the resident, and are then recorded in a Recovery Plan. Typically, residents work on their recovery plan in weekly sessions with a recovery worker and update it as goals are achieved or are changed.

In a few Services, while planning is done separately, there is regular discussion between clinical and non-clinical service providers (i.e. the MHS and NGO) concerning all aspects of a resident’s recovery. In most of the Services, however, there appears to be little sharing of knowledge, experience and information to ensure a coordinated approach to providing care for the resident.

**Good practice example:**

A comprehensive Management Plan has been developed by the MHS and NGO at Mt Claremont Community Options. This combines all of the resident’s treatment and recovery planning and includes family and external paid carer input. It reflects family as well as resident needs and wishes and is updated every three months. A joint plan means that clinical and non-clinical staff, external carers and family members are fully informed about all aspects of the resident’s needs and can be consistent about supporting the resident’s recovery. A simplified version of this joint plan is being developed to enhance resident interest in, and involvement with, planning.

From the evaluation survey, nearly three quarters of respondents reported that staff at their Service ‘usually’ or ‘always’ understand their hopes for the future and just over 80 percent reported that the program of support and activities at their accommodation was tailored to meet their individual needs. These results indicate that overall the Services are actively responding well to the aspirations of the residents.

**Safe and comfortable accommodation**

One of the Program intents is to offer home-like accommodation which provides a safe and comfortable environment for residents. This is achieved partly through building design and furnishings and also by the style of service delivery – less structured than a hospital and with more independence of movement, where residents are able to make a sandwich when they feel like it or have some responsibility for the running of a house (e.g. cleaning, laundry). Most Services are situated in suburban streets and are undistinguishable from other housing. The two Homeless Services are more hostel-like in their building design but service delivery is geared to freedom of movement and independence.

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7 Carers employed by an NGO (not the supported accommodation provider) to whom residents pay a fee
Specialist Services are located within aged care settings in high dependency or dementia-specific units where the focus is on providing a home where residents have the freedom to move around indoors and outside in a secure environment.

With three exceptions, Services in the metropolitan area are located close to public transport and residents can get themselves to jobs, training, medical or other appointments, meet up with friends and exercise independence. In regional areas, the Services are not located centrally and public transport is limited so that residents need to have the capacity to walk long distances or pay for a taxi. In many cases residents of these Services rely on family or recovery workers for transport which reduces their independence. Across the Program, few residents own cars.

Older Services tend to have been established in existing housing but the newer ones (e.g. Community Options, CSRUs, Homeless Services and Jacaranda House) were purpose-built. In some instances, a lack of NGO provider input has meant that building designs were not consistent with the Program’s intentions. For example:

- CSRUs – there are no communal areas which are important for providing a safe place for those who are isolated by their illness to gradually become part of the CSRU community and mix with others in an easy-going environment. There are no private rooms where recovery workers can meet with residents or hand out medication, which is a problem for residents living in two or three bedroom units
- Community Options – in one Service an NGO had to install sound proofing to make the premises suitable for residents who hear voices and become distressed with additional background noise, such as that coming from other residents’ televisions, radios or conversations
- Homeless Adult Service – the kitchen was built to a commercial-scale and residents cannot do their own cooking or develop menu planning, shopping and budgeting skills.

Of the two publicly operated services, Jacaranda House is very well designed to meet residents’ needs: a bathroom enables access for residents with physical disabilities, the house provides privacy in a peaceful suburban setting not on a health campus and there are comfortable, quality furnishings. The Service was designed with input from clinicians. Conversely, Hampton Road Service is located in a Federation-style house on a busy main road. There is minimal privacy for residents outside the house while shared bedrooms provide little privacy inside. Restrictions on making changes to the building mean that rooms cannot be altered to provide more privacy in the bedrooms.

Service providers strongly believe that comfortable, pleasant surroundings make residents feel valued and also make an important statement about the value of supported accommodation and the work of the staff.
A concern raised by a few providers was that providing residents with quality housing, (fitted out with microwave ovens, flat screen televisions and so on) made it difficult for them to move to more independent living where they were unlikely to be able to afford the same standard of housing and would have to provide their own furnishings and equipment.

Residents and families tend to take a holistic view of their Service, without focusing on accommodation but those who did so were very pleased:

“She has a very safe place. But it's like a home. It's better than my home. It's great. Yeah. It's astounding actually. So yeah, we're very happy with how it's turned out” (family)

“It's a really good house. It's $188 a fortnight. You get $100 back with the gift voucher for food. So it works out to $44 a week, living right in the middle of Fremantle...it's a really nice place to live” (resident)

“Well it is fantastic, because I've lived in another sort of hostel where I had to share a room” (resident)

A number of residents singled out feeling safe as one of the aspects they most liked about their Service. Findings from the evaluation survey indicate that 90 percent of residents ‘usually’ or ‘always’ feel safe and secure, and 84 percent ‘usually’ or ‘always’ feel welcome at the Service. Some residents contrasted this with experiences in guest houses, hostels or other places where they said they had felt unsafe. None indicated whether feeling unsafe was related to their mental illness (e.g. suicidal thoughts), to physical safety in terms of being abused, threatened or assaulted or some other reason.

“I feel safer here and it gets rid of a lot of the paranoia or worry, you know?” (resident)

“This would have to be one of the top places in terms of getting along and feeling safe” (resident)

Residents and their families are treated with respect and kept informed

The evidence suggests that residents and families are treated with respect and are kept informed of their options concerning care and recovery. The evaluation survey found that 86 percent of respondents reported being ‘usually’ or ‘always’ treated as an individual and 80 percent of residents reported being ‘usually’ or ‘always’ involved in planning their care, support and medical treatment.
Including families in planning residents’ care and treatment (when the individual concerned has given their permission to do so) is an important component of recovery. Not all residents want their families to be included and some families do not want any involvement due to past history or for other reasons. Of the families responding to the evaluation survey, 75 percent reported that their needs were ‘usually’ or ‘always’ understood by staff at the Service and 63 percent reported their views were ‘usually’ or ‘always’ taken into consideration when decisions were being made (e.g. concerning transition to different accommodation or changes to support services).

Family respondents reported less involvement in care management with 57 percent of respondents reporting that staff ‘usually’ or ‘always’ asked their opinion about the progress of the person concerned and 59 percent of respondents reporting they were ‘usually’ or ‘always’ involved in planning their relative’s care, support and treatment. It is not clear if this reflects their choice, as families who were interviewed face to face were happy with the way both clinical and non-clinical service providers included them in decision-making:

“I can meet with them [case manager, psychiatrist] any time I like...I’m very happy with my involvement with the people here [the Service]” (family)

“If the staff are concerned they ring and if I’m concerned I go and speak to them. I actually had a phone call when they weren’t happy. They thought he wasn’t well because he wasn’t taking his medication. What happened then, you know, doctor and nurse came to visit him and, you know, it was obvious he wasn’t well because he hadn’t been keeping up with his medication. So now he just comes into the office and gets his medication in the evening. So that’s worked really well. So basically, if I’m concerned, I just knock on the door and have a chat with someone or if they’re concerned they ring me at home. But most of the time it just jogs on really well” (family)

Recovery program

Agreement to actively engage in recovery work is a condition of entry to some Services (excluding Jacaranda House, Hampton Road Service, those located in aged care facilities and Community Options). Some individuals take time to engage and others never do and can be asked to leave for that reason:

“We’re here to assist in rehabilitation but the resident has to be willing to make the journey” (NGO)

“For some guys, in their 40s and 50s, the willingness to change is not there and just wanting some accommodation is not enough” (NGO)

“We ensure people know it’s crisis accommodation and they’re expected to work towards identifying and changing what it was that brought on the crisis” (NGO)
Typically, residents meet once a week with their assigned recovery worker to review progress in moving towards achieving their goals. This is sometimes referred to as ‘recovery work’ or ‘key work’. Many residents find identifying goals and doing recovery work is difficult or confronting but come to see value in it and enjoy a sense of accomplishment in ticking off steps towards achieving goals:

“When I was at [Service] I missed quite a few key works and that... since I’ve been here I’ve gone to every key work [session]. [At first] I didn’t really think that I needed key work, but it’s good...it’s a good way to release your problems and talk about your goals and stuff” (resident)

“The big difference is I moved out of home – big. Doing the budgeting myself, doing my food shopping and stuff like that. Finally I’m in my own area –my own space. The support just helped me do my own personal things like I didn’t do at mum and dads. They actually push a lot, but I’m getting on pretty good” (resident)

Others, such as individuals with impaired cognition, are unable to understand the concept of goals and some service providers have changed the way they work with those residents:

“We’ve learned we need to set goals on ourselves not have expectations of the residents” (NGO)

Recovery plans take a holistic approach and include structured activities which are part of the program offered by the different NGOs, together with those that reflect the particular interests and aspirations of the resident. Structured activities usually include cleaning and cooking (with assistance if needed), as well as other activities designed to develop living skills. Residents also attend weekly sessions with a recovery worker. CSRUs, in particular, seem focused on providing a structure. Some residents and families at CSRUs and other Services commented on the benefits of having a structure:

“You have to be up every day ready to participate and clean the unit. My health has improved. I think clearer – having less stress makes that easier. Support from the workers is good. They want to help you – they make me happier and help along the right pathway” (resident)

“A structure’s been very good for her and this structure is very good” (family)

Service providers offer a range of group and one-to-one activities, on-site and externally, to cater for residents’ individual capacities, age range and interests. Examples of on-site activities include cooking lessons, meal planning and budgeting. Examples of external activities include visits to the recreation centre, gym or swimming...
pool, outings such as beach barbecues or bus trips, walking groups, camping and fishing. Some Services bring in people from the community such as women’s groups, who run craft sessions, or ‘buddies’ - local people who volunteer their time to take a resident for a swim, a coffee or whatever they want to do. Residents attend mental health and recovery programs run by MHSs (e.g. Horizons, Armadale Mental Service) or NGOs (e.g. June O’Connor Centre), drug and alcohol programs, education or training courses. Some residents are in paid or voluntary employment.

Challenges for service providers include:

- Offering the best mix of structured, group or community activities and one-on-one time for each individual
- Encouraging and motivating residents without applying too much pressure
- Alleviating boredom in residents who are unable to concentrate and may easily be drawn into destructive patterns, or in those who need distraction from auditory hallucinations
- Promoting independence while managing risks
- Managing the tensions of providing person-centred care while also fulfilling duty of care responsibilities. For example, a resident in one Service was in the habit of cooking ‘fry-ups’ in the middle of the night and could not be dissuaded from doing so. Locking the food cupboards and fridge at night, with a view to protecting his health, was not considered an appropriate response as this would have infringed his right to choose what and when he would eat. The Service continued looking for effective ways of supporting him to make better decisions about his health and nutrition.

Eighty-one percent of residents responding to the evaluation survey indicated they ‘usually’ or ‘always’ made the most of the services and assistance available to them. A number of residents who were interviewed acknowledged their lack of motivation with some of these attributing this to side-effects from medication. Services seek to motivate residents by recruiting diverse staff with special skills (e.g. a recovery worker who uses music to get residents to open up; a worker who is good at sports and to whom residents can relate as a role model, who engages them in getting fit) and report that this is a constant challenge:

“Our team is working on two edges – the first purpose is to get people out of bed to do something constructive [and] the challenge is working out what people want to do – not just the superficial stuff” (NGO)

“Lack of motivation is a problem – getting up in the morning. Post trauma, some of our young people may not want to wake up” (NGO)
Few MHSs commented on the Program’s recovery activities other than to stress their importance. Clinicians involved with CSRUs had differing views on the amount of support these residents require: some considered 2-4 hours a day to be sufficient but, in two MHSs, 2-4 hours was said to be insufficient:

"they [residents] could be doing so much more” (MHS)

“some don’t have the cognitive function to do much and need distractions to break the boredom” (MHS)

The evidence base for the decision to provide 2-4 hours support cannot be identified.

Good practice examples:

Albany CSRU residents spend time each week working at a community garden. Two residents who would not have been able to gain entry to TAFE were subsequently awarded a Certificate II in Horticulture as a result of their work at the garden. This has had a significant effect on their self-esteem and belief that they are able to contribute to themselves and others.

St Bartholomew’s House employs a Health Promotions Officer whose role is to set up healthy living programs for CSRU residents across a number of locations. A “Biggest Loser” weight loss program attracted a lot of interest and participation by Kelmscott CSRU residents.

Access to clinical services

Residents are required to have ongoing clinical support guaranteed by a MHS, private psychiatrist or GP at the time of referral.

Typically, residents have a case manager or liaison officer from the local MHS who is responsible for coordinating delivery of community mental health services. Arrangements vary across different MHSs. At one Service, there is a dedicated MHS team of 2.8 FTE co-located, in effect. At another, the case manager visits almost daily. More usually, case managers visit weekly or on an ad hoc basis. This is a weekday service and obtaining clinical care on weekends and public holidays can be difficult, especially in regional areas where resources are limited. A resident needing care can wait for four hours at the hospital, which is problematic for everyone concerned.

Eighty-four percent of residents responding to the evaluation survey said they ‘usually’ or ‘always’ had ‘access to all the medical care and treatment I need to get better’. In interviews, most residents and some families reported they were happy with access to clinical services:
“*She has access to the staff that she needs - carers and psychologists and psychiatrists and GP and social worker and physio and all of that*” (family)

Some NGOs and families are concerned that residents may not be receiving the clinical care they need. This is discussed in the next section of the report (KEQ 2), in relation to delivering coordinated services.

**Responsive to changing needs**

Clinical and non-clinical service providers appear to be responsive to residents’ changing needs. Care Plans are reviewed every three months and Recovery Plans are reviewed weekly and updated at that time, if necessary, to reflect changed goals. An example of responsiveness concerns a resident who had strong feelings about discontinuing his medication and was ultimately able to do this safely with the advocacy of staff at his Service, the support of his family and the agreement and assistance of the MHS clinical team. The resident’s family, who were interviewed as part of the evaluation, were happy to see their relative’s clinical and non-clinical service providers working together to respond to his wishes.

The Program seeks to respond to changing needs by providing a mix of long-term or permanent accommodation and shorter-term (‘transitional’) accommodation intended to assist residents make the transition to more independent living. For instance, the Community Options service model offers permanency but residents can move to the lesser support of a CSRU if this becomes more appropriate for them. In transitional Services, exit planning starts on entry and residents know their accommodation is time limited. While Crisis Accommodation may suit people who need short-term support and have a home to return to, or can find a home with relative ease, the rationale behind transitional services is not entirely clear. For example:

- The intended length of stay (three months at Crisis, 12 months at Intermediate) seems arbitrary, particularly when Services report that residents have extended stays because there is nowhere for them to move on to
- Some residents interviewed for the evaluation had moved from one transitional Service to another raising the question of whether their basic problem is lack of a secure home, rather than a need for the particular kind of support provided by the Program: would they be in crisis if they had a home?
- Moving from one geographical location to another disrupts the trusted relationships residents may have developed with case managers and recovery workers, makes it difficult to maintain community connections and may result in loss of a job or training opportunity
- If the decision to transition a resident is made as the result of Service specifications or funding, this would seem to cut across the principle of empowering people to make their own decisions
When the message all through a person’s stay is that they are being supported to move to more independent living, it is understandable they may experience anxiety, and possibly a sense of personal failure, if a place cannot be found for them. This is a significant concern for NGOs who report that their experience is that residents lose motivation and “go backwards” if they are unable to move to more independent living at the right time.

People experiencing mental illness have individual needs and transitional arrangements may be the best option for some. Nevertheless, it seems that at least some of the time people are being moved to fit the available Services, rather than Services being sufficiently flexible to meet the changing needs of individuals. This may affect recovery:

“If I know something isn’t going to work out or will end, I don’t engage...I’ve had to move on a lot of times in my life so I haven’t really got any attachments” (resident)

“Sometimes I get worried I might have to leave and I don’t know where to put my stuff and that, you know? Because I’ve always been scared to accumulate too many things. Because [when I’ve moved] I could only take what I could carry, you know? So I’ve lost a lot of gear over the years, a lot of tools and all that” (resident)

The service models

Ten service models were in scope for the evaluation. Aside from Specialist Residential Services (which is not so much a model as funding for extra staff to manage extreme behaviours associated with mental illness), there is no evidence of strong distinctions between the models. They all address needs that can be remediated – provision of a home and developing or restoring functional capacity in an enabling environment – and take a recovery approach which recognises the importance of both medical treatment and psychosocial support. Differences between the service models are those of intensity, reflected in hours of support per day and length of stay.

A focus on particular groups, such as Homeless Adults, Homeless Youth or people who have been hospitalised for many years, makes it easier to deliver an efficient service tailored to individual needs but there is really only one model of care.

Hampton Road Service is classified as a subacute treatment service but is similar to the three Crisis Services and, like them, also provides respite care as a means of preventing re-hospitalisation. Hospitals find it easier to discharge patients to Crisis Services because they can get people in quickly, something they are not always able to do at, say, the Adult Homeless Service or a CSRU due to the length of time required for referral to these Services and, at times, a lack of vacancies.
Vincentian Village and Bayswater House are classified as Hostels but seem very similar to CSRUs and Intermediate Care, respectively. The reasons for making this assessment are detailed in a separate report.

**Program limitations**

The extent to which the Program can meet the needs and aspirations of residents is limited in two respects, both of which are of considerable concern to NGOs and MHSs:

1. Inappropriate or incomplete referrals
2. Lack of affordable housing, preventing residents from transitioning to more independent living when they are ready to do so.

Each of these is discussed below.

**Inappropriate or incomplete referrals**

Referral pathways differ across the Program and this part of the report does not apply to the two publicly operated Services (Jacaranda House and Hamilton Road Service) or Special Residential Services.

Pathways include self-referral, family referral, cross-referral from other organisations (e.g. Salvation Army, Ruah Community Services, drop-in centres), GPs, private psychiatrists, community MHSs and hospitals. Referrals to the Community Options Services can come only from Graylands Hospital. There is no standard referral form across the Program but the information requirements of individual NGOs are similar.

At newer Services (e.g. CSRUs and Supported Accommodation for the Homeless) referrals are reviewed by a panel comprising the local MHS, the Service to which the referral has been made and often a consumer representative. The panel decides whether or not to offer a place. Referrals to other Services are reviewed by the NGO before a decision to offer a place is made.

The extent and reliability of information provided in referrals varies considerably. One NGO estimated that one-third of referrals was inappropriate or incomplete and for another NGO the figure was said to be 50 percent. NGOs report that some individuals making referrals are well known to them for making inappropriate or incomplete referrals.

Incomplete or inappropriate referrals occur at three levels:

1. In some instances it is obvious that important information has not been provided, e.g. there is no risk assessment attached, no care plan, or the referral has not been signed by the prospective resident in which case the NGO does not
know if the person concerned has agreed to the referral or is perhaps being coerced. In these instances, the NGO simply requests the missing information be provided.

2. Referrals may appear to be appropriate for the Service in question but information important to the management and support of a resident has been omitted. For example, Services need full information on Family Court Orders to plan how a parent can see their child in accordance with the Orders. The same applies to Violence Restraining Orders so that Services know how to work with the individuals concerned to manage risk issues and ensure compliance with the conditions of the Order. A similar situation applies to residents who are on Community Treatment Orders.

3. More seriously, critical information (e.g. a recent forensic history) is omitted from referrals.

The following examples from several Services and MHSs illustrate some of the issues:

- A referral included a forensic history going back some years but did not mention that the potential resident sexually assaulted a nurse a few months before the referral was made. The omission was discovered because the Service asked the MHS for advice about the referral and the clinician accessed PSOLIS for information. The person making the referral also had access to PSOLIS and was therefore in a position to provide full and complete information. The referral was declined.

- A clinician on a panel assessing a referral recognised the name of the potential resident and recalled information that made the person unsuitable for the Service concerned. The clinician verified the information and the referral was declined. At this point, considerable time had been spent by both the MHS and NGO to develop plans for how best to manage the potential resident.

- A potential resident had a documented history of aggressive and anti-social behaviour, which included comments from the Mental Health Review Board that he was prone to aggressive interactions with his family, support services and the community. None of this information or his forensic history was included in the referral and only became apparent once additional documentation had been forwarded from the resident’s previous clinical service. By the time the documentation was received the potential resident had been accepted into the accommodation.
- A hospital referred a man to a low to medium support Service without mentioning he was in a wheelchair and needed 24 hour care. It seems likely that this person’s hopes for finding a home were raised and then let down.

- A person identified as ‘low risk’ on referral was working through a graded entry process to a Service (to prepare for full-time residence). The Service considered the person was clearly unwell during day visits and both the MHS and NGO raised this with the referring hospital. At first, no information was forthcoming and then hospital staff ‘informally’ advised that the person had assaulted a nurse the previous night. The Service then requested Brief Risk Assessments prior to each visit but the information provided in these was inconsistent and unreliable. Following a further incident the individual was placed in a locked ward. The Service will consider a referral in the future if the individual agrees.

When an incomplete or inappropriate referral results in an individual taking up residence without the NGO or MHS being aware of their needs and relevant history there can be damaging consequences all round. Service providers consider that this kind of referral sets residents up to fail, because if a placement does not work out and a resident has to leave (through eviction or return to hospital), this disrupts the person’s recovery, is disappointing to the individual and their family and potentially heightens mental distress. Other residents, recovery workers and MHS staff may be exposed to unacceptable risks.

Once a person takes up residence, NGOs tend to see it as their responsibility to do whatever is needed to manage the issues. They report that returning a resident to hospital is extremely difficult. For example:

- A current resident of one Service is extremely difficult to manage and some staff will not work with the person at all. Graylands Hospital will not admit the person and there are no long-term beds locally. The Service has put on extra staff to deal with the resident and the MHS continues to work with Graylands to have the resident admitted.

- Another Service has had residents who the MHS says need to be hospitalised but beds have not been available. The Service recently had to manage such a person from Thursday to Tuesday, at which time a bed became available. The NGO says they are not resourced to do this and may not have been competent to do so.

Some clinicians consulted in this evaluation reported that hospitals are constantly being pushed to discharge patients and that finding appropriate accommodation and rehabilitation services for them is difficult. This becomes even more difficult when individuals have complex risk profiles. A great deal of effort can go into sourcing a place for a patient and if a referral is rejected, hospital staff may attribute this to NGOs being
“too fussy” or wanting only to take “easy cases”. If a patient has been in several placements which have not worked out, clinicians can feel desperate about finding a home for them and then hold back critical information to achieve what they consider to be the best outcome for the individual.

Non-clinical and clinical service providers consider the drivers of inappropriate or incomplete referrals to include:

- Pressure on hospitals to discharge patients, leading to information (such as the extent of drug and alcohol use or aggressive behaviour) being omitted from the referral
- Lack of options for ‘difficult placements’, such as individuals with a forensic history\(^8\) or very high acuity and/or complex needs
- Lack of accountability or personal responsibility by some individuals within the health system
- Turnover of clinicians, such that some referrers do not have sufficient information about an individual
- Lack of thorough risk assessments in some instances
- Lack of a clear understanding about the Program with some referrers seeing it as primarily about accommodation and secondarily about rehabilitation
- Lack of critical information about the Program (e.g. that Services do not have the capacity to provide care for individuals requiring feeding and toileting or that they are not resourced to provide care for individuals with very complex risk profiles).

Inappropriate or incomplete referrals are said by NGOs to be widespread. They are a significant issue for NGOs to manage and are of concern to MHSs. More communication concerning the Program’s structure and operations, and feedback at an individual level explaining the reasons for a referral being rejected (such as a poor fit with other residents or too high a level of acuity than can be properly managed under funding arrangements), might be helpful. From the evaluation evidence it seems, however, that inappropriate or incomplete referrals are fundamentally an expression of a whole of system issue.

Lack of affordable housing

\(^8\) Services do not necessarily reject referrals where there is a forensic history and, indeed, some feel strongly that this is a group that is in need of their skills and support; what they want is to be properly informed at the time of deciding whether or not to accept a referral
NGOs operating transitional accommodation and those operating CSRUs identified a housing shortage as the single biggest problem they face. As noted earlier, some residents stay longer than the three or 12 months defined by the Commission’s Service Definitions or Guidelines for transitional accommodation because appropriate, affordable accommodation cannot be found. NGOs spoke of residents whose “bags are packed” but have nowhere to go and a number of residents commented on the uncertainty they felt about where they would move on to:

“I was very fortunate to be here for a year and now it’s come to the time that we have to find a place for me. Because there’s only a year’s lease on this place so it’s coming up to the time. I’m having a bit of trouble getting accommodation. My key worker, she looks like she’s banging her head against a wall trying to get a place for me” (resident)

Good practice example:

In Geraldton, an accommodation group has been established by Central West Mental Health Service, Fusion (operator of CSRU and Cameleers Guest House which has a significant number of people with mental health problems but is not part of the Program) and Baptist Care (operator of Compass House Crisis Accommodation and a number of houses for people who can live independently with support services). All referrals go to a panel with two representatives from each of the three organisations and joint decisions are made to meet individual needs and make the best use of the available accommodation which has been in short supply for some time.

The big issue for the accommodation group is a severe shortage of affordable housing in the Mid-West Region with its rapid population growth due to expansion of the mining industry. People with severe mental illness are living in caravan parks, on verandahs and in other unsuitable places.

Summary of key findings

1. Residents reported receiving good clinical and non-clinical care and feeling comfortable and well supported at their accommodation. Feeling safe was one of the aspects they most liked about their Service.

2. Families reported a relatively low level of involvement in planning treatment and support.

3. There are significant advantages in drawing on the knowledge and expertise of service providers in designing and planning infrastructure that will support Program objectives.
4. There is no evidence of strong distinctions between the service models.

5. Inappropriate or incomplete referrals are of significant concern to NGOs and MHSs.

6. Lack of affordable housing is said by NGOs to be the single biggest problem they face. It causes residents in transitional accommodation to over-stay and may halt or reverse progress towards recovery. Some residents in long-term accommodation are similarly affected.

**KEQ 2: To what extent are the partnerships between service providers and Area Health Services effective in delivering coordinated services?**

Based on the evaluation rubric developed for this question (Appendix 5) judgements were made on a five point scale: excellent, good, adequate, poor or detrimental. Overall, the Program was rated ‘poor’ at delivering coordinated services, as the following statement generally holds true, based on the evidence from the evaluation:

<table>
<thead>
<tr>
<th>Evaluation Rubric</th>
<th>Description of ‘Poor’ rating</th>
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<td><strong>Clinical and non-clinical services are poorly integrated and do not function to treat the whole person. The partners do not respect or fully understand each others’ roles and responsibilities and do not communicate in the interests of residents. Residents and families have to jump through hoops to access services and can feel like second-class citizens.</strong></td>
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The findings from the evaluation that support this statement are described below. In addition, the matter of resource constraints is discussed as a limiting issue affecting the extent to which the partnerships could be effective in delivering coordinated services.

**Establishing partnerships**

The Program is premised on Care Coordination\(^9\) principles which involve ‘developing an integrated system of clinical and community support services for people with severe and persistent mental illness who also have complex needs and require assistance and support from multiple service agencies and their families and carers.’\(^{10}\) The newer Services (CSRU, Community Options, Homeless Adult and Homeless Youth) were

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9 Care Coordination is a flagship initiative of the National Action Plan on Mental Health 2006-11 to which Western Australia has a formal commitment

10 Department of Health, Government of Western Australia, 2009. ‘Community Supported Residential Units Service Guidelines’
established specifically as a means of delivering mental health services as partnerships between NGOs, Area Health Services, the Commission and the Department of Housing in line with the these principles.

Under their Service Agreements (contractual arrangements) with the Commission, NGOs are required to have Service Level Agreements (SLA) in place to formalise the partnership arrangements between their organisation and their Area Health Service. Clinical mental health services are delivered by community MHSs. For reasons which are unclear, some Services (including two CSRUs) instead have a Memorandum of Understanding (MOU). The MOUs are less detailed than the SLAs and do not clarify roles, responsibilities and expectations or provide a stable point of reference for the partnerships.

While there are contractual obligations requiring formal partnerships that deliver coordinated services, the process of establishing the partnerships has been difficult and appears to be highly dependent on relationships between the individuals involved. The evidence suggests that partnerships between NGOs and MHSs are still being established and there are many issues that need to be resolved before trusting and effective partnerships are achieved. In some situations the relationship between the parties has been described by NGOs as “a marriage under stress” or “a challenge”. During consultations for the evaluation, some MHSs were surprised to be asked about the nature of their “partnership” with NGOs and clearly did not consider this way of working to be necessary. From their perspective, they are delivering clinical mental health services to their clients, some of whom happen to live in supported accommodation.

Negotiating SLAs/MOU has not been easy and some have taken a long time to come to fruition. Some smaller NGOs have no SLA/MOU or what they do have requires updating. It has not always been possible for them to achieve the necessary cooperation of their local MHS. It seems unreasonable to expect NGOs to carry responsibility for negotiating service arrangements with a large public sector agency.

Nevertheless, the evaluation identified a number of good partnerships between NGOs and MHSs. These are marked by mutual respect, ease of communication and a focus on joint care of residents. Where partnerships work well they have been hard won, taking time, effort, goodwill and leadership. Where partnerships did not work well, but have become better, the situation has only improved when particular individuals have left their roles or organisations. There may be some correlation between the existence of up to date, signed SLAs and good, working partnerships.

Where a good relationship has been developed, there is frequent contact in person, by telephone or email, to share information. NGOs are able to seek advice concerning a resident’s mental illness and this, in turn, enables the case manager to stay fully informed about a change in mood or behaviour that may signal deteriorating health so
that swift action can be taken. If the case manager is not available or is non-responsive, the pressure on the NGO can be extreme.

**Good practice example:**

Weekly clinical review meetings of five residents per meeting are held at the Adult Homeless Service. The whole clinical team attends, together with each resident’s recovery worker. Residents are invited to attend and have been choosing to do so. The NGO and MHS have forged a strong partnership, meeting fortnightly for service development purposes. Inner City Community Mental Health Service is represented on both the Adult Homeless Service’s Reference Group, which meets every second month, and the selection panel for new residents, which meets every two weeks.

**Coordination of health services**

Generally, clinical services are not coordinated and do not function to treat the person as a whole. An exception to this is the MHS working with the Homeless Youth Service. Case managers or liaison officers from MHSs coordinate mental health multidisciplinary teams. Some will arrange appointments with a dietician or other allied health professional but, more commonly, there is no integration of mental and physical health care. Any coordination (such as with private psychiatrists, GPs, surgeons, dentists etc.) is undertaken by the NGO or a resident’s family.

The lack of integration does not reflect the evidence base: people with mental illness, relative to those without mental illness, suffer higher rates of chronic health conditions related to behavioural factors such as smoking, alcohol and drug abuse, obesity, poor diet and other lifestyle factors. Two Services have registered nurses (RN) on staff specifically to monitor residents’ physical health. Should other Services decide to follow suit, to ensure residents receive the ongoing physical health care checks and support they need, this is likely to increase Program costs in the future.

NGOs register residents with a GP, when necessary, and can experience difficulties with this as not all GPs bulk bill or will take on patients with a severe mental illness: one NGO takes residents a distance of 30 kilometres because staff consider the quality of care provided by the GP makes the journey worthwhile.

Fifty-three percent of family respondents to the evaluation survey indicated that ‘the extent to which staff here and at the health service (e.g. psychiatrist, psychologist, social worker and case manager) work together as a team’ was ‘very good’ or ‘excellent’.

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11 Department of Public Health and Department of Psychiatry and Behavioural Science, University of Western Australia 2001. ‘Duty to Care – Physical Illness in People with Mental Illness’

Relative to other questions in the survey, this drew a high proportion (21 percent) of ‘don’t know’ answers.

Some NGOs and families taking part in interviews expressed concern over a perceived lack of coordination between medical and mental health professionals with poor communication between psychiatrists and GPs being singled out for comment:

“There often seems to be a brick wall between them” (NGO)

“We had a sort of health and behavioural issue last year. I felt that one of the reasons it might have come about is because there’s a lack of communication on the higher levels between the psychiatrist and the GP. When I raised it with the psychiatrist he talked around [it] by saying it’s a complicated relationship and there’s all sorts of theoretical problems about direct communication between a GP and the psychiatrist and yada-yada-yada. I was thinking, well, there are telephones...that sort of thing isn’t as big a problem as they seem to make it, you know - phone, text, [it’s] really not that hard to keep in touch with people and what they’re doing” (family)

It was reported that poor communication between health professionals had resulted in medication being wrongly prescribed.

Residents’ experiences, however, are largely positive. They consider their service providers are coordinated, with 82 percent of respondents to the evaluation survey indicating that ‘staff here and at the health services (e.g. psychiatrist, psychologist, social worker and case manager) work together as a team’, ‘usually’ or ‘always’.

Lack of specialist care in regional areas was a concern identified by NGOs, MHSs and families and relates to shortages and turnover of psychiatrists, surgeons and other specialists creating problems with continuity of care and establishing relationships of trust:

“Because unless you have an integrated system from illness to rehabilitation, I just don’t understand how this is going to work on a consistent basis, so it just seems potluck to me...We have seen nine psychiatrists, nine, okay, and more than half of those we’ve seen once and once only” (family)

Program limitations

Two limitations were identified in the evaluation:
1. Resource constraints
2. A culture clash between MHSs and NGOs

Resource constraints

There is a view, widespread among mental health clinicians and other stakeholders, that patients with serious mental illnesses are being discharged from hospital too early\(^{13}\) and that this is straining the resources of MHSs. This has implications for the Program as some MHSs report having to ration resources by seeking to limit case loads and case work. They assess requests from NGOs for information, advice or attendance and make decisions concerning the level of service they can provide to residents. There are times when NGOs consider their residents are not receiving the level of care that is needed due largely to MHS resource constraints and this is a source of stress in the relationship. Some MHSs say they are providing less service to supported accommodation residents now than previously but that needs are being adequately met:

“We’re there to trouble-shoot, do assessments, make appointments with psychiatrists or psychologists. Our aim is to keep them out of hospital...the system works – residents get minimal support but it does work” (MHS)

A few NGOs also consider that patients are being discharged too early and that this has had an impact on their service provision.

As noted earlier, case managers or community mental health nurses have different arrangements for visiting residents. Due in part to the Public Mental Health Transfer of Care Policy (known as ‘the three month rule’), where a resident’s case manager remains responsible for that person for a period of three months after transfer from one MHS to another\(^{14}\), Services can be working with several MHSs at a time and also with different case managers at the same service. This makes it all the more important for all parties to have shared expectations and to have these documented and signed. When this occurs, day to day matters can more easily be resolved:

“If there’s a problem, we talk to each other and sort it out” (MHS)

“She’s always available to answer questions and provide advice” (NGO)

The ‘three month rule’ creates difficulties when a person has been transferred from one side of Perth to the other because the amount of travel time involved limits contact

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\(^{13}\) Locating objective evidence to validate this was beyond the scope of this evaluation. The forthcoming publication of the Stokes Review of Admission and Discharge Planning of Mental Health Patients could be expected to shed light on the matter

\(^{14}\) This rule does not apply to Specialist Residential Services
between the case manager and the resident. If the local MHS has to step in and provide care, case managers report that they are hampered by not having access to case notes and not having had the opportunity to establish a good understanding of the resident.

**Culture clash**

Evidence from the evaluation indicates there is generally a lot of goodwill between NGOs and MHSs as demonstrated in the good partnerships and working arrangements that have been developed. Where there are difficulties, these seem often to relate to differences of culture and barriers created by historical practice. In some instances NGOs and MHSs do not respect or fully understand each others’ roles and responsibilities.

Some mental health clinicians are not comfortable working with NGOs on an equal footing, notwithstanding a plethora of policy frameworks and practice standards\(^{15}\) developed in the last decade which recognise the importance of partnering to provide individuals with integrated care and seamless transition between public, private and NGO sectors. NGOs report that resistance is manifest in practices such as mental health nurses not letting NGO staff know they are onsite, going straight to see a resident without seeking up to date information concerning the person’s health status, leaving without providing information about treatment given or not responding in a timely way to missed telephone calls.

Others appear to lack respect for non-professional staff, notwithstanding that these often have highly developed communication skills and come from a range of backgrounds and education (including community development, youth work, disabilities and mental health) that make them attuned to individual residents and their particular needs.

A disparity in pay and conditions between public and non-government sectors, as well as between professional and nonprofessional staff, may serve to heighten perceived differences in status.

An additional factor emerging from consultations with a range of stakeholders is resentment among some clinicians at the establishment of the Commission and subsequent loss of ‘ownership’ of mental health services and consumers. A shift in the balance of power towards the non-government sector is perceived to have occurred and some in the public health sector are reacting to changes with a mix of real concern.

about the ongoing provision of much needed specialist services and less worthy, but understandable, ‘turf warfare’.

NGOs were critical of some community mental health staff for not understanding recovery, being threatened by it and disliking that it requires more of them than the “old ways”. Some clinicians expressed similar concerns.

MHSs reported failures by NGO recovery workers to share important information about residents because they saw it as ‘personal’ and NGOs expressed concern about MHSs not sharing information because it was ‘confidential’.

**Summary of key findings**

1. There are a number of good partnerships between NGOs and MHSs, but these have taken a long time and strong leadership to develop. In some Services the relationship between NGOs and MHSs is somewhat distant and does not reflect the Program intent.

2. Not all Services have up to date, signed SLAs with their local MHS.

3. Generally, physical and mental health services are not integrated.

4. Families and NGOs consider that residents would benefit from better communication between medical professionals.

5. Resource constraints on MHSs were identified as a Program limitation.

6. Cultural differences between NGOs and public mental health services were identified as a barrier to the delivery of coordinated services.
KEQ 3: To what extent do governance arrangements and management processes facilitate achievement of Program objectives?

A rubric was not developed for KEQ 3 because variations between the Services made it difficult to develop standard criteria against which to assess governance arrangements and management processes.

The first part of this section of the report deals with governance arrangements including Service Agreements, funding, relative costs, regulation and reporting and the National Standards for Mental Health Services.

Governance arrangements

The Commission purchases property management and delivery of on-site non-clinical services from NGOs under contractual arrangements formalised in Service Agreements. Service Agreements for the newer services (CSRUs, Community Options, Homeless Adult and Homeless Youth) are more specific in terms of requirements than older Services which work to historical contracts that, essentially, cover only basic reporting requirements. Different arrangements apply to the Hostels (Vincentian Village and Bayswater House), Specialist Residential Services and the two publicly operated Services (Jacaranda House and Hampton Road Service).

Service Agreements due to end in 2012 have been rolled over for another 12 months to enable contractual and funding matters to be reviewed and updated. This is a looming issue for NGOs which will have to re-tender for supported accommodation services in 2013 at a time when program funding from other agencies is also ending. Without funding certainty staff positions cannot be guaranteed, leading to potential loss of staff as operational planning is unable to proceed if the future of the organisation is in doubt. Lack of funding certainty can erode stakeholder confidence in the community sector and make individual NGOs appear unsound.

The current Service Agreements are input-focused. The rationale for determining the major inputs (hours of service, number of bed-days and duration of transitional services) is largely related to mandatory reporting of key performance indicators that are audited by the Office of the Auditor General for publication in annual reports. This type of quantitative data is readily auditable.

In a shift which will bring the Commission into line with other agencies purchasing extensive services from the non-government sector, the current input-focused arrangements will be replaced in 2013 by outcomes-focused purchasing arrangements.

The new arrangements are intended to form part of a quality framework to establish fair and ethical monitoring of NGOs and support them to embed a culture of measurement
and continuous service improvement in day to day practice. The framework will include processes to evaluate the quality and impact of services against six outcomes and to assess compliance with the National Standards for Mental Health Services 2010. Outcomes reporting will be included in Service Agreements from July 2013.

**Funding**

NGO Services, other than Specialist Residential Services, are funded by either block funding or bed occupancy. Block funding allows for some flexibility: the NGO can put more effort into a resident who is not travelling so well, or one who seems more likely to make a full recovery and can then go out to work and be fully participatory:

> “In mental health, some people can make a full recovery [unlike the aged care and disability sectors] but you never really know about people’s needs and capacities until you’ve got them in your Service” (NGO)

The two Homeless Services are funded on a bed occupancy basis. For reasons which are not documented, the Adult Service is funded at less than the Youth Service ($55,000 per person and $80,000 per person respectively). A problem for the NGOs operating these Services is that they cannot control occupancy rates but still have the same overheads. During the evaluation, the Commission decided to vary the funding arrangements for 2012-13 to payments made at a bed occupancy rate that will achieve at least financial break even. The 2012-13 year is being treated as a trial period during which the Commission will investigate long-term strategies to ensure the financial viability of the two Services.

There are some other apparent funding inconsistencies:

- The Long-Term Supported Accommodation Service, at Mann Way, Bassendean, has 12 residents funded for 1.5 hours a day. In terms of resident acuity and the operations of the Service residents’ length of stay it appears to be the same as a CSRU, which is funded for 2-4 hours a day.
- Some Services are funded under a regional formula, with the quantum making these more viable than metropolitan-based Services, which do not receive the additional funding.
- Two Crisis/Respite Services are said to be running at a loss and the Board of at least one NGO has decided not to continue picking up the deficit.

In addition, there appears to be considerable variation in the number of hours of service provided to residents by Services delivering the same model. From the information available, however, it is not possible to quantify this observation.

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16 NGO Service Definitions describe this as a service for people with high support needs but other documentation identifies it as a service for people with low needs
Two further matters will need to be considered when a funding model is developed to reflect the new purchasing arrangements:

- Early discharge from hospitals (referred to earlier) has reportedly resulted in people with higher needs coming into the Program. In addition, MHSs consider there are now more outreach services which are taking care of those with lower acuity.
- Some NGOs consider that current staffing levels are too low to provide enough of the one-to-one support residents need and that additional staff would increase the recovery rate.

The evaluation is unable to shed light on these matters. Without evidence, the current funding levels cannot be judged nor can the effect of increased staff be determined.

**Relative costs**

One of the aims of the Program is to keep individuals experiencing mental illness out of hospital by providing clinical and non-clinical services. It is estimated that the resident cost per day¹⁷ at some of the Services in scope for the evaluation is as follows:

- Crisis Accommodation $146-189
- Intermediate Care Accommodation $65-80
- CSRU $89-167
- Homeless Adult $185
- Homeless Youth $276
- Community Options $445-462
- Long-Term Supported Accommodation $122

Comparable information for Specialist Residential Services and the two Hostels included in the evaluation (Vincentian Village and Bayswater House) is not available.

It has been estimated that 43 percent of people in specialised mental health hospital beds in Western Australia could be discharged if housing and/or other appropriate support services were available¹⁸. If these individuals could be provided for within the Program, considerable efficiencies could be achieved while also improving quality of life and general wellbeing. Based on an estimated cost of around $1000-1200 per day for hospital inpatients, at $89-462 per day the Program is relatively inexpensive.

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¹⁷ Calculations assume full occupancy, are based on funding for 2011-12 and exclude rent/board fees and charges retained by NGOs

¹⁸ Mental Health Commission, 2010. ‘Mental Health 2020: Making it personal and everybody’s business’, Perth, Western Australia
Regulation and reporting

NGO Services operate under three regulatory agencies: the Council of Official Visitors, Office of the Chief Psychiatrist and Licensing and Accreditation Regulatory Unit.

Under the Hospital and Health Services Act 1927, they are subject to inspection by Official Visitors from the Council of Official Visitors in accordance with the provisions of the Mental Health Act 1997 (section 190) and may meet with residents to receive feedback concerning any matters they may wish to raise. If the new Mental Health Bill is passed into legislation, the Council structure will change and it will lose its inspection role. A number of Services expressed regret about this as they believe the Council provides an important service to residents.

Service performance has been monitored against the Service Standards for Non-Government Providers of Community Mental Health Services, January 2004, Office of the Chief Psychiatrist. At the time of consultations for the evaluation being conducted, NGOs believed this monitoring had been halted as of January 2012 and were uncertain what any future requirements may be.

As Licensed Psychiatric Hostels, the Services are required to provide regular reports to the Licensing and Accreditation Regulatory Unit (LARU) which conducts annual inspections. The standards cover a wide variety of sites, making it difficult for LARU to be sensitive to different situations. For example, an illuminated ‘Exit’ sign in a two-bedroom unit is superfluous, detracts from the intention to provide a home-like environment and reportedly contributes to residents’ paranoia. One service provider noted that when a new resident arrives, the provider anticipates having to repair damage to the signs several times in the first few months.

Jacaranda House and Hampton Road Service, operated by South Metropolitan Area Health Services, come under different regulatory arrangements.

NGOs typically receive funding from several different sources and are required to submit reports on these to Commonwealth or State agencies, contribute to National Minimum Data Sets and meet requirements specific to their core business (e.g. the Aged Care Standards Agency requires reports, conducts spot visits and undertakes regular audits), in addition to meeting the reporting requirements of their own organisations. Other required reports include those related to Disability Access and Inclusion, and Carers Recognition Act.

Under the regulatory arrangements described above, Services appear to be heavily regulated by agencies which do not share information between themselves or make it available to the Commission. Services are required to spend a large amount of time

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19 Since then, responsibility for monitoring standards of care in NGOs has been transferred to the Commission and steps have been taken to resolve any confusion that may have existed.
reporting on relatively small numbers of residents. Regulatory and funding agencies use different definitions, requiring different data collection:

“The questions are asked in different ways so we have to revisit the data for each report” (NGO)

“We do 29 reports to five different departments” (NGO)

There appears to be scope to reduce the administrative burden on NGOs consistent with the State’s Partnership Forum Directions\(^{20}\).

**National Standards for Mental Health Services 2010**

The National Standards for Mental Health Services apply to public mental health services, private mental health services, office-based mental health services (GPs) and NGOs. Their implementation has the potential to build a common understanding - across the whole of the service system - of the range of interventions and supports that, together with acute medical interventions and medication regimes, are required for recovery.

At the time of consultations for the evaluation being conducted there was little awareness of the National Standards among NGOs and less among MHSs. As noted earlier, the Commission is responsible for assessing NGO compliance against the National Standards as a first step towards implementing a comprehensive quality framework\(^{21}\) and has funded the Western Australian Association for Mental Health to deliver training to NGOs concerning accreditation and compliance requirements.

The following section of the report deals with Program planning and includes information concerning occupancy, fees and charges and service providers.

\(^{20}\) Government of Western Australia, 2012. ‘Partnership Forum Directions’

\(^{21}\) The Gregor Henderson report recommended development of a quality assurance mechanism relating to the (proposed) new Mental Health Act, contracts and other matters. At the time of the evaluation, the extent to which implementation of the mechanism had been funded was unclear. (Gregor Henderson Limited, 2011. ‘Developing a Quality Assurance Framework for Mental Health in Western Australia’
Program planning

For historical reasons, the Program comprises a mix of newer and older Services developed without a planning framework. Establishment of the Commission with its reform agenda provides an opportunity to remedy this by initiating a comprehensive, state-wide plan based on identified need for a range of services. This would provide the clear rationale for retaining, expanding or discontinuing some currently funded Services that is beyond the scope of this evaluation. NGOs are keen to be involved in planning at both a big picture and service-design level and both they and highly experienced clinical service providers have much to offer.

Recent experience, discussed earlier in this report, indicates that failure to take advantage of service providers’ knowledge and experience of providing support to individuals with serious and persistent mental illness has resulted in infrastructure that is less than optimum. It has also resulted in NGOs incurring additional costs and a ripple effect of other consequences:

- One NGO was provided with the key to a CSRU only on the day the units were finished, having been unable to gain access beforehand. Six units were found to be non-compliant. A week later the site flooded and they had to return the key for six months.
- At other CSRUs there were significant delays because of toilets not being connected and lighting being below the required standard. Because the NGO was not allowed on-site until the units were handed over, they had to pay for storage of all the furniture they had purchased. The delays caused problems with recruiting, deploying and retaining staff and setting up admissions panels which, in turn, meant that units stood empty for months.
- Service providers have obtained funding from Lotteries West to make site alterations necessary to meet residents’ needs (for instance, sound proofing to reduce disturbances to people with auditory hallucinations).

“There has been no acknowledgement of service providers...we’ve been cut off from planning” (NGO)

Two service providers are currently doing their own planning and building of new accommodation and see this as the most cost-effective and viable way to proceed.

Occupancy

Given the reported demand for supported accommodation/housing for people experiencing severe mental illness it could be expected that Services would operate at, or close to, maximum occupancy rates. Nevertheless, activity reports for the period July-December 2011 indicate vacancies in some Services. A contributing factor may be
the practice of holding beds for residents who go either into hospital or on social leave. A key principle underpinning the Program is that the Service is a resident’s home. Relatively short stays in hospital are part and parcel of their illness for some residents and visits to family are encouraged in order to maintain or re-establish good relationships. Service guidelines specify the number of nights a resident may be away during the year. Other factors identified by NGOs during the evaluation include:

- Gate-keeping by local MHSs to maintain control over caseloads. MHSs sometimes turn down referrals presented to panels, for people who could be offered a place, so that case loads do not increase in a practice known as ‘gate keeping’
- Building designs which make it difficult to maximise occupancy, e.g. three bedroom units at Bunbury CSRU, and a three bedroom house at Trimmer Road where one room is said to be too small to be used and there can be difficulties finding people who are compatible and placing them in a situation where staff contact hours are limited
- The need for service providers to consider the existing mix of residents when making decisions concerning potential new residents. Depending on the site, factors such as gender, acuity, behaviour and support needs are important considerations and not all referrals meeting the criteria can be accepted. At the Homeless Youth Service, when a high acuity new resident is accepted, the NGO may allocate two ‘beds’ to enable provision of the appropriate level of care
- Delays in filling a vacancy due to the time lag required for referral panels to obtain referrals for potential residents and assess them for need and compatibility with other residents. Waitlists are not kept for most Services.

Fees and charges

Fees at Services operated by NGOs are based on Program guidelines, in line with the Hospitals (Licensing and Conduct of Private Psychiatric Hostels) Regulations 1997 and are set at a rate affordable to individuals on limited income. Some flexibility with payments is allowed, depending on individual need and capacity to pay. Income from fees is incorporated into the budget for service provision and retained by NGOs.

The standard practice is for Services to set up arrangements with Centrelink to have accommodation fees deducted automatically, with residents moving in timed to coincide with Centrelink payments. Some Crisis/Respite Services require new residents to pay two weeks rent in advance when they move in and at Hampton Road Service there is a $50 bond payable on entry. Neither service providers nor residents raised

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22 A culture of gate-keeping, making it difficult for clients to access mental health services, was identified as a key issue in a review of emergency services conducted in 2010. Smith, G, Williams, T and Lefay, L. 2010. A Review of Emergency Mental Health Services in Metropolitan Perth. Department of Health, Perth.
concerns over accommodation fees, although a Crisis Service has had clients leave without settling fees/charges.

Fees at the Homeless Adult Service, where all meals are provided, are set at 80 percent of the disability support pension\(^{23}\) with some stakeholders commenting that this amount is too high for the target group. This may be so or could reflect a choice made by homeless people to spend their money in other ways. At Vincentian Village and Bayswater House, where all meals are also provided, fees are set at 72 percent of the pension to allow residents to choose and purchase their own toiletries and personal care items, instead of having ‘standard issue’ products purchased by the Service.

Eviction

Most of the available data on eviction (or ‘early exit’) policies centres around breaches of resident codes of conduct and sets of rules agreed to before entering the Service. A three-month probationary period generally applies for residents. Typically, possession of alcohol or drugs, verbal or physical aggression and other breaches of the code of conduct may result in eviction; two warnings and some counselling are provided before a resident is asked to leave. Serious breaches may result in immediate eviction.

In practice, NGOs exercise considerable discretion: some breaches may not result in a warning if this is deemed to be counter-productive to the resident’s recovery, and there is tolerance for residents affected by alcohol or drugs provided they do not place staff or other residents at risk. A few residents interviewed for the evaluation commented on other residents breaking rules (e.g. unsocial behaviour, using drugs or drinking alcohol at the Service) and were in favour of seeing rules enforced more rigorously. This view was particularly strong among those who were dealing with their own substance issues.

From the limited evidence available, it seems that evictions are not common and that NGOs have clear processes for dealing with breaches; these result in eviction as a last resort. A few NGOs reported that they regarded having to evict a resident as a failure on their own part. This evaluation has found no evidence of residents being unfairly evicted although, as mentioned earlier, a limitation is that exit interviews with former residents were not conducted.

\(^{23}\) The maximum under the Regulations is 87.5 percent of the pension
Service providers

There are ten service providers (nine NGO and one public sector organisation) operating the Services in scope for the evaluation. Among the NGOs there is considerable diversity:

- There are small and large organisations
- Some specialise in providing services for people experiencing mental illness or homelessness and mental illness
- Others (whose core business is residential aged care or is focused on services for young people) have become supported accommodation providers to meet the complex needs of their primary audience or respond to the growth in community services for people experiencing mental illness.

In consequence, the depth of experience, knowledge and skill is mixed and there is a need for capacity building. Nevertheless, diversity can be a positive factor when innovation, new energy and change are required, such as with the introduction of new approaches to service delivery, and these are some of the strengths of the Program.

The following section of the report deals with management processes, including staffing and training.

Management processes

The extent and sophistication of management processes varies across NGOs. Larger organisations have more capacity than some others to implement systems that enable efficient information collection and development of policies and procedures. NGOs appear to have appropriate management processes in place, including complaints processes and other methods for capturing feedback from residents and families. Given the extent of regulation and reporting discussed earlier, it could be expected that any omissions would have been identified and dealt with by this stage in the life of the Program.

Good practice example:

Vincentcare has implemented a computer-based case management system providing records that can be shared across all sectors of the organisation. The system has been configured to mirror specific work flows including the focus on individuals. It provides a rules based care planning/pathway tool. Embedded assessment tools link the process and provide real-time decision support including admission and discharge assessments, risk and suicide assessments and the Recovery Star.
Other features include a detailed consumer database, longitudinal records, the capacity to share Care Plans with GPs, allied health and mental health services, staff management and quality management.

**Staffing**

Recruitment and selection practices differ across the NGOs. Seventy-five percent of the sites in scope for the evaluation are managed by or employ professional staff such as clinical psychologists, social workers or registered nurses. Most, if not all, NGOs require non-professional staff to have, or be working towards, Level IV or III certificates in mental health, alcohol and drugs, disabilities, community services, youth work or aged care services. One NGO, however, is reviewing its policy requiring staff to achieve Level IV certification because the TAFE course content, as it is currently designed, is considered by that organisation to be insufficiently oriented towards recovery and not of a high enough standard. The organisation is likely to seek training elsewhere because both management and staff want any course of study that is undertaken to be relevant to their work and to advance their skills and competencies.

A large proportion of the workforce has poor pay and conditions. MHSs commented that NGO staff routinely work ‘above and beyond’, including inconvenient or split-shifts, for little financial reward.

NGOs place a great deal of emphasis on selecting professional and non-professional staff with the right qualities to work effectively with residents and identify this as a particular challenge, given a general workforce shortage in all areas of community services. As with other employment categories including psychiatrists, psychologists and mental health nurses, recruitment difficulties are more acute in regional areas.

Staff turnover has been an issue for most of the Services but was reported to have stabilised at the time of the evaluation. Contributing factors are a 15% increase in funding (Component 1 funding, targeted at not for profit organisations delivering community services, as part of the 2011-12 WA Government Budget) and the maturing of newer Services such that there is a clearer understanding of residents’ behaviour and how to manage this, together with a more developed capacity to support and train staff.

There appear to be no defined, standardised mental health workforce competencies however two initiatives are underway to remedy this. Under the Fourth National Mental Health Plan, a National Mental Health Workforce Strategy is being developed to define competencies and roles in clinical, community and peer support areas and, in WA, work has started on a Mental Health Workforce Development Plan.
Training

NGOs are highly committed to capacity building. Based on consultation with NGOs and some secondary data, all NGOs provide ongoing training for staff. Some joint training with MHSs has been conducted and some Services have received training from their local MHS. Training tends to be opportunistic, with staff seeking information on specific topics to help them understand how best to support residents with particular diagnoses or conditions.

Summary of key findings

1. There is a need for an overhaul of Program planning, contract management and accountabilities and for a new funding model to fund Services on an equitable basis

2. There appear to be considerable variations in hours of services provided by Services using the same model

3. There is scope to reduce the administrative burden placed on NGOs.

4. Occupancy rates are affected by a number of factors beyond the control of NGOs.
KEQ 4: To what extent does the Program increase residents’ independence, participation, quality of life and wellbeing?

Based on the evaluation rubric developed for this question (Appendix 5) judgements were made on a five point scale: excellent, good, adequate, poor or detrimental. Overall, the Program was rated ‘excellent’ at increasing residents’ independence, participation, quality of life and wellbeing as the following statement generally holds true, based on evidence from the evaluation:

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<th>Evaluation Rubric</th>
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<td>Description of ‘Excellent’ Rating</td>
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<tr>
<td>Residents feel they have come a long way and are optimistic about things continuing to improve for them. They are engaged in social and recreational activities within their accommodation and in the broader community and have a network of people with whom they feel safe, supported and valued. They have goals and events to look forward to. They contribute to their environment and to those around them. They are more competent in daily living skills and have developed ways of self-managing their illness. They are encouraged and supported to pursue activities of interest to them and experience a developing confidence in their capacity to live a good life.</td>
</tr>
</tbody>
</table>

Findings from the evaluation that support this statement are described below.

**Resident and family feedback**

The evaluation found that the majority of residents perceived the Program to be very positive in terms of supporting them to improve their lives and work towards recovery. The evaluation survey supported this view. The following table shows how residents rate their experience in terms of the effect of the Program:

<table>
<thead>
<tr>
<th>The effect the Program has had on:</th>
<th>Good</th>
<th>Very Good</th>
<th>Excellent</th>
<th>Total Good to Excellent</th>
</tr>
</thead>
<tbody>
<tr>
<td>My overall wellbeing</td>
<td>25%</td>
<td>27%</td>
<td>42%</td>
<td>94%</td>
</tr>
<tr>
<td>My ability to lead a good life</td>
<td>26%</td>
<td>32%</td>
<td>32%</td>
<td>90%</td>
</tr>
<tr>
<td>My ability to engage in meaningful activity</td>
<td>29%</td>
<td>25%</td>
<td>32%</td>
<td>86%</td>
</tr>
<tr>
<td>My ability to socialise</td>
<td>22%</td>
<td>30%</td>
<td>30%</td>
<td>90%</td>
</tr>
<tr>
<td>My ability to be more independent</td>
<td>22%</td>
<td>33%</td>
<td>35%</td>
<td>90%</td>
</tr>
<tr>
<td>My ability to manage everyday life</td>
<td>31%</td>
<td>28%</td>
<td>33%</td>
<td>92%</td>
</tr>
<tr>
<td>My hopefulness for the future</td>
<td>24%</td>
<td>26%</td>
<td>38%</td>
<td>88%</td>
</tr>
</tbody>
</table>

Table 3: Residents’ rating of Program effects
Families’ perceptions of the Program were somewhat less positive. The survey supported this view. The following table shows how families rate their relatives’ experience in terms of the effect of the Program:

<table>
<thead>
<tr>
<th>The effect the Program has had on his/her:</th>
<th>Good</th>
<th>Very Good</th>
<th>Excellent</th>
<th>Total Good to Excellent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall wellbeing</td>
<td>30%</td>
<td>26%</td>
<td>26%</td>
<td>82%</td>
</tr>
<tr>
<td>Ability to lead a good life</td>
<td>30%</td>
<td>26%</td>
<td>20%</td>
<td>76%</td>
</tr>
<tr>
<td>Ability to engage in meaningful activity of his/her own choosing</td>
<td>34%</td>
<td>21%</td>
<td>15%</td>
<td>70%</td>
</tr>
<tr>
<td>Ability to socialise</td>
<td>30%</td>
<td>22%</td>
<td>15%</td>
<td>67%</td>
</tr>
<tr>
<td>Ability to be more independent</td>
<td>26%</td>
<td>28%</td>
<td>13%</td>
<td>67%</td>
</tr>
<tr>
<td>Ability to manage everyday life</td>
<td>23%</td>
<td>25%</td>
<td>25%</td>
<td>73%</td>
</tr>
<tr>
<td>Hopefulness for the future</td>
<td>22%</td>
<td>28%</td>
<td>6%</td>
<td>56%</td>
</tr>
</tbody>
</table>

Table 4: Families’ rating of Program effects

In these tables the family ratings were less positive overall than those of residents. The biggest differences relate to ability to socialise, be more independent, manage everyday life and hopefulness for the future. Some of this difference may be due to residents in Specialist Residential Services (Frank Prendergast House and Lefroy Hostel) being unable to participate in the survey due to their lack of cognitive capacity, together with a relatively high proportion of family responses (23 percent) coming from those with relatives living in Specialist Residential Services.

Many of the interviews of residents and their families identified important individual impacts resulting from the Program. Two methods were used to collect this evidence:

- **Most significant change process**
  This included conducting face to face, semi-structured interviews with residents and families to gain an understanding of their experience of the Program and how it is affecting their lives. The focus of the interviews was on collecting stories of the most significant change that has occurred as a result of Program participation. From 37 interviews with residents, 27 stories were obtained. In ten interviews, residents were so preoccupied or agitated their comments (some of which were used to inform identification of themes) could not be documented as a story. From 15 interviews with families, 15 stories were obtained. A total of 42 stories were collected.

- **Survey of residents and families**
  Two paper-based surveys were conducted (the designs of which were informed by the semi-structured interviews referred to above). The purpose of the surveys
was to gauge experience across the Program and quantify perceptions of functional improvement; increased independence; increased enjoyment of life; and a greater sense of wellbeing. There were 127 completed questionnaires returned by residents and 47 completed questionnaires returned by families.

**Most significant change process**

In this process, once the changes had been captured through interview and documented in the words of the resident or family member, a set of stories was discussed by the Stakeholder Reference Group. Members were divided into three groups and each group was given six stories to read aloud and discuss in terms of the perceived value of the reported change. Groups then selected the story/stories that resonated most with members and gave reasons for making their choice. Information from the discussions and reasons for selecting particular stories were used to help draw out key themes, identified below.

Four of the stories selected in this process (two from residents and two from families) are included in this report, with the permission of the individuals concerned. Names have been changed to protect their privacy.

**Resident story 1: ‘Being settled’**

“I’m Serbian. I’ve been in Australia since I was 16. It’s a big change, very big change and I had a bit of a culture clash in Sydney because the Eastern Europeans act quite differently from the rest of Europe.

The climate is very good for me because I’ve got condition, sinuses, my sinuses are actually - that’s why I’m in this place as well for the first place. Because my - I had headaches before and they influenced like my - they affected my health.

Well I got diagnosed with schizoaffective disorder, but it actually, it’s a mix of things with me because it’s physical and mental as I said - and it - I don’t actually have any sort of voices or anything like that, but it’s just that my doctor in Sydney thought that I was over sensitive physically.

I’ve been in this Service for four years but I was about a year before that - about five years I’ve been in Perth. Five, six years - five I think. I was referred to the mental health centre in Perth by psychiatrists in Sydney. And they did a good job on me because they made me secure - they talked to me and they said if you’re - like if you get stronger physically, your spiritual condition is going to increase as well. Just recently the doctor discharged me from the mental health clinic as well, so. Because he said I can see a GP for the medicine because it’s only medicine that I need because - that actually fixes the imbalance.
I started taking care of myself for the first time. Cleaning, planning my day, I went to the doctors regularly. And the staff here are quite helpful actually because - I understand that’s their job - but they are helpful in a spiritual way as well.

They have a good kitchen and they’ve got - everything’s on time. Also the staff, whenever you need help they will provide help whether it be school or communications or anything else like transport. Also it’s quite advanced, like technologically, because we have swipe cards and stuff like that.

It has helped me to settle down, yes. It has actually, because as I say it’s very close to shops and stuff and if you walk around the place you get a feeling for it, atmosphere for it. It all seems a little bit complicated, but it’s not actually, it’s - when you change places a lot like I did, like from Europe to Sydney to Perth - it can be a bit unsettling.”

Themes
The story was selected because it is about the difficulties of moving and being disconnected and how that affects mental health. Other themes include:
  - Experiencing many changes, including cultural change and geographical change
  - Becoming physically strong can help with being mentally strong
  - Information sharing between clinicians in Sydney and Perth

What has changed? This person:
  - Has a sense of belonging, something of great importance to recovery
  - Feels secure
  - Has developed the capacity to take care of himself
  - Feels confident that staff will always help and support him
  - Feels nurtured spiritually
  - Is being helped by the Service in practical ways, including with education, communication and transport
  - Is enjoying life, including the atmosphere where he lives and in the surrounding area
  - Feels settled in his home, after years of moving around
  - Has experienced an improvement in his health

Resident story 2: ‘I’m lucky because I’ve never lived on the streets’

“I stayed at a centre before I came here. That was alright – it was a bit annoying because there was a lot of people. So it was just a bit frustrating sometimes, like because people would always bum smokes off you and stuff like that – but yeah, it wasn’t too bad. I sort of lived in pretty much hostels since probably about 2009.

I was diagnosed with paranoid schizophrenia in 2010 after two hospital admissions. I’ve seen like three different psychiatrists and the doctor I saw the first time said it could
have just been drug-induced psychosis, because I was using a lot of weed. I had my first bong, cone, when I was about 10 or 11 and then smoked it on and off until I was 18. Then I quit weed and I moved into a centre and about two months later I had a paranoid episode. I thought, like, people were out to kill me and, like, the police were after me, and all that. Yeah, it was just mainly paranoia and a few delusions but yeah I haven’t been back to hospital. I’ve only been there twice.

I’m pretty much settled in here but yeah, it’s been alright but there’s been a few people coming and going so yeah, but that doesn’t really bother me too much. It’s a lot better here. The good thing about the Service is you get your meals cooked for you, so that’s pretty good, but if I could choose, like, it’s better here, you know, it’s more independent and stuff like that.

Doing key work is pretty good, like, being able to work out your goals and stuff like that. Working on your goals and that and moving forward. One of my goals is to start TAFE mid this year and do my Year 11 and 12. Then from that, go out and get myself a job, probably just something like retail or something to do in a factory.

Having a plan and just having somewhere to live, not living on the streets, like, I’ve been lucky, I’ve really never sort of lived on the streets, like, I’ve spent maybe one or two nights total not having anywhere to stay for the night, so I sort of stayed in the city and didn’t sleep, just stayed up all right. But that was when I was younger, I’m only 20 now but that was when I was probably 16, 17. So it’s just good that I’ve got a place over my head, somewhere to sleep at night and that, food in my stomach.

It’s all pretty good here, it’s all pretty covered – just maybe a longer stay would be good. I’ve only been here for like four months so it’s quite a long time to go but it’ll be good if they could extend it from 12 months to maybe two years so then, if you’re on a waiting list for housing, you’ve got more of a chance to get yourself into a place. I haven’t actually signed up with any waiting lists so that’s one thing that I should really start thinking about doing, like, we’ve spoken about it in key work so I’m going to put my name down for Homeswest and that, so yeah.

One thing here is you have to do three meaningful activities a week so at the moment I’m going to June O’Connor twice a week, just until I start TAFE. It’s pretty much like a drop in centre, you can play pool, go on the computer, talk to staff if you need to. But it’s not really my thing because – not being rude – but everyone’s like 40 plus. Not just that, everyone’s a bit sort of in their own little world. Yeah.

Probably, just using my key work to full effect. When I was at [Service] I missed quite a few key works and that but towards the end I realised it was helpful, it wasn’t just something that you did. When I first got there I didn’t really think that I needed key work, but it’s good. Since I’ve been here I’ve gone to every key work. It’s a good way to release your problems and talk about your goals and stuff.
I’m doing really well. I feel more independent because I’m cooking my own food, doing chores again.”

Themes
This story was selected because it’s about a young person with positive expectations of life and of himself. He has stopped taking drugs and the Service is getting him active.

Other themes:
- A lot of short-term accommodation over the last four years
- The current Service seems appropriate to needs but is also short-term
- Started using drugs as a child and has now stopped
- The need for age-appropriate services
- Appears resilient and optimistic

What has changed? This person:
- Has a plan for further education or training
- Has engaged with recovery work
- Is more independent
- Feels he is doing well

Family story 1: ‘A bumpy road but now he’s off his medication’

“Over 12 years Steve lived alone in private rental with family contact and occasional extra financial support and holidays with family. Then, unable to get accommodation, he went between his dad’s and my places but really it wasn’t working. I’ve got a very small place and so has his dad, he is up in the country. Steve ended up in Graylands in 2006 and we were promised he would have accommodation on leaving. But he was discharged with nowhere to live but with his dad, and on waiting lists for everything.

I kept ringing people I knew across services and ex colleagues from Mental Health where I had worked for many years. I followed every lead pushing to see where he could go. There were two more hospitalisations from the country and three short trials at shared accommodation. None were suitable because all had shared bedrooms and no withdrawal place and no room for activities.

Once, in desperation, we tried to force him to stay at a new hostel in Geraldton. His dad and I travelled there and went with him. It was big and he had to share with a 45year old and cook and do everything in the same place. He absolutely refused to stay as it was too hospital-like and with a keyed lock on the bedside drawer. His dad and I left him there to give him no alternative, knowing he had nowhere to go. Later in the day the nurse drove him out the road and left him near his brother’s house where we were all gathered and wondering what to do next. He went home with his dad again. Soon he was back in Graylands.
I was at a Mental Health Conference when a woman called me over to join her table for the next activity. We were absolutely desperate at this stage because he was discharged to shared housing and was just three weeks out of hospital and was really bad. He was staying in bed all day and couldn’t cross the busy road to get food because the medication made him feel unsafe.

Sitting down with the woman at the table I asked what do you do? Do you have any vacancies? Yes. The next day I took Steve out for an interview and he read the vision statement for the Service and saw it was a positive thing for him. The way the housing was set out seemed to work. He wasn’t too sure about getting involved with other residents but this offered him a room, his own bathroom, the means of getting some food for himself if he wanted to or coming to the dining room. It gave him space to get his art stuff out, as well as to have his own computer and to follow his research and game interests. This has been such a godsend. He’s been here since Anzac day 12 months ago.

The other thing is, it’s safe. To him it means there’s gates around so people can’t come knocking on your door. He had a dream about a break in we had at our home one night and he said when I woke up I thought oh but there’s gates around here, I’m safe. So it’s all those things and he just keeps saying positive things about the place. Like even the caretaker, on the first anniversary of the last hospitalisation he was worried about what might happen. But the caretaker comes and knocks on his door late at night and says are you okay, Steve? He said yeah and nothing happened.

He’s really only been off medication entirely for about three to four weeks so it’s early days and there was a lot of discussion about risk management. Steve was a bit anxious for a while because mental health were saying they still had to be involved and Steve was saying I don’t want you involved. But the Service staff went with Steve on that and they managed to negotiate a plan that has satisfied everybody. It helps having a Mental Health Nurse as Clinical Manager here.

Since he’s been off the medication he’s started his running, I’ve noticed a huge difference. So, there’s really good things happening here. Steve himself will say it’s the best place to be. He is happy here and is making so much progress. He’s playing pool with the guys; he’s joining in stuff.

It’s just a huge relief. My own health has improved significantly as I was having difficulty coping and gave up my job early and it’s meant I’ve had to go on the aged pension, which I really shouldn’t have to after working for 40 years. So it’s been a really big struggle.”
Themes
This story was selected because it is about the impact on the family of trying to find accommodation and support for a son and about a resident being supported in his decision to come off medication. Themes include:

- Difficulties obtaining stable accommodation
- Finding out about the Service through a chance meeting
- Help was provided only after several years of searching
- The Service is well matched to resident’s needs

What’s changed? This person:

- Feels safe
- Has been given the opportunity to pursue his own interests
- Achieved his goal of ceasing medication, with the support of the Service and MHS
- Feels happy and is making progress
- Has taken up running and interacts with other residents

What’s changed? This person’s family:

- Feels great relief following several years of struggle and stress
- Is experiencing improved health

Family story 2: ‘They should make more places like this’

“Well my husband is a schizophrenic and I was his carer for a long time - and the children as well because my children have grown up...So they weren't there all the time. But it became difficult for me because Dave's mood changes with change all the time. He'd become aggressive.

I'll tell you something, right at the very beginning when my husband did become sick there was a privacy act and there still is. If the patient - which was my husband - doesn't want family or his wife to know, they will not tell you. That's a cruel thing, a very cruel thing because the wife is up in the air. All these crazy things are happening in her life, nothing to do with her but with her husband or her child, or whoever the case may be, and she's getting told nothing because of the privacy act. I think that can be very damaging sometimes.

Marriage is like a team....Heavens above if you take a man on for better or for worse at the very beginning - and I've been married over 40 years now to my husband - you should have a say or you should know what's going on. He shouldn't keep it a secret and nor should the medical people. If you're allowed to know the good things, you should be allowed to know the bad things. Because, if you don't know, you start wondering. You're lying in bed at night time worrying. You're putting yourself in an early grave.
It was the young nurse who let it slip that he was a schizophrenic. I nearly fainted. I had to sit down. I had to put my head on the table and I even went and looked up schizophrenic to see what it meant because I knew schizophrenic was a disease - a sickness I mean. But I never actually knew what it meant because it had never involved me and I'd never been associated with it.

I put up with it for a long time, I mean years, and it was getting me down. So I was becoming a nervous wreck and something had to be done. I didn't want to divorce him or kick him out of my life forever which I think would have been a sad thing for him. So a friend of mine told me about the place. So I went there to see the young lady who was interviewing you to see whether they would accept your husband or not and they did. That was the beginning of a much better time for me at home. I still have a lot to do with Dave but he's here and I'm there. I don't have to put up with his horrible moods.

I took it on my initiative. My friend who knew about the place, she told me about it you see. I would not have known otherwise. It was just really a couple of friends talking together that started me off looking for a place for Dave.

This is his home. Funny enough he calls it his home. He's as happy as a bumblebee here. In his little unit that he's got there now, he loves it because it's his and it's private. He can do what he wants so long as he doesn't break the law or the rules of this establishment. That's what he likes. He's got no responsibilities.

The difference for me is that he's cared for and the people here are highly responsible for everything they do. They look after him very well. We keep in touch, we got him a phone. He rings, I ring him. He comes over for coffee. We'll do a little bit of shopping and have a cup of coffee and a cake, buy Chinese if he wants lunch or something like that. He's still in the family...well as far as I'm concerned, this has been a godsend to me and I can't think of anything that could make this place better for me...they tell me straight away if anything's happening. They ring me up and let me know. I think that's good.

But I'm still happy with what I've got, and I'm so happy that he's here because it's been so good for me and my children. I think they should make more places like this for people in my situation. But make it easier for us to know about because how would I have known if...my friend hadn't have put me on the right track? I wouldn't have known. I wouldn't have had a clue. That's the truth."
Themes
This story was selected because it shows the perspective of both a family and a resident. All of them have better lives now. Themes include:

- Carer excluded from planning medical care and treatment
- Finding out about the Service through discussion with friends
- Many years before help was provided
- The Service meets the needs of both the resident and his family

What’s changed? This person:

- Feels happy at having his own home
- Has remained in touch with his family

What’s changed? This person’s family:

- Can stay connected to their husband/father without have to be responsible for his care
- Is kept well informed about his care and treatment
- Are happy with the arrangements and feel free to get on with their lives

Key themes from resident interviews

In addition to the most significant change stories, themes from which are outlined above, a number of themes emerged from the resident interviews. These are identified below, starting with two over-arching themes (homelessness, and drugs and alcohol) followed by the remaining themes grouped under headings relating to the KEQ, i.e. independence, participation, quality of life and wellbeing.

Over-arching themes: homeless, and drugs and alcohol

Homelessness – this has been a significant problem for a number of younger and older men and, as identified in Resident Story 2, above, some residents have moved several times from short-term accommodation to different short-term accommodation. This suggests there may be a degree of churn in the Services:

“I was homeless for about three years. It was a bit of a relief coming here because I had a problem with my bladder. I need to wash my clothes in the morning...I wanted accommodation where it was reasonably affordable. Some hostels, they take all your money off you... It’s like my life began when I started staying here. I’ve had a terrible time before I came here. It’s been a relief” (resident)

“Last year was rough. Absolutely rough. I had to beg. I had to beg, absolutely beg. I was homeless there for a bit. What I’d do is, I was working at McDonalds during the night and then sleeping at the domestic airport. It was a nightmare. An absolute nightmare. It’s behind me now so the future’s looking much brighter” (resident)
Drugs and alcohol – substance abuse has also been a significant problem for a number of residents:

“I started experimenting with drugs at a very young age. Marijuana when I was about 14 ...and I was always a drinker”. At age 30 the resident was introduced to heroin and “within three months I had lost everything. I just couldn’t get enough of it”. After being away from Perth for many years she returned and, after being back two days, the local newspaper carried a front page story about “the city train station, awash with heroin, and I thought, you little beauty”. The resident used heroin for the next nine years and then got clean before starting to use “speed, meth and all that horrible stuff”. She had several bouts of paranoia and was hospitalised. A few years later she started using kronic and “after six weeks my whole life just fell apart and it made me so paranoid. So as a result I accidentally overdosed and here I am” (resident)

Independence

Supported accommodation provides independence – people experiencing mental illness have a place of their own and do not have to keep living with parents. Parents or other family members feel relieved that they no longer have to manage difficult behaviour and that their adult children or family member have a good home and are safe and happy.

A resident described the best thing about living in supported accommodation as “having my independence”. She had previously been living with her mother who was “a bit controlling” but now the resident was enjoying some freedom. “Well, I'm starting to cook for myself. I'm starting to go out by myself” (resident)

Participation

Almost all residents reported some form of increased participation, such has having a job, reuniting with their families or learning to get along with other people. Many residents are working in a voluntary or paid capacity - they enjoy having some money and doing the work:

“Three days a week I go to volunteer work at Technology Assisting Disability WA – they’re like a computer shop. I just help them out. On Thursday I do gardening work and I have Friday off. I’m always looking forward to Thursday night because I know I don’t have to work the next day. I’m pretty happy with what I have but, if change comes, I wouldn’t mind sharing a house with someone but still having contact with a clinic or with a doctor or nurse or someone I can talk to. I would like work to start paying me, because they’ve recently started paying two guys that were volunteers, so I’m hopeful. I’d be happy if they did” (resident)
Several mothers have been reunited with children or are planning interstate trips to visit their children:

“I would like to move forward, with a man and have a baby. I’d like to get my son back from Sydney. His father and I are divorced and he lives with his father. I miss him and I’m going to see him in the holidays. My sister’s organising the trip, the airline tickets and the accommodation for me at a bed and breakfast. I’m going to get supervised because apparently I push my son too much and I need supervised access. So my sister’s going to supervise access for me” (resident)

Some residents have developed social skills as a result of sharing accommodation with others:

“I tend to isolate a lot and have a lot of anxiety so this is really good for me because I can go into a share house and I’d pretty much live in my room. So this has given me the confidence to mix with other people, live with other people, learn new skills, you know... So it’s been wonderful, even on those days when you think, I could kill you. But you learn. You just learn to fit in” (resident)

Quality of life

A number of residents reported improvements in their overall quality of life through having a secure home and obtaining employment, as discussed above. Other aspects of improved quality of life include feeling safe and achieving goals. Feeling safe is considered to be a significant benefit provided by the Program, described under KEQ 1 and in Family Story 1.

Achieving goals produces feelings of pride and accomplishment:

“I’m proud of what I’ve done, achieved when I’m here. When I came, I was a bit nervous and didn’t know what was going to be expected of me. But they gave me an award for progress, saying I’ve done level two and I’ve got a certificate. That was very nice of them. I am very happy here” (resident)

Wellbeing

The most common reports of improved wellbeing related to taking medication as prescribed, having a routine or structure and improvements in physical health:

“The most useful aspect about being here is having a structure and medication” (resident)

Being supported to get fit and lose weight has increased self-esteem and feelings of achievement and has led to a number of residents valuing their physical health:
“I’ll lose another 25 kilos to be the right weight for my size. I’ve lost 20 kilos so far”
(resident)

Key themes from family interviews

There were three over-arching themes which constantly occurred in family interviews:

- Families find it difficult to obtain information on how to help their loved ones and stumble upon it by accident rather than through accessible, formal channels
- Families experience profound relief at their loved ones being part of the Program after years of worry and bad experiences with “the system”
- Families are grateful and relieved that their loved one has found a good, safe home at last.

These themes are illustrated in the two family stories included above.

Positive bias

Many residents expressed feelings of gratitude for having a good place to live and for the support and assistance they received so there was a positive bias in the interviews.

Negative experience

The only complaint or negative experience with the Program related to:

- A view by some residents that other residents were not pulling their weight in shared units/houses or were breaking the rules and getting away with it
- Annoying behaviour

“Some of my housemates have been hard to live with – like cleaning up after them and that, because I’m very neat and clean. Listening to their music day and night. I don’t let that bother me, you know” (resident)

Feeling responsible

In a couple of interviews, residents reflected on their lack of participation in their recovery program or blamed themselves for not improving:

“It’s good here. Not working out as well as I was hoping for. But that’s on my part a bit...I haven’t noticed any change, a bit worse even. That’s why I was just sent to hospital. I was getting paranoid. It helped a bit, it does go up and down. But that’s my fault” (resident)
Good outcomes

A majority of most significant change stories involved getting better, enjoying life more, having a plan for the future or achieving tangible outcomes such as getting a job or taking action to improve physical health:

“\textit{I’ve also quit smoking since I’ve been here. I’ll probably have to try for the rest of my life to stay away from it, you know what I mean?}” (resident)

“\textit{I’ve come a long way since being here, spiritually, mentally, physically – well, not physically really - and I’m much better now}” (resident)

“\textit{That defining moment when you see someone laugh, when you haven’t seen them laugh for so long, it really brings tears to my eyes. It’s wonderful. So I think that’s where he is now. It has been wonderful, sort of like a staging post for him. To get him back to fitness again, I think it’s terrific}” (family)

The key to good outcomes

There is widespread agreement among clinical and non-clinical service providers that knowing residents well is fundamental in moving them towards recovery. One of the Program’s strengths is that it provides the time for service providers to get to know each resident. Through understanding a resident’s history and experience, service providers can pick up clues about what they like, could be interested in or motivated by; pre-empt difficult or destructive behaviour; and help individuals understand how to keep themselves out of hospital:

“\textit{The beauty of [the Service] is we get to know residents very well and we prevent re-admissions by knowing the triggers}” (MHS)

“\textit{Knowing the person is essential to knowing how to manage them...outcomes are achieved through treatment of depression and other symptoms and having well-trained staff who can pre-empt behaviour or situations leading to exacerbation of fear, disorientation or embarrassment}”(NGO):

“\textit{...[when we know them better] including all the other issues like drugs and alcohol, depression and anxiety, we’re able to support them better}” (NGO)

The nature and extent of moves towards recovery varies according to the individual. For someone who has never been able to maintain a tenancy, remaining in supported accommodation for six months is a significant change - even if they are subsequently evicted.
For a resident in Special Residential Services, a good outcome is effective management of behaviour through the dementia cycle so that the resident can be discharged to a mainstream nursing home, and supporting a family so they can support staff in caring for residents.

**Potentially preventable hospitalisation**

There is currently no centralised data collection on the Program’s impact on potentially preventable hospitalisation. A pilot project is currently under development between the Commission, Department of Health and the Telethon Institute of Child Health Research. The purpose would be to link de-identified data from supported accommodation Services with data-sets such as Mental Health Community Care Data, Hospital Morbidity Data, Emergency Data and Mortality Data, to enable access to information on diagnoses, health outcome measures, inpatient and community-based service utilisation levels and individuals’ health status over time.

Not all re-admissions can be prevented, e.g. a resident may need to spend a few days in hospital because of a change in medication or may become sufficiently unwell as to be a risk to themselves or others. Service providers see potentially preventable hospitalisation as a key outcome because residents do not want to go back to hospital and, if they need to be returned forcibly, it is traumatic for them. It can also reduce moves towards recovery and independence. Two residents’ experience of being forcibly taken to hospital are illustrated below:

“Things were going fairly well [then] they said I was acting erratically but no-one spoke to me, they just sent doctors with the police. The police officers, they take you away...you can say no but they will take you. So that wasn’t very good. They never talked to me about it, they didn’t even say a word. Not one of the staff said anything until there were two doctors saying come on, you’ve got to go” (resident)

“...they dragged me out of where I was, got me to hospital down on the floor and gave me needles and they wonder why I’m difficult” (resident)

Success factors in preventing re-admissions identified by NGOs and MHSs all relate to knowing the resident and understanding how their mental illness affects them:

- Trust – residents knowing the service provider cares about their wellbeing and can be counted on to provide support (e.g. a resident returned home after being with friends and told staff he had been smoking marijuana; they were able to keep an eye on him and when his hallucinations returned ensured he had the medication required)
• Well trained recovery workers who are alert to signs of potential deterioration and can take preventive action (e.g. discussing the situation with the case manager, providing more intensive psychosocial support)
• Putting a management plan in place around a potentially risky period (e.g. a bereavement, anniversary of a bereavement, a ‘milestone’ birthday or other significant event)
• Supporting residents to self-manage their illness, recognise signs they are becoming unwell, maintain their medication regime and seek additional support when needed.

The Crisis/Respite Accommodation Services and Hampton Road Service are seen by their operators as playing a role in preventing re-admissions by providing the opportunity for an individual with mental illness to re-stabilise in a safe environment before becoming so unwell that hospitalisation is the only resort. Other Services expressed similar confidence in their effectiveness in preventing re-admissions.

Findings from the evaluation indicate that 73 percent of residents reported having had fewer hospital admissions since being in the Program. A number of residents said that not being hospitalised since living at their Service was one of the most significant changes they had experienced:

“I’ve been here 14 months, haven’t been in hospital... that’s a change” (resident)

Outcome measures

Under their Service Agreements, NGOs are required to collect quality of life outcome measures. Some use the Recovery Enhancing Environment Measure (REE) questionnaire, which indicates values such as motivation and feelings of self-worth as well as development of life skills, health status, symptom management and income management. Other NGOs prefer to use Life Skills Profile, Outcomes Star or other tools to record residents’ strengths and their progress in developing daily living skills, ability to self-manage their illness (including making and keeping medical appointments and taking medication as prescribed), establish social connections, engage in meaningful activity or other desired outcomes.

Information collected through these measures is reportedly used by NGOs to better understand residents’ needs and improve service delivery but is not collected by the Commission. Some NGOs do, however, provide a ‘snapshot’ of outcomes – such as residents getting jobs, moving to less supported accommodation and so on – as part of their six monthly Activity Reports to the Commission.

There is no mechanism in place for NGOs to record and report on outcomes at either a Service level or Program-wide. As noted earlier, at KEQ 3, outcomes reporting will be
included in Service Agreements from July 2013. Public mental health services use a mandatory data collection mechanism, known as the National Outcome and Casemix Collection. NGOs do not have access to this data and neither was it available for the evaluation.

**Summary of key findings**

1. The Program is achieving significant positive outcomes for residents
2. Families are grateful and relieved that their loved one is safe, well and living in a good home
3. Families and people experiencing mental illness find it difficult to obtain information concerning mental health services and supported accommodation and pathways into the Program are hard to access
4. NGOs and MHSs report that the key to achieving good outcomes is knowing residents well
5. Evidence from the survey and interviews with residents indicates that the Program reduces preventable re-admissions to hospital.

**5. CONCLUSIONS**

This is valuable Program delivering tangible benefits to people experiencing severe and persistent mental illness. As well as being provided with a good home, residents receive good clinical and non-clinical care and feel comfortable, safe and well supported. Many residents are pleased with the changes they have made in their lives and are optimistic about things continuing to go well for them. The Program is achieving good outcomes even in circumstances where families had previously held few expectations of improvement in the lives of their partners, adult children or siblings. Families are grateful and relieved that their family member is safe, well and happy. There are indications that the Program reduces preventable re-admissions to hospital.

The stories and interviews informing this evaluation provide a window into the experience of young and older people living with severe mental illness, both before and since moving into supported accommodation. NGOs and clinical service providers have drawn on their experience to illuminate the challenges faced by residents and the ways in which treatment and support can best be provided and the evaluation identifies several examples of good practice.
Many of the evaluation findings have implications not only for this Program but for other developments forming part of the Commission’s reform agenda.

The intent of high-level MOUs between the Commission and the Health Department or Area Health Services has yet to flow down to a local level and, while there are examples of good partnerships between NGOs and MHSs, these tend to be personality-dependent and have taken time and significant effort to achieve. The evaluation highlights aspects of a culture clash that are barriers to coordinated service delivery, not only for this Program but for other programs and initiatives where clinical and non-clinical service providers need to work together. A report commissioned by the National Advisory Council on Mental Health, ‘Fitting Together the Pieces: Collaborative Care Models for Adults with Severe and Persistent Mental Illness’\textsuperscript{24}, identified eight mechanisms to support clinical and non-clinical partnerships and could be useful to the Commission.

In the short term, high level leadership would lend impetus and strength to the development, or updating, of SLAs. That, in itself, would be progress but real change takes longer to achieve and will require a strategic approach including identification of some ‘change champions’. The strategy should also identify how physical and mental health care can be better integrated for people experiencing severe and persistent mental illness.

Lack of affordable accommodation was identified as a significant issue. The evaluation identified a number of residents who had endured terrible conditions before entering the Program, as well as some in transitional accommodation who were anxious about where they would go next.

There is a need for population-based planning. Service providers have a wealth of knowledge and experience that could contribute to this.

Families and people experiencing mental illness find it difficult to obtain information concerning mental health services and pathways into the Program are difficult to access. Overall, families reported a relatively low level of involvement in planning the treatment and support of their family member.

It is evident that establishing new Services and introducing different ways of responding to people experiencing severe mental illness takes time and challenges traditional ways of working. It would be valuable to capture the experience of those involved in the establishment of the newest Services (CSRUs, Community Options and the two Homeless Services) so that these learnings can be applied to the development of new services in the future.

\textsuperscript{24} National Advisory Council on Mental Health, 2010. Monash Alfred Psychiatry Research Centre. ‘Fitting Together the Pieces: Collaborative Care Models for Adults with Severe and Persistent Mental Illness’
Possibly as a result of their different core businesses and, for NGOs, the realities of competitive tendering, service providers do not see themselves as part of a Program and there is little or no networking taking place. With the ongoing development and expansion of services for people experiencing mental illness, this seems to be a missed opportunity for capacity development. More forums for clinical and non-clinical service providers to share knowledge and experience could be encouraged to extend and build upon existing Commission initiatives such as consultations and working groups. Members of the Stakeholder Reference Group established to provide input to this evaluation, including NGO and public sector service providers, have expressed a desire to continue working together in some capacity.

The energy, commitment and skill of NGOs and MHSs is producing real change in the lives of residents of supported accommodation and their families. These clinical and non-clinical service providers are eager for change in the mental health system in WA that will further improve the lives of people experiencing severe and persistent mental illness.
### Appendix 1

#### Services models and Services in scope for the evaluation

<table>
<thead>
<tr>
<th>Accommodation</th>
<th>Number of Places</th>
<th>Location</th>
<th>Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Crisis Accommodation</strong></td>
<td></td>
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<tr>
<td>Bentley Crisis Unit</td>
<td>6</td>
<td>Cannington</td>
<td>St Bartholomew’s House</td>
</tr>
<tr>
<td>Ullswater Place</td>
<td>5</td>
<td>Westminster</td>
<td>Richmond Fellowship</td>
</tr>
<tr>
<td>Compass House</td>
<td>4</td>
<td>Geraldton</td>
<td>Baptist Care</td>
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<tr>
<td><strong>2. Intermediate Care Accommodation</strong></td>
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<tr>
<td>Trimmer Road</td>
<td>3</td>
<td>Albany</td>
<td>Albany Halfway House</td>
</tr>
<tr>
<td>Walton Street</td>
<td>10</td>
<td>Queens Park</td>
<td>Richmond Fellowship</td>
</tr>
<tr>
<td><strong>3. Community Supported Residential Units</strong></td>
<td></td>
<td></td>
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<tr>
<td>Kelmscott CSRU</td>
<td>22</td>
<td>Kelmscott</td>
<td>St Bartholomew’s House</td>
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<tr>
<td>Ngurra Nganhungu Barndiyigu</td>
<td>14</td>
<td>Geraldton</td>
<td>Fusion Australia</td>
</tr>
<tr>
<td>Albany CSRU</td>
<td>11</td>
<td>Albany</td>
<td>Albany Halfway House</td>
</tr>
<tr>
<td>Bunbury CSRU</td>
<td>15</td>
<td>Bunbury</td>
<td>Richmond Fellowship</td>
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<tr>
<td><strong>4. Supported Accommodation for the Homeless</strong></td>
<td></td>
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<tr>
<td>Moore Street – Adult service (Ngulla Mia)</td>
<td>32</td>
<td>East Perth</td>
<td>Richmond Fellowship</td>
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<tr>
<td>Alma Street – Youth service (Ngatti)</td>
<td>16</td>
<td>Fremantle</td>
<td>Life Without Barriers</td>
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<tr>
<td><strong>5. Community Options</strong></td>
<td></td>
<td></td>
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<tr>
<td>Hick Road</td>
<td>8</td>
<td>Kelmscott</td>
<td>Richmond Fellowship</td>
</tr>
<tr>
<td>Mt Claremont House</td>
<td>7</td>
<td>Mt Claremont</td>
<td>Southern Cross Care</td>
</tr>
<tr>
<td><strong>6. Long-Term Supported Accommodation</strong></td>
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<td></td>
<td></td>
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<tr>
<td>Mann Way</td>
<td>12</td>
<td>Bassendean</td>
<td>Richmond Fellowship</td>
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<tr>
<td><strong>7. Specialist Residential Services</strong></td>
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<tr>
<td>Lefroy Hostel</td>
<td>6</td>
<td>Bullcreek</td>
<td>Amana Living</td>
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<tr>
<td>Frank Prendergast House</td>
<td>8</td>
<td>Success</td>
<td>Southern Cross Care</td>
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<tr>
<td><strong>8. Hostel Accommodation</strong></td>
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<tr>
<td>Vincentian Village</td>
<td>28</td>
<td>Woodbridge</td>
<td>Vincentcare</td>
</tr>
<tr>
<td>Bayswater House</td>
<td>5</td>
<td>Bayswater</td>
<td>Vincentcare</td>
</tr>
<tr>
<td><strong>9. Publicly operated</strong></td>
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<tr>
<td>Hampton Road Service</td>
<td>10</td>
<td>Fremantle</td>
<td>South Metro Mental Health Service</td>
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<tr>
<td>Jacaranda House</td>
<td>5</td>
<td>Armadale</td>
<td>South Metro Mental Health Service</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>228</strong></td>
<td><strong>20 sites</strong></td>
<td><strong>10 service providers</strong></td>
</tr>
</tbody>
</table>
Appendix 2

MENTAL HEALTH COMMISSION
EVALUATION OF THE SUPPORTED ACCOMMODATION PROGRAM

EVALUATION FRAMEWORK

SCOPE

The Program provides supported accommodation for people with a severe and persistent mental illness; people who are homeless, at risk of homelessness, in unsuitable accommodation or living for long periods in inpatient units. It is delivered through 30 sites in the metropolitan area and country locations, providing places for around 369 people.

The evaluation examined components of the Program, chosen to represent a range of service providers and service delivery models. The original scope of the evaluation was extended from 18 to 20 Services to include two Hostels. The scope of the evaluation covered:

- Ten service providers: nine non-government and one government
- Ten service delivery models (Crisis Accommodation; Intermediate Care Accommodation; Supported Accommodation for the Homeless; Community Supported Residential Units; Community Options; Long Term Supported Accommodation; Specialist Residential Services; Hostel; Sub-acute Step Down; Permanent Accommodation)

See list at Appendix 1 of the evaluation report.

APPROACH

A participatory approach was used to develop a framework to focus the evaluation, drive data collection and determine the criteria against which assessments of impact and effectiveness were made. A Stakeholder Reference Group had input to the development of the framework, as did an Internal Reference Group which also contributed to the development of the evaluation rubrics.

Evaluation rubrics

Evaluation rubrics are an explicit way of defining “quality” and “value”, consisting of three dimensions:

- Evaluative criteria – what aspects are important? (column 2, below)
- Merit criteria – how good is “good”? (the rubrics, at Appendix 4 of the evaluation report)
- Merit determination – the judgement made, using these two sets of criteria, about how good, excellent or poor a program or initiative is.

### Evaluation Framework

<table>
<thead>
<tr>
<th>Key Evaluation Questions</th>
<th>Sub-questions (evaluative criteria)</th>
<th>Existing Data Sources</th>
<th>Key Informants</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. To what extent does the Program provide clinical and non-clinical services appropriate to residents’ needs and aspirations?</td>
<td>Individuals’ expectations about length of stay</td>
<td>Service profile (including basic demographics)</td>
<td>Individuals</td>
</tr>
<tr>
<td></td>
<td>Individuals’ satisfaction with accommodation, clinical and non-clinical care and support services</td>
<td>Activity reports</td>
<td>Families</td>
</tr>
<tr>
<td></td>
<td>Comparison between needs assessment and actual delivery</td>
<td>Service Level Agreements</td>
<td>Area Health Services</td>
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<td></td>
<td>Level of service appropriate to individuals’ needs</td>
<td>Satisfaction surveys</td>
<td>Service Providers</td>
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<td></td>
<td>Service standards meet requirements</td>
<td>Licensing and Accreditation Regulatory Unit monitoring reports</td>
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<td></td>
<td>Referral process appropriate for individuals’ needs</td>
<td>Other standards and monitoring records</td>
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<td>Transition plans appropriate for individuals’ needs</td>
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<tr>
<td>2. To what extent are the partnerships between service providers and Area Health Services effective in delivering coordinated services?</td>
<td>Enhanced access to specialist and generalist services</td>
<td>Activity reports</td>
<td>Individuals</td>
</tr>
<tr>
<td></td>
<td>Service gaps</td>
<td>Service Level Agreements</td>
<td>Families</td>
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<td></td>
<td>Waiting times</td>
<td>Partnership documents</td>
<td>Area Health Services</td>
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<td></td>
<td>Formal and informal partnership</td>
<td>Protocols</td>
<td>Service Providers</td>
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<tr>
<td>Supported Accommodation Program Evaluation: Sankey Associates Pty Ltd – Final Report</td>
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<tr>
<td><strong>3. To what extent do governance arrangements and management processes facilitate achievement of Program objectives?</strong></td>
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<tr>
<td><strong>mechanisms in place</strong></td>
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<tr>
<td>Impact of wider system in which partnerships operate</td>
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<tr>
<td>Extent of information-sharing</td>
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<td>Individuals’ satisfaction that whole of life needs met</td>
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<td><strong>Joint reports</strong></td>
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<td>Satisfaction surveys</td>
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<tr>
<td><strong>3. To what extent do governance arrangements and management processes facilitate achievement of Program objectives?</strong></td>
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<tr>
<td>Stakeholders find governance arrangements clear, usable and relevant</td>
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<tr>
<td>Program delivery consistent with service provider guidelines</td>
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<td>Service delivery tailored to individuals rather than health system</td>
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<td>Comprehensive staff training</td>
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<td>Staff retention</td>
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<tr>
<td>Individuals consulted and choice maximised</td>
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<tr>
<td><strong>Activity reports</strong></td>
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<tr>
<td>Service Level Agreements</td>
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<tr>
<td>Satisfaction surveys</td>
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<td>Service provider guidelines</td>
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<td>Workforce profile</td>
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<td>Staff turnover</td>
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<td>Staff induction and ongoing training</td>
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<td>Operations manuals</td>
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<td>Complaints processes</td>
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<tr>
<td><strong>3. To what extent do governance arrangements and management processes facilitate achievement of Program objectives?</strong></td>
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<tr>
<td>Individuals</td>
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<tr>
<td>Families</td>
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<tr>
<td>Area Health Services</td>
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<tr>
<td>Service Providers</td>
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</tbody>
</table>
4. To what extent does the Program increase individuals’ independence, participation, quality of life and wellbeing?

- Individuals experience change in wellbeing and quality of life
- Individuals experience observable or measurable changes in life skills functioning
- Individuals experience increased community participation

Outcomes monitoring

- Satisfaction surveys

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Individuals</th>
<th>Families</th>
<th>Area Health Services</th>
<th>Service Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Satisfaction surveys</td>
<td>Individuals</td>
<td>Families</td>
<td>Area Health Services</td>
<td>Service Providers</td>
</tr>
</tbody>
</table>

METHODOLOGY

The evaluation was conducted in two stages:

**Stage 1: Planning**

Included:
- Review of key documents
- A quick scan of relevant WA, national and international literature to ensure an up to date knowledge of trends and evidence to provide context for the evaluation and identify examples of good practice
- Meetings with Stakeholder Reference Group to receive input to the framework and discuss plans for distributing questionnaires
- Workshop with the Commission to finalise the framework and develop the rubrics
- Preparation of interview protocol
- Preparation of consent information and consent forms
- Preparation of discussion guides and questionnaires
- Pilot testing questionnaires

**Stage 2: Collection and analysis of primary and secondary data**

**Primary Data**

<table>
<thead>
<tr>
<th>Qualitative</th>
<th>Quantitative</th>
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<tr>
<td>37 interviews with residents, conducted at</td>
<td>Paper-based survey of residents at 18 Services</td>
</tr>
</tbody>
</table>
(a) Residents and families

Face-to-face, semi-structured interviews were conducted with residents to develop an understanding of their experience of the Program and capture their ‘story’ of the most significant change they have experienced since living in supported accommodation. Interviews were conducted with men and women, from 18 to 63 years of age, at eight Services including three in regional areas. The majority of the interviews were audio recorded. A thematic analysis of interviews was undertaken and ‘most significant change’ stories were written.

A similar method was used with families of residents. Face-to-face, semi-structured interviews were conducted with siblings, parents, partners or ‘adult’ children of residents to develop an understanding of their experience of the Program and capture their ‘story’ of the most significant change they have observed in their relative since he/she has lived in supported accommodation. Interviews were conducted at five Services including two in regional areas. The interviews were audio recorded. A thematic analysis of interviews was undertaken and ‘most significant change’ stories were written.

Two paper-based surveys were conducted at the selected Services – one of residents and one of families. Questionnaires were pilot-tested before being implemented. Service providers distributed questionnaires to 180 residents and 80 families. Respondents completed the questionnaires and placed them in reply-paid addressed envelopes to ensure confidentiality. Completed questionnaires were received from 126

<table>
<thead>
<tr>
<th>nine Services</th>
<th>(N= 126)</th>
</tr>
</thead>
<tbody>
<tr>
<td>15 interviews with families, conducted at five Services</td>
<td>Paper-based survey of families at 19 Services (N=47)</td>
</tr>
<tr>
<td>Consultations with ten service providers conducted at 20 Services</td>
<td>Consultations with ten community MHSs</td>
</tr>
<tr>
<td>Consultations with seven other key stakeholders: Council of Official Visitors Department for Child Protection Department of Health, Strategic Business Unit Department of Housing Licensing and Accreditation Regulatory Unit Office of the Chief Psychiatrist Dr Bryant Stokes’ representative (Review of Admission and Discharge Planning of Mental Health Patients)</td>
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</table>
residents and 47 families. The combined total of 173 represents a 66 percent response rate. Survey findings were analysed using SPSS and Excel.

(b) Service providers, mental health services and other stakeholders

Face-to-face semi-structured consultations were undertaken with the following key informants:

- All service providers, on-site at all 20 Services; an additional four consultations were undertaken with CEOs/Managers of some service provider organisations who wished to provide input

- Case managers, team leaders and/or other clinical staff at ten mental health services (the Community Options Program, North Metro Mental Health and community MHSs at Armadale, Bentley, Great Southern, Inner City, Mid-West, Mirrabooka, South-West, Swan and Youth Reach South); 14 individual or group consultations were undertaken

- Other key stakeholders: Office of the Chief Psychiatrist; Licensing and Accreditation Regulatory Unit; Council of Official Visitors; Department of Housing; Department for Child Protection; Department of Health, Strategic Business Unit; and Dr Bryant Stokes’ representative (Review of Admission and Discharge Planning of Mental Health Patients).

Secondary Data

In parallel with primary data collection, existing data from the 20 sites was examined for quantitative and qualitative information relevant to the key evaluation questions and sub-questions, in three phases:

- Overview of available records and development of information categories, by Service
- Examination of records and extraction of detailed information in summary form
- Analysis of summaries to identify information to use to answer the key evaluation questions.

ETHICS APPROVAL

Based on guidelines published by the National Health and Medical Research Council, the current project is a quality assurance study and the results will be used to improve care. The guidelines state that: “an appropriately planned activity can proceed without review by an HREC [Human Research Ethics Committee] if both:
(a) the activity is undertaken with the consent of the patients, carers, health care providers or institutions involved; and

(b) it is an activity where participants, including patients, carers, health care providers or institutions are unlikely to suffer burden or harm (physical, mental, psychological, spiritual or social)“.

The consultants are members of the Australasian Evaluation Society and are bound by its code of ethics, as well as their Guidelines for the Ethical Conduct of Evaluations.

WRITTEN SUBMISSION

Written submissions were not part of the methodology, however one was prepared by an NGO and was accepted.
### APPENDIX 3
### SUPPORTED ACCOMMODATION EVALUATION REFERENCE GROUP MEMBERSHIP

<table>
<thead>
<tr>
<th>Representation</th>
<th>Name</th>
<th>Organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chair</td>
<td>Danuta Pawelek</td>
<td>Mental Health Commission</td>
</tr>
<tr>
<td>Consultants</td>
<td>Mary Sankey</td>
<td>Sankey Associates</td>
</tr>
<tr>
<td></td>
<td>Carina Calzoni</td>
<td></td>
</tr>
<tr>
<td>NGO service providers</td>
<td>Linda Borrison</td>
<td>St Bartholomew’s House</td>
</tr>
<tr>
<td></td>
<td>Graydn Spinks</td>
<td>Southern Cross Care</td>
</tr>
<tr>
<td></td>
<td>John Titmus</td>
<td>Richmond Fellowship</td>
</tr>
<tr>
<td></td>
<td>Lee Burwood</td>
<td>Amana Living</td>
</tr>
<tr>
<td></td>
<td>David Dickinson</td>
<td>Life Without Barriers</td>
</tr>
<tr>
<td></td>
<td>Irene Muthui</td>
<td>Fusion Australia</td>
</tr>
<tr>
<td></td>
<td>Vera Ford</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Julian Gimpel (to June 2012)</td>
<td>Baptist Halfway House</td>
</tr>
<tr>
<td></td>
<td>Kwame Selormey</td>
<td></td>
</tr>
<tr>
<td>South Metro Health service</td>
<td>Una Bridson</td>
<td>Jacaranda House</td>
</tr>
<tr>
<td></td>
<td>Sharon Delahunty</td>
<td>Hampton Road</td>
</tr>
<tr>
<td>Consumer representatives</td>
<td>Janette Louise Farmer</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Jane Helen Churchill</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Phillip Hardy</td>
<td></td>
</tr>
<tr>
<td>Carer representatives</td>
<td>Dr Lesa Morgan</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Grace Toczylowski</td>
<td></td>
</tr>
<tr>
<td>Mental Health Commission</td>
<td>Lisette Kaleveld</td>
<td>Mental Health Commission</td>
</tr>
<tr>
<td></td>
<td>Graeme Donovan</td>
<td>Mental Health Commission</td>
</tr>
<tr>
<td>Department of Health</td>
<td>Daniel Rock</td>
<td>Department of Health</td>
</tr>
<tr>
<td></td>
<td>Leanne Sultan</td>
<td>Department of Health</td>
</tr>
</tbody>
</table>
Appendix 4
SUPPORTED ACCOMMODATION EVALUATION
MENTAL HEALTH COMMISSION INTERNAL REFERENCE GROUP
MEMBERSHIP

Danuta Pawelek
Eric Dillon
Carly Dolinsky
Lisette Kaleveld
Judi Morris
Harriett Pears
Elaine Paterson
Ken Smith
Appendix 5
Evaluation Rubrics

KEQ 1: To what extent does the Program provide clinical and non-clinical services appropriate to residents’ needs and aspirations?

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excellent</td>
<td>Clinical and non-clinical service providers have a high level of understanding of residents’ aspirations and life goals and are highly supportive of their journey towards recovery. Residents feel very comfortable, safe and secure and that they are in a home-like situation. Residents and their families feel they are always treated with respect and that they are partners in their care and recovery. Residents are supported to engage in mainstream activities as well as those provided by their accommodation. Residents and families feel a high level of trust and confidence in clinical and non-clinical service providers. Residents have access to all the clinical services that they need and these, together with non-clinical services, are highly responsive to their changing needs.</td>
</tr>
<tr>
<td>Good</td>
<td>Clinical and non-clinical service providers understand residents’ aspirations and life goals and are supportive of them. Residents feel comfortable and safe in their supported accommodation facility. Residents and their families feel they are treated with respect and are informed of their care and recovery options. Residents are encouraged to engage in a range of activities. Residents have access to clinical services, but there may be some delays in accessing these services. Clinical and non-clinical services are mostly responsive to residents’ changing needs.</td>
</tr>
<tr>
<td>Adequate</td>
<td>Residents and their families are aware that they are progressing towards recovery but are unaware of treatment options. Clinical and non-clinical service providers are aware of residents’ hopes for the future but efforts to support them achieve their goals are limited. Safety is provided but the comfort and well-being of residents is given less consideration than the need to achieve organisational efficiencies. Residents and their families feel that their treatment and care is somewhat effective. Residents have access to some clinical care, but there are often delays and clinical and non-clinical services are slow to respond to changing need.</td>
</tr>
<tr>
<td>Poor</td>
<td>Residents are not positive about the future and do not know the next steps towards recovery. Staff do not understand residents’ aspirations and recovery services and options are not appropriate. There are significant delays in the provision of required treatment. Families are not consulted about, or informed of, treatment options and they are anxious about the care their family member is receiving.</td>
</tr>
<tr>
<td>Detrimental</td>
<td>Residents fare badly as a result of the services provided. Staff are neglectful of residents’ safety and their psychosocial needs and are placing them at risk of harm. Residents do not have access to the required level of clinical and non-clinical care.</td>
</tr>
</tbody>
</table>
**KEQ 2: To what extent are the partnerships between service providers and Area Health Services effective in delivering coordinated services?**

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excellent</td>
<td>Systems and processes are designed to promote coordinated service delivery. Service providers have in-depth knowledge about the range of available services and are linked into mental health and mainstream networks that can support residents. Mechanisms are available for filling service gaps and eliminating unacceptable waiting times. The partners work together to achieve optimum resident outcomes, enjoy mutual trust and respect and consistently display good will; they are adept at giving and receiving constructive feedback. Residents know they are receiving high quality care and support in all aspects of their lives and feel confident they will continue to be well supported in their recovery journey. They are better able to manage their illness and are achieving personal goals.</td>
</tr>
<tr>
<td>Good</td>
<td>Structural barriers to delivering coordinated services have been removed. Information sharing systems are up to date, easy to use and consistent with residents’ confidentiality and privacy rights. The partners understand their interdependence and work together to improve residents’ outcomes. Residents are assisted to identify and set personal goals. They and their carers are involved in decision-making and receive the range of clinical and non-clinical services they need. They do not have to keep re-telling their story. They are facilitated to develop independence and to engage in mainstream as well as mental health specific services.</td>
</tr>
<tr>
<td>Adequate</td>
<td>Service providers understand each others’ roles and responsibilities and comply with partnership agreements. They work alongside each other and have their own care plans and ways of measuring or assessing residents’ outcomes. Residents are involved with a lot of different clinicians and service providers and they and their families have to work hard to know what is going on and what is going to happen. Essential needs are met, but they have wishes and aspirations that remain unacknowledged by themselves and others.</td>
</tr>
<tr>
<td>Poor</td>
<td>Clinical and non-clinical services are poorly integrated and do not function to treat the whole person. The partners do not respect or fully understand each others’ roles and responsibilities and do not communicate in the interests of residents. Residents and families have to jump through hoops to access services and can feel like second-class citizens.</td>
</tr>
<tr>
<td>Detrimental</td>
<td>Partnerships are dysfunctional, characterised by lack of cooperation, poor communication and failure to comply with agreements and contractual arrangements. Service providers complain to residents and carers about lack of proper resources, undermine confidence in the program and create an insecure environment. There is a high staff turnover and recruitment is difficult due to in-fighting. Residents fail to receive the psychosocial support and on-time clinical services they need to work towards recovery.</td>
</tr>
</tbody>
</table>
A rubric was not developed for KEQ 3 as variations between the Services made it difficult to develop standard criteria to fairly assess the governance arrangements and management processes across the Program.

**KEQ 4: To what extent does the Program increase residents’ independence, participation, quality of life and wellbeing?**

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Excellent</strong></td>
<td>Residents feel they have come a long way and are optimistic about things continuing to improve for them. They are engaged in social and recreational activities within their accommodation and in the broader community and have a network of people with whom they feel safe, supported and valued. They have goals and events to look forward to. They contribute to their environment and to those around them. They are more competent in daily living skills and have developed ways of self-managing their illness. They are encouraged and supported to pursue activities of interest to them and experience a developing confidence in their capacity to live a good life.</td>
</tr>
<tr>
<td><strong>Good</strong></td>
<td>Residents can see a positive change in their life and how they interact with those around them. They feel more in control of their life, are clear about their goals and are taking action to achieve these. They participate in individual and group recovery work and are developing the capacity to self-manage their illness, including making and keeping appointments, seeking assistance when needed and taking medication as prescribed. They go out to see friends or family, join in activities outside their accommodation and get wherever they need to go under their own steam. They feel supported and encouraged by those around them and are generally happy with the progress they are making.</td>
</tr>
<tr>
<td><strong>Adequate</strong></td>
<td>Residents are attempting to develop life skills but need more structure to do so and rely on family or workers to meet their needs. They attend groups inside the accommodation or go on organised excursions but seldom go out otherwise. They have aspirations but little motivation to take steps towards achieving any goals or engaging in meaningful activity. They need reminding about medical appointments and are usually taken to these but self-manage their medication. They feel that life is better and will probably improve.</td>
</tr>
<tr>
<td><strong>Poor</strong></td>
<td>Residents are passive and not well engaged with the recovery program. They have poor personal care and have to be assisted to do the basics like laundry and cleaning. They do not socialise with other residents or recovery workers and rarely attend group activities. They are reliant on family or workers to shop for basic needs and prepare meals. They do not follow through on agreements to participate and do not undertake any meaningful activity. They engage in risky behaviour, do not self-manage their medication and have to be taken to medical appointments.</td>
</tr>
<tr>
<td><strong>Detrimental</strong></td>
<td>residents are allowed to neglect personal care and are not developing daily living skills. They have no plan for the future and are not receiving enough support to make any changes in their life. They are socially isolated and feel there is no one they can trust. They are reliant on support workers for meals, transport and administration of medication. They regularly engage in risky behaviour and miss medical appointments.</td>
</tr>
</tbody>
</table>
Appendix 6

EVALUATION OF SUPPORTED ACCOMMODATION PROGRAM
MOST SIGNIFICANT CHANGE TECHNIQUE

MSC is a form of participatory monitoring and evaluation. It is participatory because many project stakeholders are involved both in deciding the sorts of change to record and in analysing the data. It is a form of monitoring because it can occur throughout the program cycle and provides information to help people manage the program. It contributes to evaluation because it provides data on impact and outcomes that can be used to help assess the performance of the program as a whole. Whilst MSC is very powerful, it is not used as a stand-alone tool for monitoring and evaluation for accountability purposes. It is best seen as a powerful supplementary tool for accountability-based systems. Unlike conventional approaches to monitoring, the MSC approach does not employ quantitative indicators and, because of this, is sometimes referred to as ‘monitoring without indicators’.

The MSC technique was originally developed by Rick Davies through his work with a savings and credit project in Bangladesh in 1994 (Davies, 1996). The process was later refined by Jess Dart (Dart, 1999). MSC is now widely used in the international development sector. It can also be found across most government sectors in Australia and New Zealand including agricultural extension, education and community health. It is used by small community groups and large corporate organisations.

The bare bones of MSC are to collect stories of change, review and select stories and to feedback and communicate the results. Essentially, the process involves the collection of significant change stories emanating from the field level and the systematic selection of the most significant of these stories by panels of designated stakeholders or staff. When the technique is implemented successfully, whole teams of people begin to focus their attention on program impact, learning occurs through discussion and areas for improvement can be identified.

Ethics

Attention must be paid to the ethics of collecting stories. When a storyteller tells a story, the person collecting the story needs to explain how the story is to be used and to check that the storyteller is happy for the story to be used in that way. The storyteller should also be asked if they wish their name to accompany the story. If not, names would then need to be deleted from the story.

If a person or group is mentioned or is identifiable within a story not told by them, the storyteller is asked to consult with the third party to check if they are happy for their
name to be mentioned. If a storyteller wants to tell a story about a third party without naming that person, the identity of the person should be protected.

**MSC and the evaluation of Supported Accommodation**

MSC was used in this evaluation because:

- Stories help to describe complex changes
- Stories provide real examples from real people
- They add depth and detail to the quantitative surveys
- They describe why change was important
- Selecting stories highlights what the group values
- It helps to facilitate discussion about what is important.

A number of ‘most significant change’ stories were collected from residents and families, providing a moving insight into their lives and how the Program has affected them. Some of these stories were read and discussed by the Stakeholder Reference Group. Four stories were selected to be included in the evaluation report and the reasons for selecting those stories were documented.