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THE UNIVERSITY OF ADELAIDE AUSTRALIA

Evaluation of the Three Community Rehabilitation Centres

FINAL REPORT

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1 EXECUTIVE SUMMARY

The Mental Health Unit, SA Department of Health commissioned the Australian Institute for Social Research (AISR) to undertake an evaluation of the three Community Rehabilitation Centres (CRCs) – Elpida House in Mile End, Trevor Parry Centre in Noarlunga and Wondakka in Elizabeth.

Please note that this Executive Summary can be read as a stand-alone document, but that detail needs to be obtained from the body of the report, and further detail from the four Accompanying Reports listed at the end of the Table of Contents.

Terms of Reference

The evaluation terms of reference reflect a number of areas of focus which have guided the methodology design and application. These include:

➢ Analysis of CBIS/CCC data, to quantify CRC client characteristics and features of service provision. (Although a specific component of the methodology, this has also been analysed against the qualitative information obtained from interviews and focus groups and the findings of the two surveys.)
➢ Assessment of the degree to which individual CRCs are in alignment with the CRC Service Model.
➢ Identification of the CRCs' "core business".
➢ Identification of the barriers associated with the design, planning and implementation of the services provided by the CRCs.
➢ Comparison of the processes and practices across all 3 CRCs – identifying commonalities and differences and an analysis of the reasons for this.
➢ Assessment of the degree to which governance arrangements for the program promote effective work practices and facilitate desired outcomes.
➢ Analysis of budget arrangements - based on an overview of relevant documentation and on interviews with service managers, and to identify the degree to which individual CRCs have been operating within or out of budget, and reasons for this.

> To enable the reader of this report to quickly identify *successes* and areas of *needed improvement* emerging from the evaluation findings, the former are denoted by a ✓ symbol and the latter by a ⚑ (flag) symbol.

REVIEW REQUIREMENT: Identify the CRCs' "core business"

The CRCs are one component of a wider reform and reconfiguration of the SA mental health system, and the evolution of a 'stepped' system of care. At the time of their implementation, some of the other 'steps' were not in place and this context needs to be taken into account in assessing how well their core business is understood elsewhere in the mental health system.

✓ Nevertheless, those service providers consulted by the evaluators (CRC-based and those working closely with them, such as non government organisations) were clear that the core business of the CRCs is rehabilitation, underpinned by a philosophy of recovery. CRCs are correctly understood by them as being part of a spectrum of services being implemented within a stepped model of care.
✓ Consumers and carers consulted also appear to have understood this fundamental role.
✓ The evaluators believe that the recent re-naming of the CRCs to emphasise their rehabilitative purpose and function will assist in clarifying their core business.

⚐ However, the majority of CRC staff surveyed believe that the role of CRCs is not fully understood by others in the mental health service system, including those who refer consumers to them. Key Workers and Support Workers surveyed, while seeing themselves as reasonably well informed about the CRCs, supported this view, seeing the need for increased awareness of the CRCs' role in the mental health sector, and by the community as a whole.

The information provided to the evaluators has consistently identified the need for *documentation* that reflects an agreed and widely understood presentation of the CRC model.

⚐ The existing documentation of the service model was described by those consulted as confusing and *incomplete* in its presentation of that model, and contributing to a lack of consistent interpretation and application of the service model by each CRC.

✓ The evaluators understand that at the time of writing, the Mental Health Unit, in partnership with Adelaide Health Service and other stakeholders, had begun the process of documenting the service model. Hence, no recommendations are being made regarding documentation.

While consistency has been promoted as supporting predictability and equity of service provision, feedback also points to the need for a balance between consistency and responsiveness to local and individual need. This is reflected in **Recommendation 1.**

A common misperception reported by those consulted is that the CRCs are viewed by many as another source of mental health 'beds' that clinicians can use for 'treatment' when other beds are not available. The evaluators agree with those consulted that the term 'bed' should not be used in relation to CRCs– see **Recommendation 2.**

REVIEW REQUIREMENTS:

Assess the extent that the services provided by the CRCs align with the Service Model

Compare and contrast process and practice across all 3 CRCs.

Fulfilment of the underpinning principles of the CRC Service Model

There is a discernible trend for CRC staff to have a more positive view than Key Workers and Support Workers regarding the fulfilment of each underpinning principle of the service model. However, there was general agreement between both groups of stakeholders about the underpinning CRC principles being applied.

✓ All Principles received positive ratings from the majority of CRC staff surveyed.

✓ Both groups have given their most positive ratings to the CRCs' fulfilment of these Principles –
   ✓ *Is non stigmatising and non discriminatory*
   ✓ *Acknowledges people's strengths and capacity to learn, grow and change.*

Addressing the general features of the model

✓ The features of the CRC model were generally seen as being well met by staff and Key/Support Workers.

The strongest level of agreement between both groups concerns these features:

✓ Provides consumers with the appropriate amount of independence while living at the CRC.

✓ Provides a 24 hour service.

✓ Considers the person in the context of their family and significant others.

⚐ The least positive rating, with both groups in agreement, concerned the supporting and educating of carers. Carers also expressed concern about lack of communication and involvement with both the CRCs and Key Workers.

Addressing Access and Equity features

⚐ Key/Support workers and CRC staff gave their most negative ratings to the CRCs' accessibility for people in rural and remote communities, or from a CALD background, or from an Aboriginal background and this is of concern. Analysis of CBIS and CCC data confirms these perceptions, showing significant under-representation for people from rural locations and underrepresentation for people from CALD or Aboriginal backgrounds- see **Recommendations 10 and 11.**

✓ However, the evaluators note the recently announced approval to establish two new CRCs in rural South Australia.

The contribution of physical infrastructure to fulfilment of the service model

The CRC model's implementation is affected to some degree by physical infrastructure and differences were evident across the three sites. The evaluators believe, and feedback supports this, that the purpose-built CRCs have a physical design that is more supportive of the underpinning principles of the CRC model and that this should be adhered to in any future expansion of CRC services – see **Recommendation 4.**

Training issues

Findings indicate that CRC staff and Key/Support Workers are satisfied with the induction and subsequent training they receive, but that this training is not being provided to all workers, and this raises serious concerns about consistency in capacity and ensuring rehabilitation expertise that fulfils the requirements of the CRC model.

The evaluators are recommending that a dedicated staff development budget is developed for all CRCs that includes provision of backfill to enable staff participation in training, and that supports consistent and evidence-based a) generic psychosocial training and b) clinical rehabilitation-focused training, applied at induction and at agreed intervals thereafter for CRC staff, Community Key Workers and NGO Support Workers. It should be part of a planned approach to training that could be operationalised through an annual Staff Training Calendar, the costs of which would be shared across CRCs, hopefully achieving efficiencies in resource allocation for training and staff development. It is envisaged that all three groups of workers would be able to

participate in the same training program and that the program would be designed in consultation with all three groups of workers and their managers. The new partnership arrangements with the NGO sector would be strengthened by such an arrangement, as would the implementation of the two new rural CRCs – see **Recommendation 6.**

Mix of staff types and disciplines

⚑ While the majority of CRC staff surveyed regard the current mixture of staff types and disciplines as being optimal, most do not believe there are sufficient staff to meet demand. This includes provision for backfill to cover periods of leave.

Adequacy of supervision guidance and operational procedures and policies

There was a trend for CRC staff surveyed to rate their supervision, guidance and support to be *somewhat adequate*.

⚑ This indicates scope for improvement in these three areas, and it will be important for CRC Managers to seek further feedback from their staff about ways to achieve those improvements.

Adequacy of team work

✓ CRC **team work** was rated positively by most staff, with less than ten per cent providing negative ratings.

Understanding and valuing of roles

✓ Most of the CRC staff and Key/Support Workers surveyed were 'very' to 'extremely' confident that they understand their specific role in relation to the CRCs.

✓ The majority of staff surveyed (60.4%) perceive that their role is **'**very' or 'extremely' valued by other staff and management.

⚑ However, there was a diversity of perception among Key/Support Workers about the valuing of their role by CRC staff.

⚑ The evaluators note that Key/Support Workers appear to feel less valued by CRC staff than they actually are. This needs to be addressed.

⚑ Many of the Key/Support Workers also identified the need for improved communication about roles, responsibilities and skills by all stakeholders –see **Recommendation 5.**

Enhancing the role of Key Community Workers and Support Workers

⚑ CRC staff and Key Workers and Support Workers surveyed believed that the **Key/Support Worker** role could be improved or enhanced, and have indicated a number of areas for this improvement. In particular, increasing the amount of contact between Key/Support Workers and consumers, and providing more training for Support Workers in rehabilitation - see **Recommendation 5.**

Partnerships and working relationships

Partnerships and effective working relationships are critical to the capacity of the CRCs to receive and make appropriate referrals within the mental health sector and across a range of other sectors. The CRC service model supports a collaborative approach between CRC staff and consumers and carers, particularly in the care planning and review processes. It is also important that the CRCs have effective working links with other services in the SA mental health system, and particularly with Key Workers and Support Workers. The evaluation has focused particularly on the latter relationship, and survey findings about that relationship are mixed. As discussed, there was a trend for CRC staff to regard these workers as valuable but those workers do not see themselves as being valued by CRC staff.

The 2010-2011 South Australian State Budget proposed to transfer day to day CRC management and provision of psychosocial rehabilitation services to the non government organisation (NGO) sector by 2012/13. This is to occur after a procurement process. Clinical mental health services will continue to be provided by publicly funded mental health services.

It is not clear to the evaluators why such a significant change to the nature of CRC management and service delivery has been initiated as a budgetary measure, and prior to this independent evaluation being completed, but it nevertheless underscores the need for CRCs to address the issues identified in **Recommendation 5.** See also **Recommendation 12** for a suggested strategy for structuring working relationships with NGO service providers.

The evaluation findings have identified that CRC working relationships with Community Key Workers in the mental health system and Support Workers in the NGO sector are developing and working well, but with scope for improvement in communication processes, frequency of contact and consistent rehabilitation-focused training (see **Recommendation 5**). Another finding is that both consumers and carers are seeking more structure in the daily activities of CRC residents, arguing that the current approach is too unstructured and leads to boredom. The opportunity exists to address both of these issues by a more structured partnership with NGO providers, and with clinical rehabilitation and day programs that would see a range of organisations working with CRC staff to provided planned activities that assist transition to independent community living. It is envisaged that these would be tailored to individual Care Plans and stepped to lead to increasing levels of self sufficiency – see **Recommendation 12**. This approach also supports the implementation of a partnership service model that was proposed in the recent South Australian budget.

Interventions applied in fulfilment of the service model

At the time that the CBIS/CCC data were extracted for the Evaluation, occupancy rates appear to have been **80-90%.** The evaluators note that a certain number of places may be held at any one time for clients who have just exited, or for new clients who are expected to arrive.

Of the CRC consumers in the period studied (10.1%) had more than one CRC stay, 1.3% of all CRC consumers had attended more than one CRC and 8.8% had two stays. However, more than two stays was a rare occurrence. Episodes at Elpida House comprised nearly half (47.4%) of all CRC episodes, due at least in part to its earlier commencement date.

Analysis of the length of CRC episodes showed that –

⇒ Around **60%** of CRC episodes had been completed **within six months**, with **29.6%** completed **within three months**.

⇒ Most of the remainder had ended within twelve months, with only 6.5% of episodes extending past one year.

⇒ The **average** length of completed CRC episodes was **169.4 days** and this did not vary with variables such as sex, age, location and diagnostic group.

⇒ When leave days were excluded from the total length of closed episode, the **mean** and **median** length of stay dropped slightly to **167.4 days** (from 169.4 days) and **135.0 days** (from 140.5 days) respectively.

CRC Managers report that a range of interventions are being applied, depending on individual consumer need. However, there is a lack of documentation regarding the range of interventions that could be applied, and this could be addressed in producing an agreed version of the service model.

Analysis of CBIS and CCC data, however, provides a clear picture of the **services being provided to CRC consumers** –

⇒ The majority of services (86.0%) provided by CRCs were face to face services, and

⇒ face to face contact comprised 88.8% of total service delivery time.

⇒ Just under two thirds of all services provided by CRCs were classified as care and treatment services (61.6%),

⇒ a further 28.7% were medication related services and

⇒ 8.7% focussed on education or information.

In terms of the amount of time associated with each type of service, care and treatment services as a whole comprised 74.8% of total service delivery time. As would be expected, individual assessment/screening services (non-NOCC) tended to be the most time-intensive, and education/information and post discharge follow-up services were the least time intensive.

On average the CRCs provide –

⇒ around **1.5 services per day** (mean 1.51, median 1.35) **to each consumer** during their stay.

⇒ This equates to around 46 services per calendar month for each consumer.

⇒ Shorter episodes tend to involve the provision of more services per day on average and there was a statistically significant negative linear relationship between length of episode and number of services per day (r=-.286, p<.05).

On average over a one month period –

⇒ each CRC consumer will receive nearly **39 face to face services**. There will also be 3 telephone communications and 4 written communications regarding that consumer during that month.

⇒ In terms of types of service, in an **average month of stay** each consumer will receive around **28 care and treatment services**, 5 education/information services, 12 medication services, and one non-NOCC assessment/screening service.

Referral and Exit Patterns

The main source of referral into the CRCs was the Community Mental Health Service's CT/CCT/MACS teams. Referrals from this source comprised **52.6%** of the referrals which resulted in CRC episodes. Most of the remaining episodes had been initiated by referral from a mental health inpatient facility (13.5%), a psychiatric/mental health service facility (10.2%) or a General Practitioner (8.3%).

Main sources of referral to CRCs
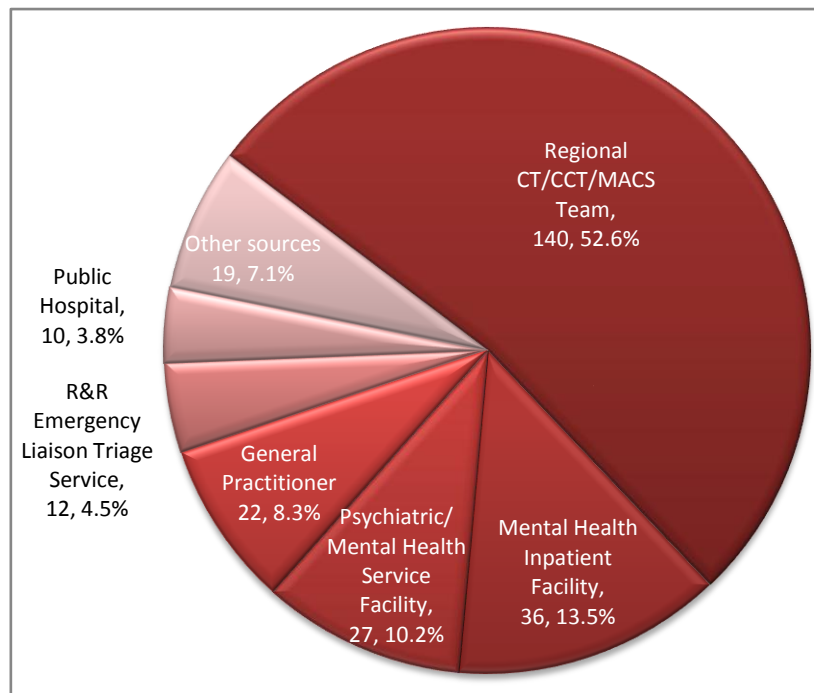
Main referral sources differed somewhat across CRCs. For example, 76.7% of referrals to Trevor Parry Centre came from CT/CCT/MACS teams, compared to 53.7% of referrals to Wondakka and 38.1% of referrals to Elpida House.

The data on reason for exit indicated that most of the 216 CRC consumers who exited the service had a **planned** exit. It was unusual for consumers to leave against clinical advice (8 consumers, 3.7%).

⇒ Upon exit from the CRC most consumers (68.1%) were referred to the ambulatory mental health service.

⇒ A small number of consumers exited the CRC to enter either specialised mental health inpatient care (5.6%) or a specialised residential mental health care facility (3.7%) – these exits would reflect acute or chronic needs which could not be managed appropriately in the CRC environment.

⇒ Other exit destinations included private psychiatry, GP and other care.

Exit destinations were essentially the same no matter what the original source of referral or the stated reason for exit. However there were significant differences (p<.05) between CRCs in terms of the proportion referred to specialised ambulatory mental health care with 93.0% of consumers exiting the Trevor Parry Centre being referred to a mental health ambulatory care team, compared with 73.5% from Wondakka and only 52.7% from Elpida House.

Addressing Care Planning, and Exit Planning features

⚐ Both CRC staff and Key/Support Workers are critical of the reviewing of Care Plans, which is scheduled to occur on a regular basis, and are seeking greater involvement in this process – see **Recommendation 3.**

✓ However, analysis of CBIS and CCC data indicates that in the main, Care Plans are being reviewed regularly and at appropriate intervals.

⚑   Exit planning initiated at the point of entry also received low ratings, from both groups of stakeholders.

✓   However, the *phasing* of exits to support consumers' transition back to the community was more positively rated by both CRC staff and Key/Support Workers.

Continuity of care

Apart from reviewing Care Planning frequency, the evaluators also analysed records of services undertaken by ambulatory teams across metropolitan areas (CBIS data) and country areas (CCC data). Statistics for the number of ambulatory services provided per consumer per month before, during and after CRC stays indicated that the number of ongoing direct care ambulatory services provided to consumers appeared to be at an acceptable level, equating to between one and three services per week on average.

Statistics for the number of ongoing direct care ambulatory services provided before, during and after CRC stays are presented in the table below.

Statistics for number of ongoing direct care ambulatory services per month per consumer around closed CRC episodes

Timeframe	N	Mean	Standard error of mean	Median	Minimum	Maximum
In the 30 days prior to CRC entry	197	9.00	0.68	7.00	0.00	64.00
During CRC episode	197	7.13	0.49	5.56	0.00	43.49
In the 30 days after CRC exit	197	7.81	0.55	5.00	0.00	40.00

The consumer perspective

The consumer age profile shows that CRCs provided a service to mostly younger adults with the average age being **32.1 years.** Around three quarters (74.8%) of these consumers were **male**. The majority (**88.7%**) reside in the **metropolitan** area.

Eleven consumers (4.6%) identified themselves as being of Aboriginal or Torres Strait origin. Only three consumers (1.3%) spoke a language other than English and nearly 90% were born in Australia or New Zealand (2 consumers). The ethnicity stated by consumers essentially mirrored the birthplace results.

Analysis of consumers' **primary diagnosis**, as recorded at their first CRC stay, revealed that –

⇒   the vast majority of CRC consumers (80.3%) had been diagnosed primarily with *a schizophrenic, schizotypal or delusional disorder*.

⇒   This was followed by *mood (affective) disorders* (12.2%).

Primary diagnostic profile of CRC consumers
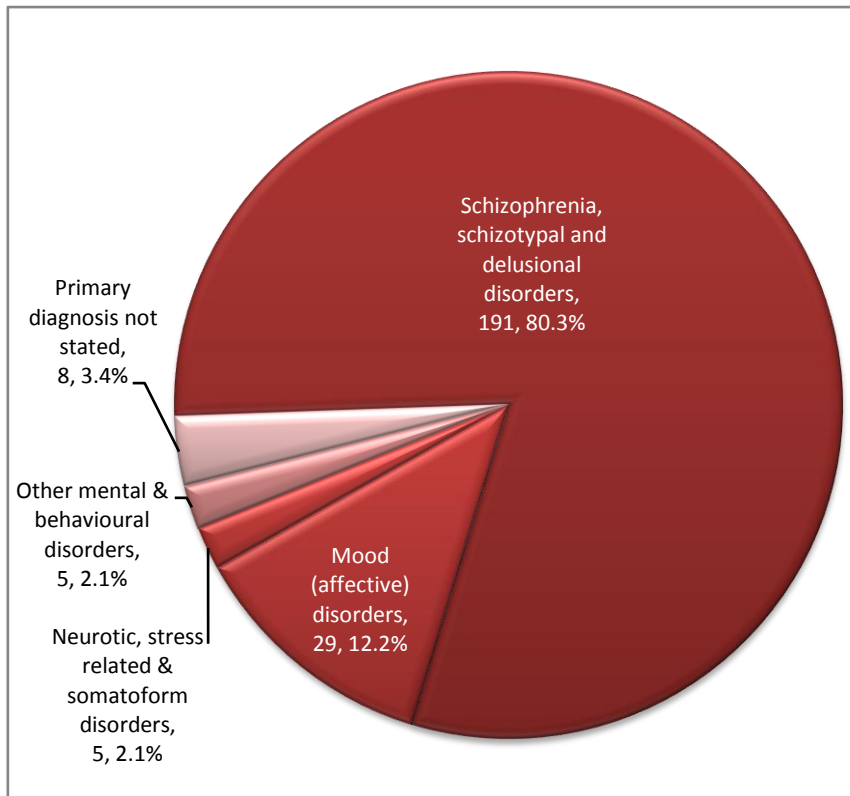
⇒ A quarter (25.2%) of the 230 consumers with a stated primary diagnosis had at least one **secondary diagnosis.**

⇒ The most common secondary diagnoses recorded for CRC consumers were *neurotic, stress-related and somatoform disorders* (21.3% of secondary diagnoses) and *mental and behavioural disorders due to psychoactive substance use* (14.8% secondary diagnoses).

According to the CBIS data, a small number of CRC consumers (17, 7.1%) were classified as involuntary clients at the time of their CRC episode.

✓ Across the three CRCs, there was strong endorsement by past and current residents of the underpinning model**.**

✓ All saw the CRC as the most *appropriate* place for them to be because without this intervention they did not believe they would recover.

✓ It was also clear that their experience had matched their expectations, indicating good pre-entry processes,

⚑ Feedback about the attitudes and quality of care of primary workers and other staff indicated a concerning degree of *variability* from one individual to another, as were the levels of care.

⚑ *Staff and Key/Support Worker turnover* was raised as a concern, with residents feeling vulnerable without continuity of staff and key worker support.

⚑ All respondents had a *Key Worker* they could identify but there appeared to be a great deal of variation in the amount of contact respondents have with them, indicating that the amount was determined by

individual Key Workers (rather than as part of agreed policy and operational guidelines). See **Recommendation 5.**

Many consumers and carers consulted identified boredom as a key source of dissatisfaction with the CRC experience. While the evaluators understand that part of the CRC purpose is to promote independence and self-management of daily activities as part of a recovery goal, it is also likely that many consumers will need specific support to achieve this. The evaluators believe there is scope for strategic working relationships to provide a structured program of activities that would fill this activity gap while assisting consumers to prepare for independent living – see **Recommendation 12.**

The carer perspective

✓ Two thirds of carers consulted for the evaluation believed that the CRC services had made a difference to their lives and the life of the person for whom they were caring and saw them as filling a much needed gap.

Carers also shared with consumers the belief that CRCs would be improved by providing more activities and more structure in those activities.

Some carers also felt that there was a need for more focus on managing physical health, particularly nutrition and medical issues.

Fulfilment of the Recovery Goal

✓ Both CRC staff and Key/Support Workers have positively rated the development and application of recovery-focused Care Plans, and the development of such Care Plans in partnership with consumers, carers and other care providers (although Key/Support Workers gave a less positive assessment of the latter than their CRC colleagues.)

Based on available data from the objective assessments of functional skills undertaken by OTs at CRCs (i.e. using the AMPS tool), it appears that around two thirds of the consumers entering a CRC may have a measurable deficit in the skills required to effectively perform activities of daily living. With independent living as a key outcome for CRC residents, ADL-focussed tools such as the AMPS and its accompanying self-assessment tool (the OSA) are an invaluable addition to the more mental-health-focussed assessment tools such as the HoNOS and the evaluators are recommending that all OTs are trained in the use of these measures so that they become an integral part of care planning and review - see **Recommendation 8.**

As the chart below depicts, analysis of the total number of days spent by CRC consumers in inpatient facilities during the 6 months before and after their CRC stay identified –

⇒ a **large increase after CRC exit in the percentage of consumers using no (nil) inpatient services** as well as a reduction across all periods of time spent in inpatient mental health services.

⇒ Statistical testing revealed that overall, **after their last CRC stay, consumers experienced a highly significant reduction in the number of days they spent in inpatient mental health facilities** (p<.01).

However, note that there was a small group of consumers (13.8%) who showed an *increase* in the number of days they spent in inpatient facilities, and 29.6% of consumers had no inpatient stays recorded either before or after their CRC stay.

Change in total inpatient days between the 6 months before and after CRC stay - categories
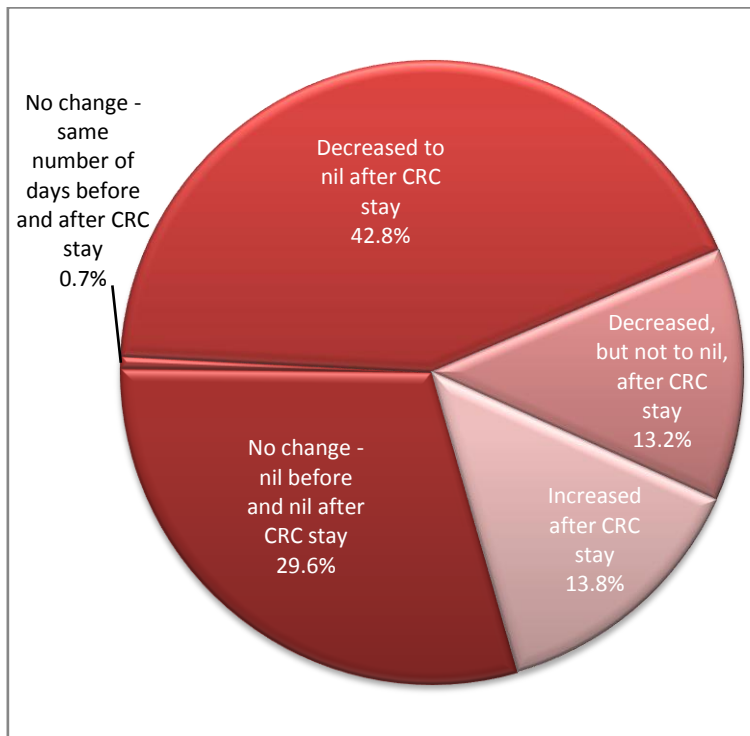
Overall, the use of inpatient services by CRC consumers **decreased from an average of 41.2 days per consumer before CRC entry** (median 21 days), **to an average of 13.0 days after CRC exit** (median 0 days). This is illustrated in the chart below.

Change in total inpatient days per consumer between the 6 months before and after CRC stay – means and medians
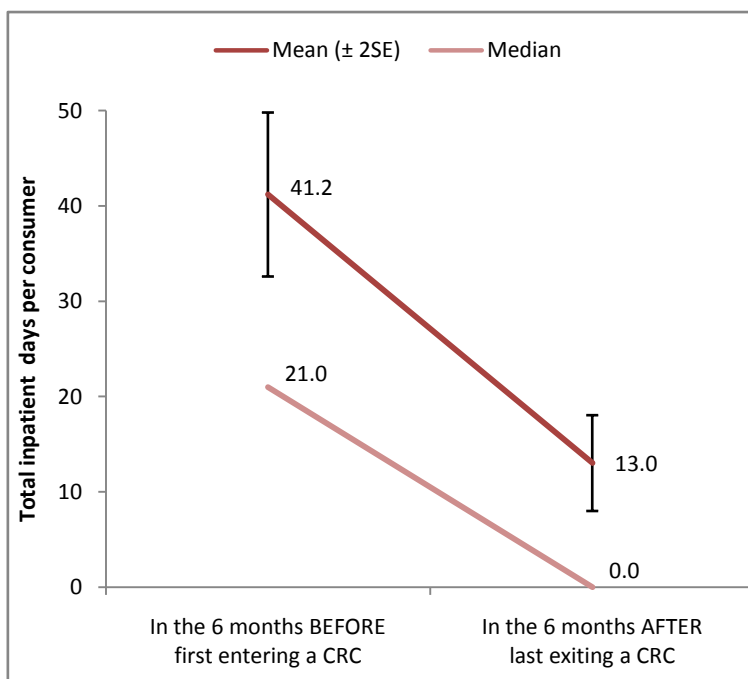
While these results are indicative of a strong reduction in the use of inpatient services after a CRC stay, some caution should be exercised when attributing a direct causal connection. Firstly, there are potential data coverage issues relating to inpatient data for CRC consumers. Secondly, there may be other factors influencing

the apparent outcomes of consumers over time, such as the contribution of other services including non-CRC residential care services. Nevertheless, the evaluators regard these findings as encouraging.

Analysis was also made of changes in CRC consumers' scores on the **Health of the Nation Outcome Scale (HoNOS)** which is designed to measure the current severity of a client's difficulties across a range of aspects of health and functioning.

HoNOS data from *residential episodes* was not provided to the Evaluators. Therefore we selected the ambulatory HoNOS assessment occasions that occurred as close as possible *on or before the first CRC entry date* and *on or after the last CRC exit date* for each consumer. A total of **126** consumers had ambulatory HoNOS assessments assessments around the time of *both* entry and exit.

It is important to note that using HoNOS scores collected by ambulatory teams rather than by CRC staff offers the advantage of being derived from assessments that are *independent* of the service being evaluated.

Degree of change in total HoNOS score between entry and exit
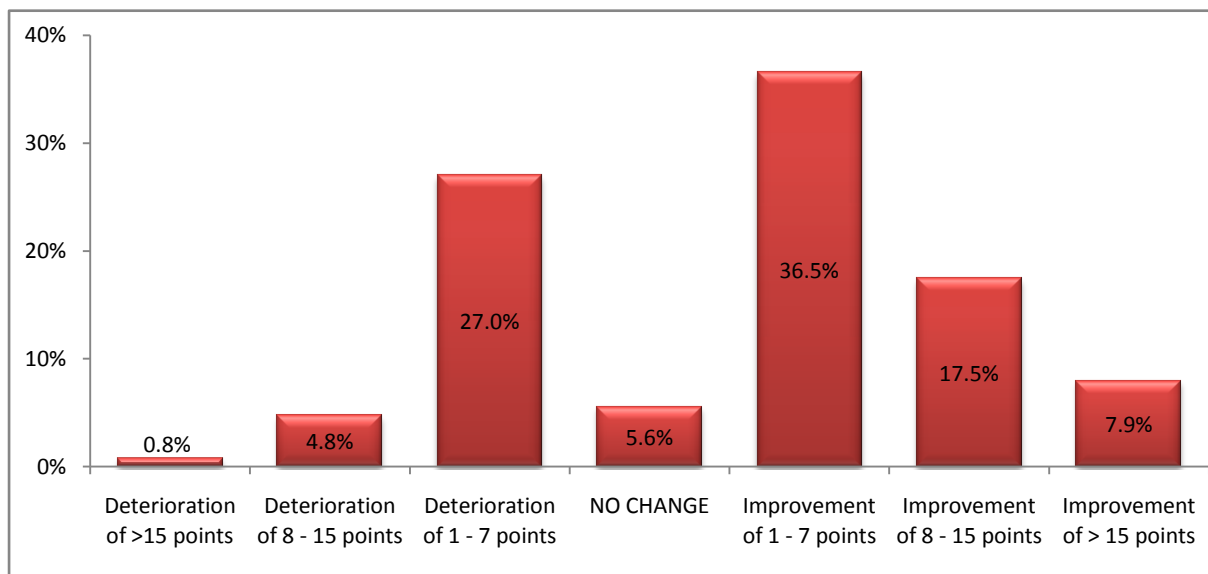
Note - clinically significant involves change of 8 points or more

The Total HoNOS score and the four HoNOS Subscale scores decreased between entry and exit for this group of 126 consumers. Furthermore, this downward trend appeared to continue past exit through to the last ambulatory HoNOS assessment recorded for these consumers. There was –

➢ a **significant improvement in Total HoNOS scores between entry and exit** (p<.05), and
➢ a **significant improvement in Subscale scores, except for the Behaviour subscale, between entry and exit** (p<.05).

Mean HoNOS Total and Subscale scores around entry, exit and last recorded assessment
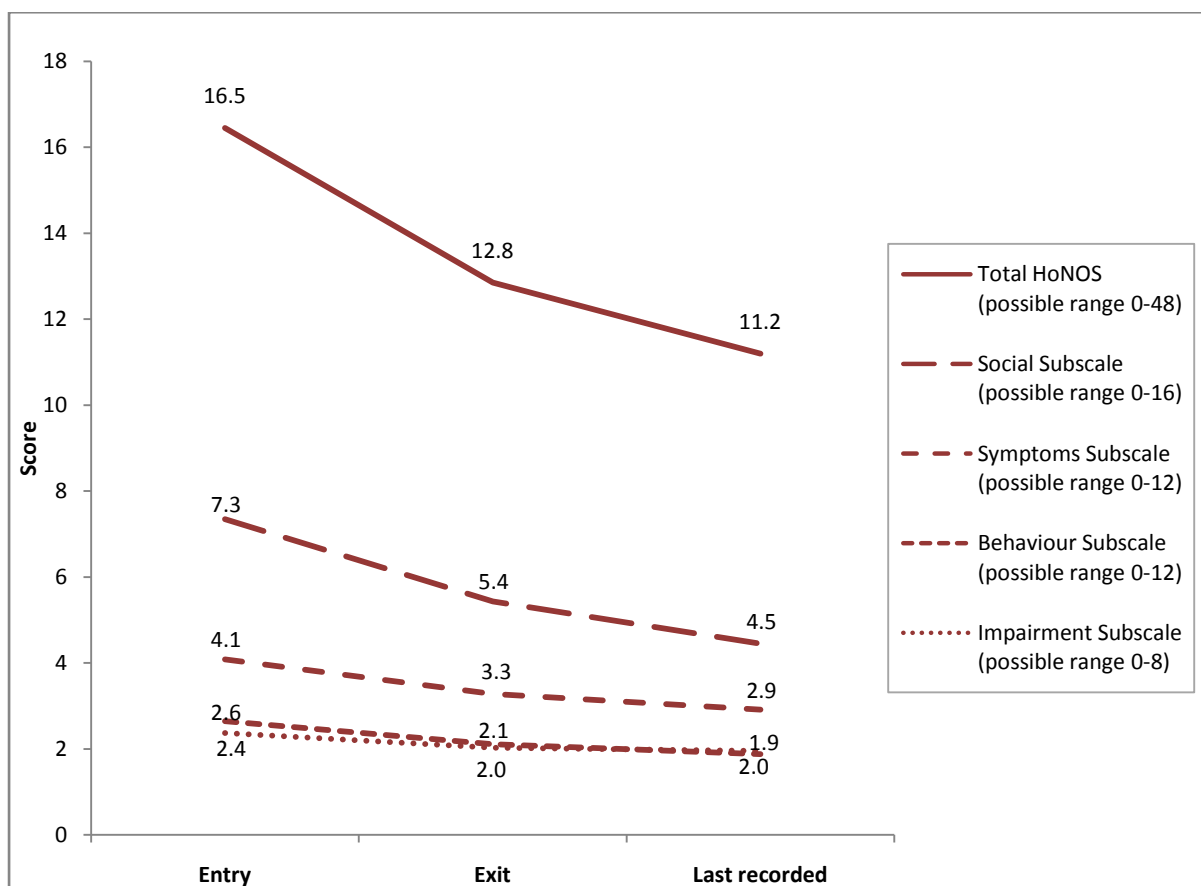
Of the 126 consumers who were assessed around the time of their first CRC entry and their last CRC exit –

➢ 61.9% recorded an **improvement** based on their Total HoNOS score,
➢ 5.6% recorded **no change** in their Total HoNOS score, and
➢ 32.5% recorded a **deterioration** based on their Total HoNOS score.

The change in the **average** HoNOS Total scores between CRC entry and exit was **3.7 points**. According to Parabiaghi et al (2005), a change of **8 points** in an individual consumer's total HoNOS score would be the minimum needed to be confident that a *clinically significant change* had occurred for that consumer.

➢ A quarter (**25.4%**) of consumers who were assessed around their CRC entry and exit experienced a **clinically significant improvement** (8 points of more) in their total HoNOS score.
➢ A small number (7 consumers, **5.6%**) experienced a **clinically significant deterioration**.
➢ For most consumers, the degree of change they experienced, as measured by their total HoNOS scores, was not clinically significant (less than 8 points)

REVIEW REQUIREMENT: Assess the extent to which the governance arrangements for the program promote effective work practices and facilitate desired outcomes

Restructuring in the metropolitan region has brought the two metropolitan regions together and in the process supported the CRCs being considered as an integrated program. Governance of the CRCs has become clearer and the evaluators understand that there is now a formal link between the Mental Health Unit and AHS. This is a positive outcome.

It will be important as the CRC model changes to a partnership with NGOs that governance remains clear.

With the recent announcement of the establishment of two new CRCs in rural locations, it will be important as the CRC Program expands to include CRCs in Country SA that governance is clear and that there are connections with the metropolitan CRCs to ensure a common service model and to support peer learning across CRCs – see **Recommendation 7**.

> **REVIEW REQUIREMENT: Analysis of Budget arrangements - based on an overview of relevant documentation and on interviews with service managers, identifying the degree to which individual CRCs have been operating within or out of budget, and reasons for this.**

It is the evaluators' understanding that all three CRCs were allocated the same budget, given they provide the same number of places (20 each).

⚑   It is difficult to understand then, why this has not occurred in practice, with a significant disparity reflected in the smaller budgets of Elpida and Wondakka (which had been part of the former CNAHS region) compared with that of Trevor Parry (which had been part of the former SAHS region). As the bulk of the CRCs' budget is allocated to staffing, this has been reflected in FTE allocations. The implications of this disparity in terms of equity for consumers, and burden for staff are of significant concern.

Barriers arising from **resource constraints** were identified from the consultation process, and given the less advantageous budgets of Wondakka and Elpida House compared with Trevor Parry, this is not surprising (although the CRC Managers did not draw the evaluators' attention to this disparity during our consultations with them). In relation to staffing the main concern was that available resources were 'tight' for supporting 20 residents and limited the type of interventions that could be offered. In addition, the provision of a 24 hour service without dedicated night staff was seen as an issue in terms of continuity of care between day and night staff.

Challenges associated with provision of a 24 hour service

CRCs are designed to offer a 24 hour service, and this feature was identified as one of the strengths of the model. However, while this is of great benefit to consumers it may bring costs for its staff in terms of physical, social and emotional well being unless managed appropriately. The survey of CRC staff has identified concerns about the way rostering is being applied and the negative health impacts this brings. A number of strategies have been identified to enhance rostering – such as, changing the length of shifts, and paying more attention to the sequencing of early and late starts – see **Recommendation 9**.

Conclusions

The recommendations made by the evaluators reflect the findings of consultation with all stakeholder groups and analysis of CBIS, CCC and other program data, and are designed to build on these achievements while also addressing the challenges involved in the continued implementation of the CRC service model.

The extension of CRC services to rural locations is a welcome beginning to addressing the needs of those living outside of the metropolitan area, not only because of the access and equity issues addressed, but because the two new centres will strengthen the existing network of CRCs. This creates significant opportunities for peer learning and support for staff and NGO partners and possible opportunities for resource efficiencies – for

example, by sharing training and development costs. It will be important to design governance structures and communication processes in such a way that this linkage is supported and that the underpinning model is applied consistently, while being sufficiently flexible to enable local adaptation.

As the CRCs transition to a government/NGO partnership, there will be increased scope to provide a wider range of activities and supports for CRC residents that build on the expertise and networks of the partners. To support this partnership it will be important to develop a joint training and development strategy for staff, as recommended by the evaluators and an enhanced approach to rehabilitation training, joint care planning and review processes.

Finally, the CRCs have been implemented in a time of significant change and reform in the mental health sector of South Australia, and this evaluation has been undertaken in the earliest stages of that implementation. This can be expected to bring a range of challenges and it is important to weigh these against the achievements made, both of which are evident in this report. The CRCs have achieved much in a short time and this will provide a solid foundation for their continued development, provided the challenges identified are addressed.

1.1   SUMMARY OF RECOMMENDATIONS

Recommendation 1

It is recommended that the Adelaide Health Service CRC Project Implementation Committee (AHS CRC PIC) ensure that an agreed documentation of the CRC Service Model is developed as soon as possible, and that this is accompanied by a set of policies, procedures and protocols that can be applied consistently across the three CRCs. These should clarify where policy is fixed and consistency is required while also identifying where local differences can be addressed, and flexibility in interpretation is possible. (Section 3.3.1)

Recommendation 2

In order to clarify the role of CRCs in the wider mental health system, it is recommended that the term 'beds' be replaced by the term 'places' in all documentation referring to the CRCs. (Section 3.3.3)

Recommendation 3

It is recommended that CRC Managers ensure that processes designed to support the review of Care Plans at agreed intervals are in place and understood by all staff, and that provision is made for this review to include Key and Support Workers, and other identified parties in line with National Mental Health Standards. (Section 4.2.3)

Recommendation 4

It is recommended that any future expansion of CRC services adhere to the physical design/purpose built principles applied to the Trevor Parry and Wondakka Community Rehabilitation Centres and incorporate any lessons that TPC and Wondakka have learnt from operating the facilities. (Section 5.1)

Recommendation 5

It is recommended that the Adelaide Health Service CRC Project Implementation Committee (AHS CRC PIC) and the Mental Health Unit ensure that partnership arrangements between service providers are clear and consistent by clarifying relative roles and responsibilities and developing agreed communication processes. It is expected that AHS PIC will develop operational protocols regarding partnership with stakeholders which will apply across all 3 CRCs. (Section 5.2.2)

Recommendation 6

It is recommended that a consistent and evidence-based rehabilitation focused training program is developed for all CRC staff and Key Workers and Support Workers, and contains both induction and ongoing training. This program would build on existing training activities and be applied consistently across all CRCs, and its design would be based on consultation with CRC staff, Key Workers and Support Workers. It would be supported by a dedicated staff development budget that includes provision of backfill for staff participating in training. (Section 5.3)

Recommendation 7

It is recommended that metropolitan CRCs and Country CRCs collaborate to ensure that there is consistency in the application of the underpinning service model. (Section 5.5)

Recommendation 8

It is recommended that the AMPS and OSA assessment tools continue to be used to measure consumer outcomes relating to activities of daily living, and that an amount be set aside each year to pay for training in the use of the AMPS so that all Occupational Therapists working in CRCs are able to administer both of these tools. The information yielded should be used to inform Care Planning and Review processes. (Section 6.9.4)

Recommendation 9

It is recommended that CRC Managers consult experts on the design of rostering and shifts that support a 24 hour service without compromising the health and well-being of staff. CRC Managers should also consult with staff on the challenges being faced and strategies for managing those issues. A uniform approach across the three CRCs to rostering for shift work should then be designed and implemented. (Section 7.2)

Recommendation 10

It is recommended that SA Health continue to monitor access and equity for rural consumers, including determining whether additional CRCs are needed outside of the metropolitan area. (Section 7.4.1)

Recommendation 11

It is recommended that the Adelaide Health Service PIC develop a series of strategies to enhance the capacity of CRC services to be culturally inclusive for people from Indigenous backgrounds and for people from culturally and linguistically diverse backgrounds, paying particular attention to cross cultural awareness raising training and strategic working relationships with organisations with specific cultural roles. (Section 7.4.2)

Recommendation 12

Recovery principles and rehabilitation principles should be embedded further in any further service model development. It is recommended that CRCs look at how they can partner with other agencies in order to provide recovery focused rehabilitation activities both on and off site. These activities may be group or individually focused and should be integrated into individual Care Plans and Reviews. (Section 7.6)

2 INTRODUCTION

The Mental Health Unit, SA Department of Health commissioned the Australian Institute for Social Research (AISR) to undertake an evaluation of the three Community Rehabilitation Centres (CRCs) – Elpida House in Mile End, Trevor Parry Centre in Noarlunga and Wondakka in Elizabeth.

The AISR evaluation team has three core members:

- o Dr Kate Barnett, Deputy Executive Director of the AISR and Evaluation Team Leader
- o Dr Frida Cheok, AISR Research Associate and Director of Frida Cheok Health Consulting Services
- o Ms Naomi Guiver, Senior Research Fellow at the AISR.

The team has worked closely with Ms Amelia Traino, Manager Rehabilitation and Recovery Services, Mental Health Unit. We are indebted to her for her support in making the evaluation process as smooth as possible.

2.1 EVALUATION METHOD

The evaluation has involved a mixture of quantitative and qualitative methodologies, including:

⇒ a review of CRC documentation;

⇒ analysis and interpretation of CBIS/CCC data (further details about this part of the methodology is provided in **Accompanying Report 4)**;

⇒ analysis and interpretation of data from OT assessments of CRC consumers, provided directly to the Evaluators by CRCs (see **Accompanying Report 3**);

⇒ structured interviews with CRC managers (undertaken twice), Regional Allocation Committees (of the then SAHS and CNAHS, the CRC Steering Committee, Regional Directors (of the then SAHS and CNAHS); the Rural and Remote Mental Health Service, representative key workers, and the Mental Health Unit;

⇒ three focus groups with consumers (one at each CRC) – undertaken in July 2010;

⇒ one focus group with carers, from across the 3 CRCs -undertaken September 2010;

⇒ a survey of CRC staff – undertaken in September 2010;

⇒ a survey of Key Community Workers and NGOs involved with the CRCs (ie staff in Community Mental Health Centres who had a Community Key Worker role; and staff in NGOs who had a Support Worker role - henceforth referred to as *Key Workers and Support Workers*) – undertaken in December 2010.

An overview of recent rehabilitation and recovery literature was also undertaken and ethics approval for the evaluation was sought and obtained from SA Health's Human Research Ethics Committee. Information from the two surveys was analysed separately and comparatively (each had a core common group of questions), and similarly, information yielded from structured interviews and focus groups was analysed separately and triangulated.

Individual reports have been provided during the evaluation relating to interview findings, focus group findings, survey findings and findings from analysis of other data. This final report combines all findings from the different components of the methodology.

For further detail, four Accompanying Reports have been provided. These present findings from the Survey of Staff (Accompanying Report 1), the Survey of Key and Support Workers (Accompanying Report 2), the analysis of OT assessment data (Accompanying Report 3), and the analysis of CBIS/CCC data (Accompanying Report 4).

2.1.1 PARTICIPATION RATES

⇒ A total of **43 staff** replied to the *Survey of CRC Staff*, giving an overall response rate of **60.6%,** which is very positive. The highest response rate came from Wondakka (70.8%) and the lowest from Elpida House (43.5%). The largest number of responses (21) came from Community Rehabilitation Workers, representing 48.8% of responses. Two of the 43 people were in a management role.

⇒ A total of **132 Key Workers and Support Workers** responded to the *Survey of Community Key Workers and NGO Support Workers*. The majority of the respondents (60.9%) were Support Workers from Non-Government Organisations (NGOs), with the remainder (39.1%) being Community Key Workers from the Government mental health service.

⇒ All **3 CRC Managers** provided feedback through structured interviews.

⇒ A total of **17 consumers** participated in one of the three focus groups held at each CRC, with the highest number of these being residents from Wondakka.

⇒ A total of **15 carers** from across the three CRCs participated in a focus group held at Elpida House.

⇒ All members of the CRC Steering Committee have provided feedback, as have the (then) two Regional Directors of Rehabilitation and Recovery. These and other key stakeholders consulted are listed in *Appendix A, Section 9.*

2.2 FOCUS OF THE EVALUATION

The evaluation terms of reference reflect a number of areas of focus which have guided the methodology design and application. These involve:

➢ Analysis of CBIS/CCC data, to quantify CRC client characteristics and features of service provision. (Although a specific component of the methodology, this has also been analysed against the qualitative information obtained from interviews and focus groups and the findings of the two surveys.)

➢ Assessment of the degree to which individual CRCs are in alignment with the CRC Service Model.

➢ Identification of the CRCs' "core business".

➢ Identification of the barriers associated with the design, planning and implementation of the services provided by the CRCs.

➢ Comparison of the processes and practices across all 3 CRCs – identifying commonalities and differences and an analysis of the reasons for this.

➢   Assessment of the degree to which governance arrangements for the program promote effective work practices and facilitate desired outcomes.

➢   Analysis of budget arrangements - based on an overview of relevant documentation and on interviews with service managers, and to identify the degree to which individual CRCs have been operating within or out of budget, and reasons for this.

To enable the reader of this report to quickly identify *successes* and areas of *needed improvement* emerging from the evaluation findings, the former are denoted by a ✓ symbol and the latter by a ⚑ (flag) symbol.

3   THE CORE BUSINESS OF THE CRCS

REVIEW REQUIREMENT: Identify the CRCs' "core business"

The Community Rehabilitation Centres (CRCs) are community-based residential, rehabilitation facilities which each have 20 places. CRCs are designed to support people with mental illness to engage in their recovery journey. They offer a residential setting with support 24 hours per day seven days a week, and 'an active, goal-focused rehabilitation program.' At the time of reporting here were three CRCs in SA (with an additional two CRCs with 10 places each, planned for country South Australia):

➢ Elpida House in the metropolitan inner-west (opened June 2007)

➢ Trevor Parry Centre in the metropolitan outer south (opened December 2007)

➢ Wondakka in the metropolitan outer north (opened 2008).

The CRC program focuses on supporting consumers to reduce their chance of relapses and to improve their wellbeing. The program also focuses on improving the consumer's connection with services in their local community, such as housing, health services and vocational and educational services.[1]

The CRCs are one component of a wider reform and reconfiguration of the SA mental health system, and the evolution of a 'stepped' system of care. At the time of their implementation, some of the other 'steps' were not in place and this context needs to be taken into account in assessing how well their core business is understood elsewhere in the mental health system. As a new care model, it is also important to acknowledge the time needed for other mental health service workers, consumers and the wider community to understand the CRC role and its relationship to other parts of that system.

✓   Nevertheless, those service providers consulted by the evaluators (CRC-based and those working closely with them, such as non government organisations) were clear that the core business of the CRCs is rehabilitation, underpinned by a philosophy of recovery. CRCs are correctly understood by them as being part of a spectrum of services being implemented within a stepped model of care.

✓   Consumers and carers consulted also appear to have understood this fundamental role.

✓   The evaluators believe that the recent re-naming of the CRCs to emphasise their rehabilitative purpose and function will assist in clarifying their core business.

All key stakeholders interviewed saw social inclusion and community integration as key features of an all encompassing rehabilitation service model. The evaluators understand that CRC Steering Committee members are examining ways to further address these two goals, including outcomes instruments to measure them.

⚐   The majority (76.7%) of staff surveyed believe that the role of CRCs is not fully understood by others in the mental health service system, including those who refer consumers to them*. Key Workers and Support Workers surveyed, while seeing themselves as reasonably well informed about the CRCs,

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[1] See SA Health website -
http://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/health+reform/mental+health+reform/community+rehabilitation+centres

supported this view, seeing the need for increased awareness of the CRCs' role in the mental health sector, and by the community as a whole.

⚑ In identifying areas of needed improvement, the issue most frequently cited by CRC staff surveyed involved clarifying to referral sources the rehabilitative role of CRCs. This was followed by a range of strategies relating to the way in which CRCs work with consumers and by the need to support a stronger rehabilitation focus, particularly through sharpened targeting of referrals.

3.1   THE REASONS CONSUMERS ACCESS THE CRCS

The evaluation asked consumers, CRC staff and Key Workers/Support Workers to stipulate the reasons consumers are accessing the CRCs, as one means of determining how the core business of CRCs is perceived.

✓ The main reasons identified by all three groups of stakeholders generally reflected the intended purposes of the CRCs – that is, to achieve recovery goals through rehabilitative interventions (in particular, independent living skills, mental health self-management skills, development of meaningful routines and roles, improvement of social skills).

✓ A lack of other appropriate accommodation was seen as a main reason for CRC entry by a significant proportion of CRC staff and emerged as an issue of concern in interviews with some key stakeholders. However, this view was not expressed by Key/Support Workers. Only two consumers consulted stated that their prime reason for accessing the CRC was accommodation, but both also expressed additional reasons relating to rehabilitation and recovery.

See *Table 1* for details.

Table 1: Reasons consumers access CRCs

REASONS BY STAKEHOLDER GROUP		
CRC staff	**Key Workers & Support Workers**	**Consumers**
✓ The majority of staff believed that the main reasons consumers accessed CRCs were to attain recovery goals ⚑ However 46.5% also believed that one of the main reasons consumers entered a CRC was a lack of other appropriate accommodation.	✓ The CKW/SWs also clearly identified recovery goals as the main reasons for consumers accessing CRCs. ✓ Only 15.9% believed that lack of other appropriate accommodation was a main reason for entering a CRC.	✓ There was a trend for consumers providing feedback through focus groups to indicate a need to learn about living in the community, and although only one specifically used the term 'rehabilitation', their answers were indicative of the need for rehabilitation.

CRC staff surveyed identified multiple reasons for consumers to access a CRC. The most commonly identified related to –

⇒ improving independent living skills (88.4%),

⇒ improving self-management of mental health (83.7%),

⇒ developing meaningful routines and life roles and

⇒ improving social skills and networks (both 79.1%).

Consumers participating in focus groups were asked what they understood by the term 'rehabilitation', and their responses indicated a good understanding of the concept, and of the role and purpose of the CRCs. Essentially this involved being supported to make the transition into effective life in the community, including learning how to manage medication and everyday living tasks, and developing socialisation skills. The examples below illustrate this understanding.

> *"To get to a place [in your life] where you can live more easily and happily. Improve your lifestyle as much as you can".*
> *"To overcome their illness …. It means to get back into the community again".*
> *"That's what rehab means to me. Learning the skills to deal with my illness."*
> *"Having the tools to live with your illness in the community".*
> *"It helps you to learn structures in your daily life".*
> *"Socialising, learning to be around people, learn to be independent".*
> *"To get off the couch…. I was just at my dad's house on the couch. To learn to get motivated".*
> *"To break the cycle of going in and out of hospital – to help stop being institutionalised".*

Almost unanimously residents agreed that the CRC experience was as expected, indicating effective pre-entry processes, which include visiting the CRC prior to admission. When asked if they thought the CRC was the best place for them to be, the unanimous answer was "Yes". Discussion about the reasons for this view indicated that consumers believed they would not recover if they were not in their CRC.

> *"I think this is the best place. The staff are nice; they help with all problems; they can talk to staff 24 hours p/day, 7 days p/wk".*
> *"We would be living on the street if we weren't here".*
>
> *"I would still be really sick. "*

✓   This feedback indicates a good understanding by consumers of the role and purpose of the CRCs.

✓   Consumer feedback also endorses the CRCs as valuable mechanisms in the recovery process.

Carers consulted also understood the rehabilitative role of the CRCs without necessarily using this term. Their focus was on CRCs as a mechanism for re-integration into independent community living, and with supported learning to achieve this.

> *"Relearning, structure, skills."*
> *"The model is to do it themselves with support."*
> *"There is nowhere else"*
> *"My son would be on the street."*

✓   Carers' feedback also indicated that they understood the role and purpose of the CRCs.

3.2   APPROPRIATE LENGTH OF STAY

The length of stay in a CRC is also central to its core business and model of operation. The evaluation has found differences between different stakeholder groups regarding the appropriate period of time consumers should be resident in a CRC.

CRC staff surveyed considered that the appropriate length of stay in a CRC usually involves between 6 and 12 months (41.9% of respondents) but a further 39.5% feel that it varies too much with individual consumer complexity to nominate a time period. Feedback from CRC staff and managers indicates that residents generally stay longer than the 6 month period suggested in the Service Model.

The evaluators' analysis of CBIS/CCC data (see Section 6.3.4) shows that around **60%** of CRC episodes had been completed **within six months**, with **29.6%** completed **within three months**. Most of the remainder had ended within twelve months, with only 6.5% of episodes extending past one year. The **average** length of completed CRC episodes was **169.4 days**, which equates to between five and six months. When leave days were excluded from the total length of closed episode, the mean length of stay dropped slightly to 167.4 days (see Section 6.3.5).

Only 18.2% of *Key/Support Workers* surveyed considered that 6 to 12 months was the appropriate length of stay, followed by 3 to 6 months (14.4%) and 'about 6 months' (11.4%). A further 32.6% believed that the length of stay varied, depending on consumer complexity.

✓ The evaluators note the level of agreement between the two groups of service stakeholders regarding tailoring the length of stay to the individual consumer.

Carers consulted understood that residencies in a CRC are for a 3-6 month period but perceived that this was not sufficiently long to support recovery.

Our daughter was at Elpida…. [it] was wonderful but it was not long enough. It was always hanging over her head that after 6 months she would need to find accommodation.

While further information is needed to quantify length of stay, it is likely that greater flexibility is needed in applying the length of stay policy so that variations in individual consumer need can be addressed.

3.3   INCOMPLETE DOCUMENTATION: BARRIER TO UNDERSTANDING THE CRC CORE BUSINESS

The information provided to the evaluators has consistently identified the need for documentation that reflects an agreed and widely understood presentation of the CRC model. This is the view of members of the Steering Committee, CRC managers, and Regional Directors and the evaluators agree with them. Without clear documentation it is difficult for core business to be understood by different stakeholders and for the service model to be implemented consistently.

Prior to the implementation of the first CRC – Elpida – it was reported that a model would be documented that would be consistent across CRCs. However, the feedback provided to the evaluators suggests that although a model was available, it was too general and ambiguous in parts, and as a consequence, different interpretations have been applied in each of the three CRC locations, resulting in different regional versions.

The CRC Steering Group was not in place at the time of the establishment of Elpida and Trevor Parry CRCs (although the evaluators note that a pre-existing CRC Advisory Group had been in place prior to the establishment of the CRC Steering Group).

⚑ This gap was described as contributing to a lack of consistent guidance and agreement about interpretation and application of the service model, and is reflected in the different policies and procedures that have been developed by each CRC.

The various versions of service model documentation were reviewed and consolidated to achieve the current version (the eighth iteration, signed off in December 2008). The evaluators summarised this document into a version against which implementation can be measured, and sought CRC Managers' feedback on the relevance of the revised document and their assessment of the degree to which implementation reflected the intended model of service. CRC Managers provided significant and detailed comment on the evaluators' consolidated version of the model (see *Section 10*, Appendix I).

- It is concluded that the eighth version of the documented model contains significant *duplication* and a *lack of specificity* about what is actually expected of CRCs. Those consulted agreed with this perception.

- The existing documentation of the service model was described by those consulted as confusing and *incomplete* in its presentation of that model, particularly in relation to the concept of rehabilitation and the location of CRCs in a wider stepped system of mental health care.

- We also sought feedback about whether *Service Agreements* specified expectations (and in a clearer manner than the service model documentation) and were informed that no such agreements were in place. Consequently, each CRC has interpreted the requirements and developed policies individually and the current model is open to varying interpretation.

- ✓ Regional directors and CRC managers have indicated to the evaluators that a process is occurring through the CRC Steering Committee and the Mental Health Unit which will support the application of a single service model (and associated protocols).

- ✓ The evaluators understand that at the time of writing, the Mental Health Unit, in partnership with Adelaide Health Service and other stakeholders had begun the process of documenting the service model. Hence, no recommendations are being made regarding documentation.

3.3.1   BALANCING THE NEED FOR CONSISTENCY WITH THE NEED FOR FLEXIBILITY IN APPLYING THE CRC MODEL

The evaluators have been presented with arguments for and against a consistent interpretation of the service model across all three sites. An individualised application of the model has been described as being more sensitive to local level need and to individual client need, and as fostering innovation. Consistency has been promoted as supporting predictability of service provision, and equity of service provision.

Ideally, there needs to be a balance that enables equitable access due to consistency without stifling responsiveness to local and individual need. This is reflected in **Recommendation 1.**

Recommendation 1

It is recommended that the Adelaide Health Service CRC Project Implementation Committee (AHS CRC PIC) ensure that an agreed documentation of the CRC Service Model is developed as soon as possible, and that this is accompanied by a set of policies, procedures and protocols that can be applied consistently across the three CRCs. These should clarify where policy is fixed and consistency is required while also identifying where local differences can be addressed, and flexibility in interpretation is possible.

3.3.2   FRAGMENTED POLICY GUIDELINES

At the time of reporting, all CRCs had separate policies and procedures, but the 3 managers were in the process of comparing these with a view to consolidation.

Table 2 exemplifies some of these differences. Staffing for 3 centres was intended to be the same (each has 20 units), however, some differences were negotiated for Trevor Parry.

Table 2: Examples of different Policy Guidelines across the CRCs

Policy Guideline	Elpida	Wondakka	Trevor Parry
Phone calls made by clients (on fixed lines)	Separate bills provided to clients for calls made	Cost of calls made are covered by the CRC (phones are linked to the LMHS system and separate accounts are not possible)	Clients are not permitted to make outside calls
Changeover time between residents	Place is left open for 7 days while client is supported in the community as a transition measure	Place is filled as soon as it is vacated	
Administration of HoNOS (supposed to occur within first 3 days of residency)		Delays the 1ˢᵗ HoNOS for 2 weeks when staff know the clients better	HoNOS applied on entry but re-administered after 2 weeks

Differences in the time available for implementing each CRC has also affected the development of policies and procedures. For example, the Manager of Wondakka had less than 2 months to implement the CRC, and the Manager of Elpida had even less time and was reported as having been established without policies, guidelines, procedures or computers for two months despite clients being accepted for services.

3.3.3 SPECIFIC GAPS IN CURRENT DOCUMENTATION

Criticism was also levelled by those interviewed at gaps in information describing how to translate the model into practice. In particular, there is an absence of information specifying –

- what each *discipline* brings to the CRC and why – nor is there any clear role definition for different *professional groups*. For example, Occupational Therapists (OTs) are considered critical to rehabilitation processes but are not identified in current service model documentation. It appears that the lack of prescription of roles for various disciplines was intentional and underpinned by the philosophy that all staff should be providing rehabilitation. Nevertheless current staff allocation is comprised of different disciplines without adequate explanation as to the specific skills each could contribute. Each discipline will have both a specialist contribution to make to the rehabilitation process, as well as sharing common areas of intervention. This lack of clarity may partly explain the difficulties being experienced in recruiting and retaining some professional groups – for example, there has been a variable presence of OTs and psychologists across the CRCs, with most Managers reporting these groups of professionals as being difficult to recruit and retain.

- The *points of interface with other services* are not clear in the existing documentation, and this has led to varying interpretations across the three CRCs. The roles and responsibilities of *Key/Support Workers* appear to be poorly understood, and vary widely. All residents must have an allocated Key Worker from a community mental health team prior to entry, and who maintains involvement throughout the residency. In addition the CRC allocates an internal coordinator. Apart from needing clarity about the roles and responsibilities of key workers, the interface between key workers and CRC coordinators requires clear documentation and agreed processes. Currently significant variation exists, for example, with some key workers attending every monthly care plan review meeting whereas others rarely attend.

⚐ In addition, documentation needs to specify –

⇒ who the client group is, including their levels of need and complexity (the evaluators note different expectations by CRC staff and those in senior management roles regarding these levels)

⇒ the services and other forms of support that can and should be provided

⇒ the partners in care and their respective roles and how these interface with CRCs.

A common misperception reported by those consulted is that the CRCs are viewed by many as another source of mental health 'beds' that clinicians can use for 'treatment' when other beds are not available. The evaluators agree with those consulted that the term 'bed' should not be used in relation to CRCs (for example, the service model documentation refers to them as 20-bed facilities).

Recommendation 2

In order to clarify the role of CRCs in the wider mental health system, it is recommended that the term 'beds' be replaced by the term 'places' in all documentation referring to the CRCs.

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4 ALIGNMENT WITH THE CRC SERVICE MODEL

> **REVIEW REQUIREMENT: Assess the extent that the services provided by the CRCs align with the Service Model**
>
> **1   Gather documentation about the CRC Service Model**
>
> **2   Gather information about the current functioning and practices**
>
> **3   Map #2 against #1**
>
> **4   Identify key stakeholder partnerships and assess the extent to which these fulfil the Service Model parameters and requirements.**

> **REVIEW REQUIREMENT: Compare and contrast process and practice across all 3 CRCs.**

The evaluators have sought information about the alignment of the three CRCs with the service model through the following methods:

⇒ Analysis of existing documentation about the service model.

⇒ Interviews with CRC Managers, members of the CRC Steering Committee, the Chairs of both Regional Allocation Committees, both SA Health Regional Directors of Recovery and Rehabilitation (as existed at the time of interview), and a Rural and Remote services representative.

⇒ Survey of CRC staff.

⇒ Survey of Key Workers and Support Workers.

The information collection has focused on the following features and issues associated with the service model:

➢ Underpinning principles of the model

➢ The general features of the model, as well as specific features of intervention, care planning, access and equity, and exit planning

➢ Fulfilment of the Recovery goal

➢ CRC staffs' understanding of their role.

➢ Appropriateness of the reasons consumers access the CRCs (see discussion in *Section 3.1*)

4.1   ADHERENCE TO THE UNDERPINNING PRINCIPLES OF THE MODEL

The surveys of CRC staff and Key/Support Workers asked respondents to rate the extent to which they believed the CRCs were fulfilling the seven underpinning principles of the CRCs (using a 5 point likert scale with '1' representing the most negative rating and '5' representing the most positive rating). Comparative analysis of the findings from both groups of stakeholders is presented in *Figure 1.*

Figure 1: Comparison of average rating scores for the extent to which underlying CRC principles are being met
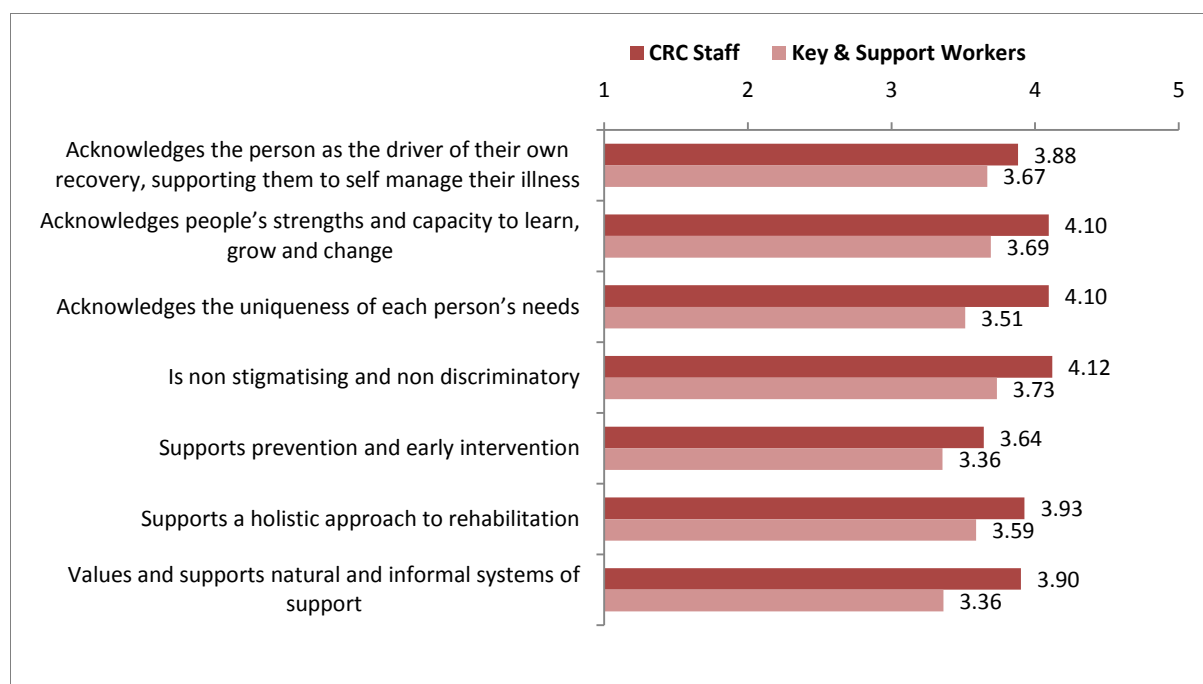
> *"The CRCs are vital for opportunities for clinical rehabilitation in a home-like environment. They enable consumers to maximise their opportunities for recovery although it is understood that for many this is where the journey begins or continues and that it is all on a continuum. My experience of the CRCs has been positive..."* (CRC staff member)

From *Figure 1* it can be seen that there is a discernible trend for CRC staff to have a more positive view than Key/Support Workers regarding the fulfilment of each underpinning principle. However, the evaluators note the general agreement between both groups of stakeholders about the underpinning CRC principles being applied.

✓   All Principles received positive ratings (ie greater than an average of 3.5 out of a possible 5.0) from the majority of CRC staff surveyed.

✓   Both groups have given their most positive ratings to the CRCs' fulfilment of these Principles –

  ✓   *Is non stigmatising and non discriminatory*

  ✓   *Acknowledges people's strengths and capacity to learn, grow and change.*

For both groups the lowest ratings were applied to the principle of *supporting prevention and early intervention*. This may be a reflection of the place of CRCs in the wider mental health system as a specific prevention/early intervention role has not been defined for them. Instead they are expected to provide rehabilitation *after* a number of other strategies have been applied. However, prevention and early intervention is expected to be implemented as and when appropriate within the overarching rehabilitation framework.

4.2 FULFILMENT OF THE FEATURES OF THE CRC MODEL

Comparative analysis of the findings from surveys of CRC staff and Key/Support Workers is presented in *Figure 2 to Figure 5* inclusive, showing the **average** ratings for the adherence to five aspects of the CRC model – general or overall adherence to the model, as well as intervention, care planning, access and equity, and exit planning features (respectively). Again there was a pronounced trend for CRC staff to more positively assess adherence to key features of the model, compared with Key/Support Workers.

✔ The features of the CRC model were generally seen as being well met by staff, with average ratings of 3.5 or above applied to most features. Key/Support Workers agree, but with lower average ratings of 3.1 or above.

✔ There was general agreement on the extent to which main areas of the model was being met.

The evaluators note that each stakeholder group assessed the fulfilment of key CRC service features somewhat differently.

As discussed, CRC staff express a slightly more positive view than Key Workers & Support Workers on most features. The main exception was –

✔ Provides consumers with the appropriate amount of independence while living at the CRC

Overall, respondents provided stronger average ratings of the CRCs' fulfilment of underlying principles of the service model than its adherence to the features associated with the application of the model.

4.2.1 FULFILMENT OF THE MODEL'S GENERAL FEATURES

Figure 2: Comparison of average rating scores for the extent to which the CRC model's general features are being met
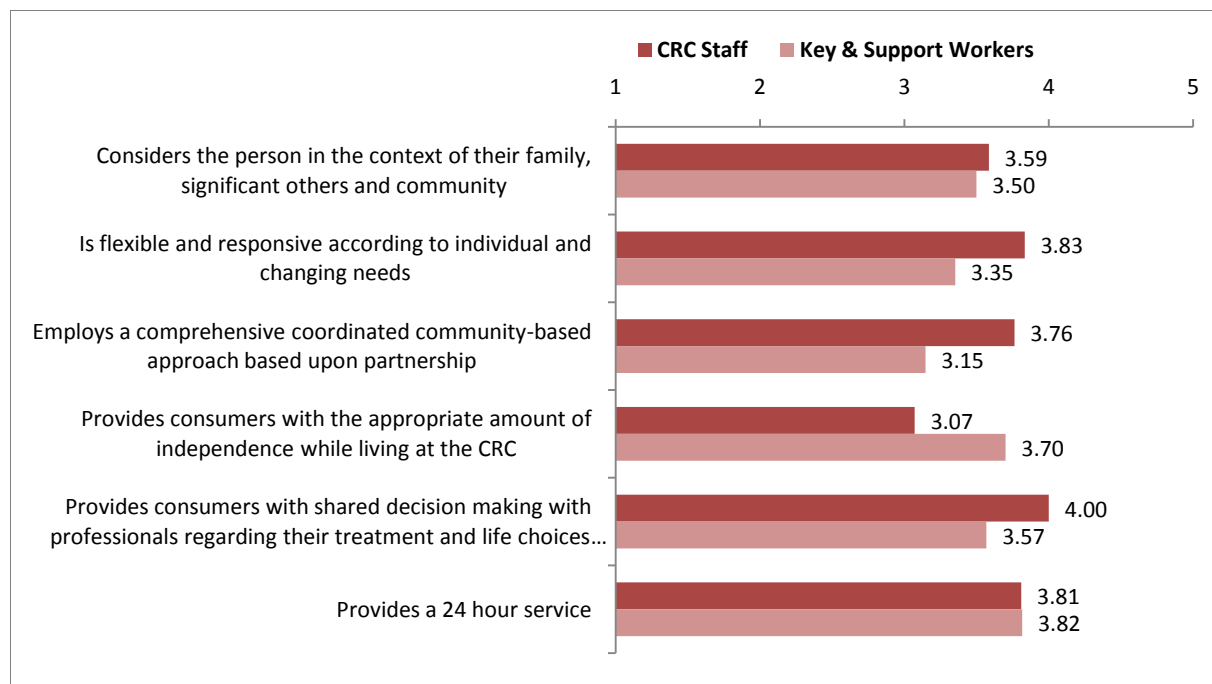
✔ It can be seen that both groups of stakeholders are in agreement that the CRCs are providing a 24 hour service, and are in close agreement about the consideration of the person in the context of their family and significant others.

CRC staff are most critical about the provision of an appropriate amount of independence to consumers living at the CRC while Key/Support Workers regard this in a much more positive light. Consumers consulted support the Key/Support Worker view on this issue – see *Section 4.3.*

4.2.2   FULFILMENT OF THE MODEL'S INTERVENTION FEATURES

Figure 3: Comparison of average rating scores for the extent to which the CRC model's intervention features are met
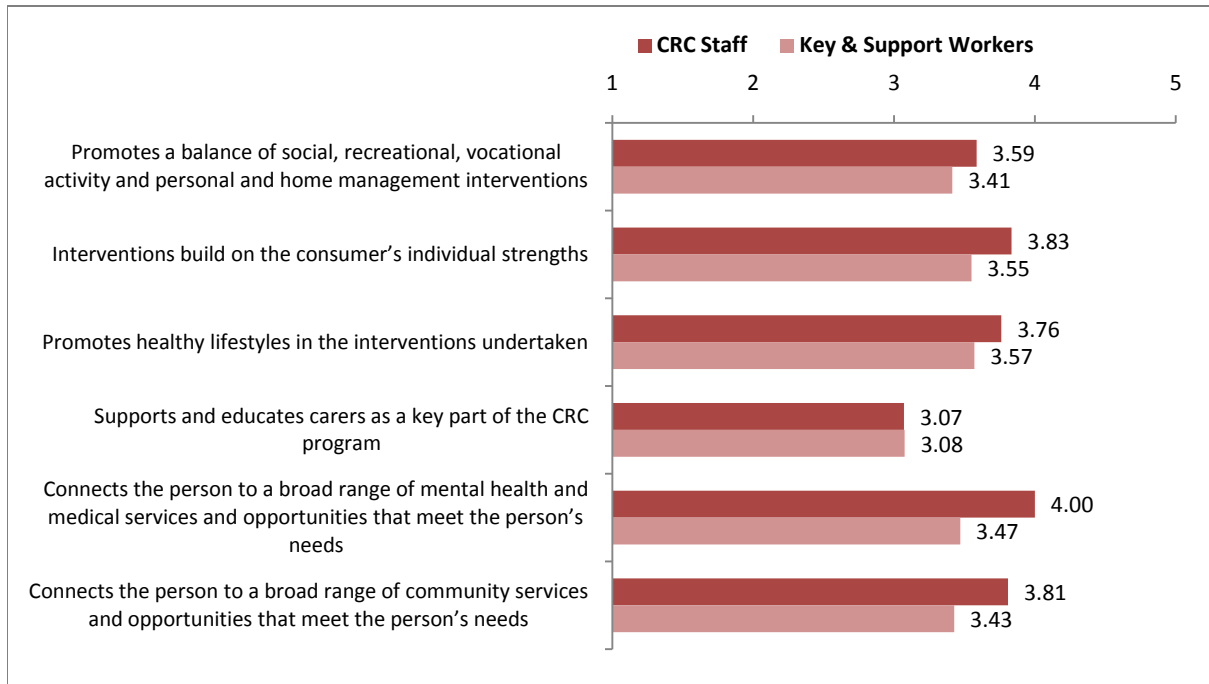
- The least positive rating, with both groups in agreement, concerns the supporting and educating of carers.

- Carers at the Carer focus group also expressed concern about lack of communication and involvement with both the CRCs and Key Workers (see *Section 3.1*).

- ✓ The most positive ratings from the CRC staff perspective were applied to the *connecting of consumers to a broad range of mental health and medical services*, the application of a *strengths-based approach* and *connecting consumers to a broad range of community services*. Key/Support Workers provided less positive, but nevertheless, relatively positive ratings to the fulfilment of these service features.

4.2.3 FULFILMENT OF THE CARE PLANNING FEATURE OF THE MODEL

Figure 4: Comparison of average rating scores for the extent to which the CRC model's care planning features are met
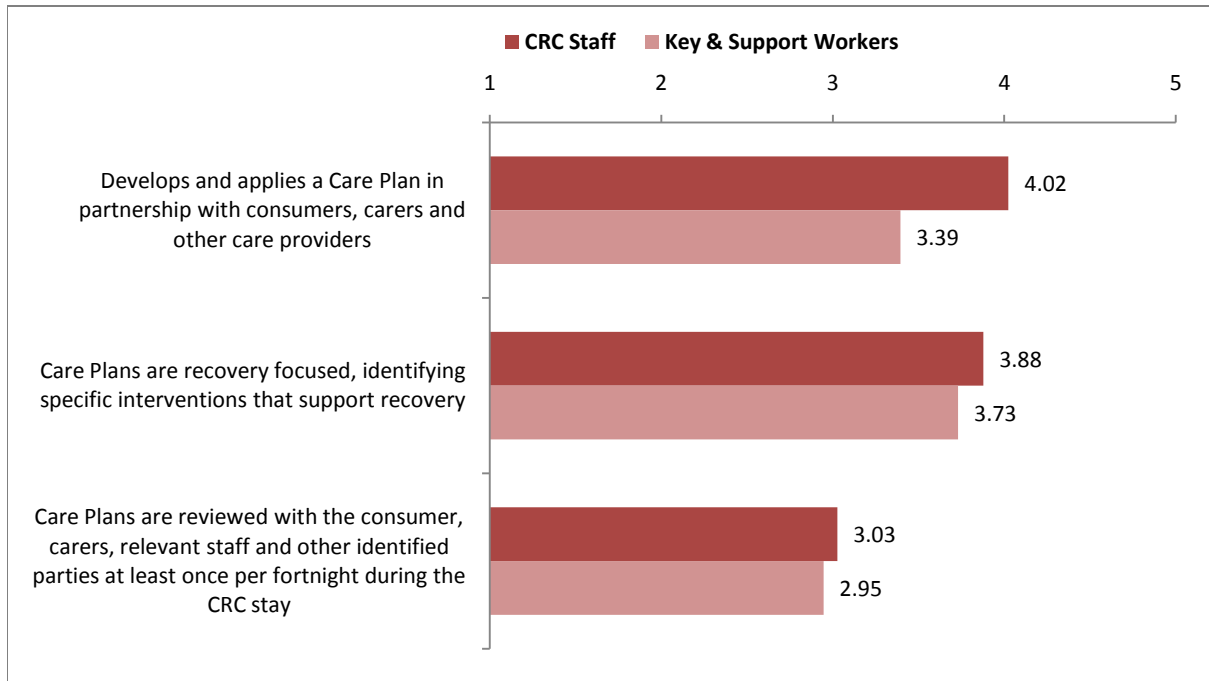
✓ As *Figure 4* indicates, both CRC staff and Key/Support Workers have positively rated the development and application of recovery-focused Care Plans, and the development of such Care Plans in partnership with consumers, carers and other care providers (although Key/Support Workers gave a less positive assessment of the latter than their CRC colleagues.)

⚐ However, both CRC staff and Key/Support Workers are critical of the reviewing of Care Plans, which is supposed to occur on a regular basis.

Recommendation 3

It is recommended that CRC Managers ensure that processes designed to support the review of Care Plans at agreed intervals are in place and understood by all staff, and that provision is made for this review to include Key and Support Workers, and other identified parties in line with National Mental Health Standards.

However, it is clear from our analysis of CBIS data that care plan reviews are taking place for a substantial proportion of CRC consumers. Only five (2.1%) of the 238 consumers who had entered a CRC during the period studied did *not* have a care plan recorded in the CBIS and those five consumers had all exited the CRC.

Furthermore, the results suggest that care plan reviews are mostly being undertaken at appropriate phases in the service pathway of CRC consumers. The majority (84.0%) of the 50 consumers who were *still residing* at the CRC at 15th September 2010 had their care plan revised during their stay. The remaining 16.0% of consumers still residing at the CRC had last had their care plan revised prior to entering the CRC. Three of those eight consumers had only been in the CRC for about one month, while a further three consumers had

their care plans reviewed shortly before entry to the CRC. Only two consumers had an unexplained delay in review - see *Section 6.7.*

4.2.4   FULFILMENT OF THE EXIT PLANNING FEATURE OF THE MODEL

Figure 5: Comparison of average rating scores for the extent to which the CRC model's exit planning feature are met
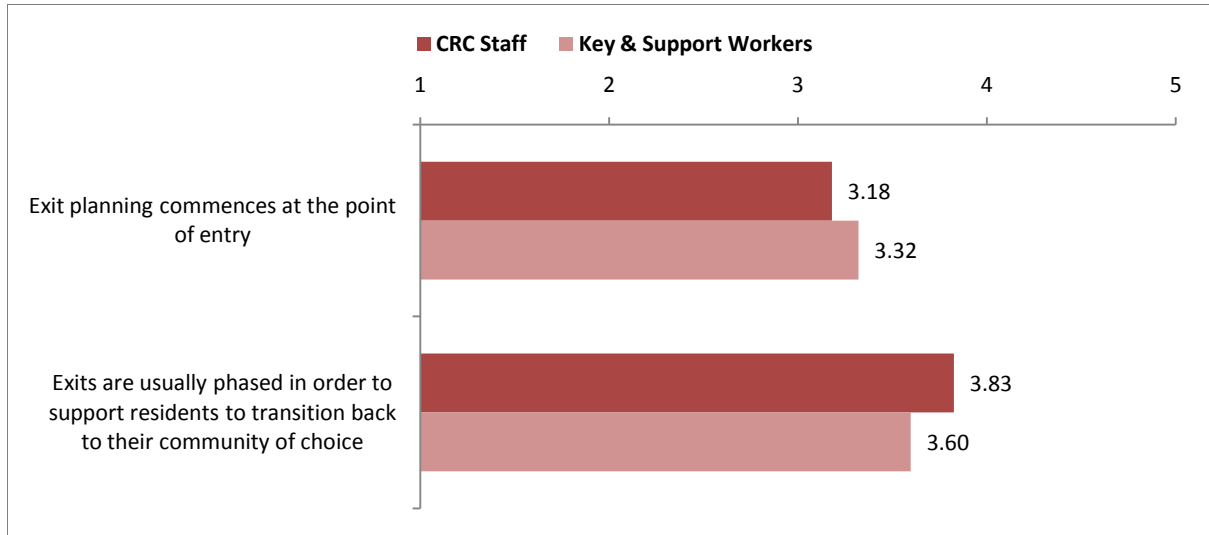
📕   Exit planning initiated at the point of entry has also received low ratings, from both groups of stakeholders.

✓   However, the *phasing* of exits to support consumers' transition back to the community has been more positively rated by both CRC staff and Key/Support Workers.

Refer to *Section 6.4.2* and *6.4.3* for information about reasons for exit and exit destinations of CRC consumers.

4.2.5   FULFILMENT OF ACCESSIBILITY AND INCLUSIVENESS FEATURES OF THE MODEL

Figure 6: Comparison of average rating scores for the extent to which the CRC model's accessibility and inclusiveness features are being met
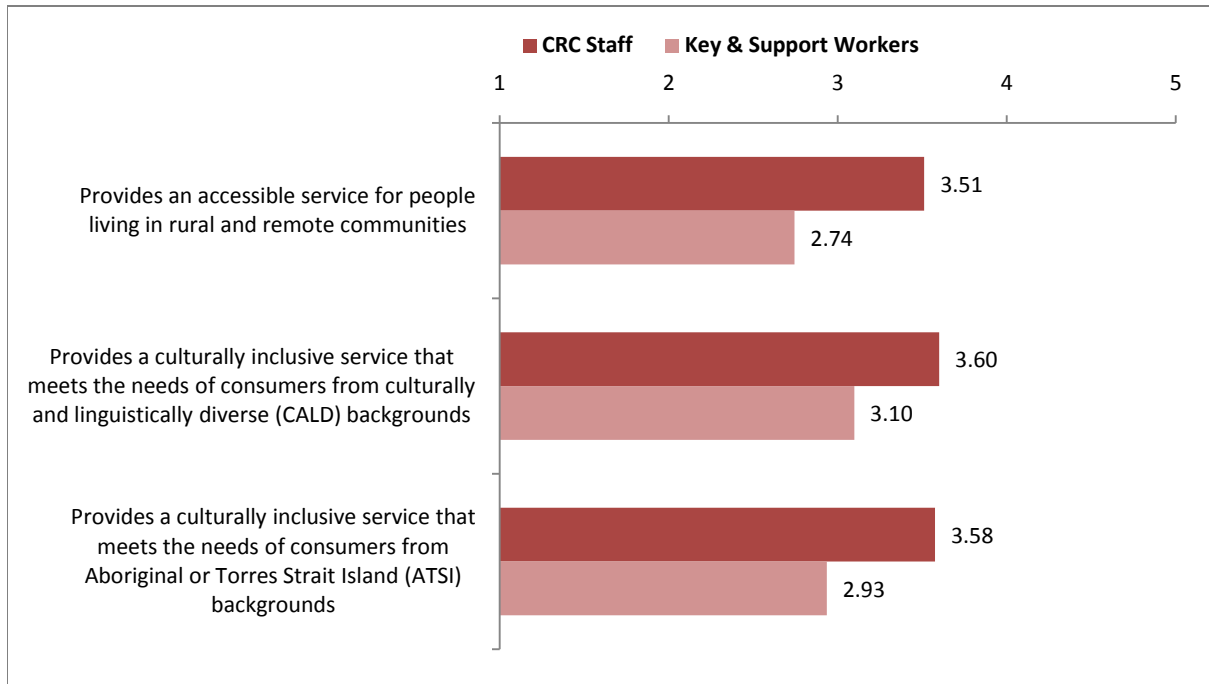
⚑ Key/Support workers have given their most negative ratings to the CRCs' accessibility for people in rural and remote communities, or from a CALD background, or from an Aboriginal background and this is of concern. Although more positive assessments were made by CRC staff, their ratings are lower on this dimension than any other service features, indicating agreement between both groups of stakeholders about this issue *(see Recommendation 10, Section 7.4.2).*

✓ The evaluators note the recently announced approval to establish two new 10 place CRCs in country South Australia.

Analysis of CBIS and CCC data quantifies and supports these findings, showing a significant under-representation of people living in rural and remote locations among CRC consumers – see S*ections 6.1.3* and *7.4.1*. It also shows an under representation of people from diverse cultural backgrounds, and of Aboriginal people relative to the mental health system as a whole – see *Sections 6.1.2 and 7.4.2.*

4.3   THE CONSUMER PERSPECTIVE

Across the three CRCs, there was strong endorsement by past and current residents of the underpinning model**.** All saw the CRC as the most *appropriate* place for them to be because without this intervention they did not believe they would recover.

✓ Consumers consulted indicated that the services varied depending on need and that this changed for individual residents over time, indicating flexibility and an *individualised* focus.

✓ Also, residents gave the impression that they are encouraged to perform tasks themselves, but are supported in gaining *independence* and confidence. Medication management was mentioned several times at all centres as a key feature of service provision.

✓ Feedback also indicates that the CRCs are following the expected operational processes with regard to *shared decision making* between consumers and professionals, and an appropriate amount of independence. However, across the three focus groups, it was difficult to engage residents in discussion about their role in setting goals.

⌘ Feedback about the attitudes and quality of care of primary workers and other staff indicated a concerning degree of *variability* from one individual to another, as were the levels of care.

⌘ *Staff and Key/Support Worker turnover* was raised as a concern, with residents feeling vulnerable without continuity of staff and key worker support.

Prior consultations with the Managers of the CRCs indicated that each resident is allocated one *primary contact* within the CRC but this did not seem to be as clearly understood by residents, particularly at Elpida.

⌘ All respondents had a *Key Worker* they could identify but there appears to be a great deal of variation in the amount of contact respondents have with them, indicating that the amount was determined by individual Key Workers (rather than as part of agreed policy and operational guidelines). See further discussion on this issue in *Section 5.2.2* and refer to *Recommendation 5*.

⌘ Many consumers providing feedback during focus groups identified boredom as a key source of dissatisfaction with the CRC experience. Several stated that access to computers would make a big difference and that recreational activities were limited, which in turn encourages less desirable leisure behaviour, such as, leaving the premises to consume alcohol. While the evaluators understand that part of the CRC purpose is to promote independence and self-management of daily activities as part of a recovery goal, it is also likely that many consumers will need specific support to achieve this. Carers providing feedback also believe that there is insufficient structure in the activities provided at CRCs and also identified that those in their care experienced significant boredom at the CRCs.

The evaluators believe there is scope for strategic working relationships with non government organisations, Clinical Rehabilitation and Day Programs who could provide a structured program of activities that would fill this activity gap while assisting consumers to prepare for independent living. This is discussed further in *Section 7.6* and *Recommendation 12.*This may also reflect the need for increased attention to staff training in engagement techniques, such as, motivational interviewing, that may assist staff to engage more effectively with consumers. **This is an issue that should be explored by CRC Managers**.

4.4 THE CARER PERSPECTIVE

Carers consulted for the evaluation were asked if the CRC service had made a difference to their lives and the life of the person for whom they were caring. Two thirds agreed that it had, and saw the CRC as alleviating the pressure they faced. All of the carers consulted were in agreement about the need for CRCs and saw them as filling a much needed gap.

'There is nowhere else.'

'It is much better than anything else.'

'They create stability to stop the ongoing cycle.'

'It saved our sanity. It gave us a 6 month respite.'

Carers consulted believe that CRCs would be improved by providing more activities and more structure in those activities. Some felt that there was a need for more focus on managing physical health, particularly

nutrition and medical issues. There was a strong trend to identify boredom for residents due to insufficient recreational and learning opportunities, and consumers themselves shared this view, but not as strongly as their carers. See also *Section 7.6* for further discussion on this issue and how it could be addressed (*Recommendation 12)*.

Carers believe that GPs and psychiatrists are not fully aware of CRCs and the services they offer. They also discussed the need for better coordination within the CRC and the need for a staff member in the CRC who understands all of the services being used by a resident, including those delivered by NGOs and ensures that these are coordinated (in other words, uses a case management approach).

4.5   PERCEIVED EXTENT TO WHICH CRCS ARE FULFILLING RECOVERY GOAL

Both CRC staff and Key/Support Workers surveyed were asked to rate the extent to which the CRCs are fulfilling the goal of supporting the recovery from mental illness of people with high and complex needs.

✓   There was a trend for CRC staff surveyed to provide positive ratings with **58.1%** assessing the CRCs as 'very much' to 'extremely' successful in fulfilling the recovery goal.

By contrast **28.8%** of Key/Support Workers considered that this goal was 'very much' or 'extremely' well met and a further **23.5%** rated it as being 'somewhat' met.

Data from the CBIS/CCC systems also indicated that the CRCs are fulfilling the recovery goal for the majority of consumers. The total number of days spent by CRC consumers in inpatient facilities was significantly lower in the 6 months following their CRC stay compared with the 6 months prior to their CRC stay. There was also a large increase after CRC exit in the percentage of consumers using no (nil) inpatient services. Furthermore, nearly 62% of CRC consumers recorded an improvement in their health and functioning (based on Total HoNOS scores) between CRC entry and exit, 5.6% recorded no change in their Total HoNOS score, and 32.5% recorded a deterioration based on their Total HoNOS score. A quarter (25.4%) of consumers experienced a clinically significant improvement in their total HoNOS score (refer to *Section 6.8*).

4.6   UNDERSTANDING AND VALUING OF PROVIDER ROLES

4.6.1   CONFIDENCE IN UNDERSTANDING OF ROLE

✓   Most of the staff surveyed **(62.8%)** are 'very' to 'extremely' confident that they understand their specific role in the CRC. Only 9.3% expressed low levels of confidence.

Five staff identified the need for clearer delineation of the roles of CRWs and CSWs and the boundaries of those roles – particularly in relation to clinical staff roles and responsibilities/

> *'Regular training sessions would be very helpful. Also a clear delineation between the roles of CRWs and Clinicians so that the clinicians are aware of what CRWs can and can't do. Many Clinicians try and get the CRWs to do their work for them.'*

✓   Most Key/Support Workers **(64.4%)** were 'very' or 'extremely' confident that they understood their specific role in promoting the rehabilitation of consumers. Only one individual indicated they were not confident in understanding their role.

✓ **The evaluators note the high and positive level of agreement between both sets of stakeholders in their assessment of their understanding of their role in relation to the CRCs.**

Slightly less than ten per cent of CRC staff have provided negative ratings of their confidence in understanding their role, and while this is a relatively low proportion, CRC Managers should nevertheless identify and work with staff to ensure that those lacking this confidence are assisted to increase their understanding, and that staff have a shared understanding of their own role and the roles of their colleagues.

4.6.2 PERCEIVED VALUE OF ROLE BY OTHER STAFF AND MANAGEMENT

✓ The majority of staff surveyed **(60.4%)** perceive that their role is **'**very' or 'extremely' valued by other staff and management, with only 9.3% indicating that they felt their role was held in low regard by others.

Key/Support Workers were asked the degree to which they thought their specific role was valued by staff at the CRCs.

🏳 There was a diversity of perception here, with almost a quarter feeling 'slightly valued', another quarter feeling 'somewhat valued' and 21.7% feeling 'very much valued' by CRC staff. Nine respondents (13.0%) stated that they were 'not at all valued' and just one respondent felt 'extremely valued'.

✓ However, there is a strong endorsement of the Key/Support Worker role by CRC staff. This was regarded as 'Very important' by 65.2% of respondents and 'Extremely important' by a further 8.7%.

🏳 **The evaluators note that Key/Support Workers appear to feel less valued by CRC staff than they actually are. This needs to be addressed.**

Slightly less than ten per cent of CRC staff have provided negative ratings of their perceived value in the eyes of other staff and managers, and while this is a relatively low proportion, CRC Managers should nevertheless identify and work with staff to ensure that this is addressed.

There was no apparent difference between the perceptions of Community Key Workers and NGO Support Workers regarding the value placed on their role by CRC staff.

🏳 Many of the Key/Support Workers also identified the need for improved communication about roles, responsibilities and skills by all stakeholders – including themselves as well as government mental health agencies and NGOs in general.

See Recommendation 5, Section 5.2.2, for a suggested response to these issues.

5 IMPLEMENTATION OF THE CRC MODEL

5.1 DIFFERENCES IN PHYSICAL INFRASTRUCTURE

The CRC model's implementation is affected to some degree by physical infrastructure and differences were evident across the three sites.

Elpida CRC is located in a redeveloped old building which has imposed certain restrictions in terms of layout, and brings relatively high maintenance costs. The other two CRCs were purpose-built and comprise 7 separate units resembling community housing while Elpida is located within a single building structure. This makes client monitoring easier for Elpida staff but is less likely to resemble living in the community than a 'cluster' type of layout. The evaluators believe, and feedback supports this, that the purpose-built CRCs have a physical design that is more supportive of the underpinning principles of the CRC model and that this should be adhered to in any future expansion of CRC services.

Recommendation 4

It is recommended that any future expansion of CRC services use the physical design / purpose built principles applied to the Trevor Parry and Wondakka Community Rehabilitation Centres and incorporate any lessons learnt during the operation of these facilities.

5.2 PROCESSES AND PRACTICES ACROSS ALL 3 CRCS

5.2.1 THERAPEUTIC AND REHABILITATIVE INTERVENTIONS BEING APPLIED

CRC Managers report that a range of interventions are being applied, depending on individual client need. Interventions identified include assistance with housing, finding employment, shopping, cooking, cleaning, making and keeping appointments, medication management, socialisation, and any other actions indicated by the goals expressed in clients' care plans. The overall goal of the interventions applied is to develop the capacity for independent community living, and this is seen as requiring flexibility in determining what constitutes appropriate support. For example, if a goal is weight loss and fitness, attending a gym may form part of the care plan.

However, there is a lack of documentation regarding the range of interventions that could be applied, and this could be addressed in producing an agreed version of the service model. It may also be useful for staff to provide case studies exemplifying effective interventions and for these to be integrated into training and staff development.

Most interventions were described as being one on one and individualised, but some of those consulted believe there is scope to introduce some group work for clients with common needs and to enhance time-based efficiencies. The regional managers also support more group work as part of rehabilitation because of its potential benefits. They noted that mental health services have traditionally focussed on individual care and that the CRCs have highlighted the need for a better balance between individual and group work. Group work was also seen as supporting interactions from a community integration perspective.

Analysis of CBIS and CCC data shows that just under two thirds of all services provided by CRCs were classified as care and treatment services (61.6%), a further 28.7% were medication related services and 8.7% focussed on education or information.

In terms of the amount of time associated with each type of service, care and treatment services as a whole comprised 74.8% of total service delivery time. As would be expected, individual assessment/screening services (non-NOCC) tended to be the most time-intensive, and education/information and post discharge follow-up services were the least time intensive. Further details can be found in *Section 6.5.*

In terms of types of service, in an average month of stay each consumer will receive around 28 care and treatment services, 5 education/information services, 12 medication services, and one non-NOCC assessment/screening service – see *Section 6.5.*

Both carers and consumers have identified the need for more structured activities to alleviate boredom, indicating scope for collaboration with service providers outside of the mental health service system, for example, VET providers who can teach skills that assist re-entry to employment – including computer related skills. However, the evaluators recognise that the capacity to engage with structured activities of this nature will vary with consumer need and capacity. **Nevertheless, this is an issue which CRC managers and staff need to explore, based on feedback from consumers and carers –** see Recommendation 12, *Section 7.6.*

The evaluators' analysis of assessment data provided by occupational therapists at two of the CRCs indicates that around half of the consumers entering a CRC have some deficit in the skills required to live independently. However nearly a third of consumers entering a CRC did *not* have a measurable deficit in the motor and process skills required to carry out tasks relating to independent living. With the small number of cases where assessment had occurred on entry as well as part of a review several months later, the analysis identified a measurable improvement in motor skills associated with daily activity tasks.

Most consumers who had completed the self-assessed instrument to measure capacity for independent living scored around the midpoint of the Competence Measure, indicating that they perceived their ability to undertake activities of daily living as being only just adequate. This was a less positive assessment than the more objective test applied by occupational therapists. For a successful return to independent living, consumers require not only actual skills but confidence in their ability to use those skills consistently and effectively. This is why tools measuring the *consumer's* perception of their own competence are an essential companion to tools which assess competence objectively. Each type of assessment provides distinct but complementary information about functional ability.

5.2.2   PARTNERSHIPS AND WORKING RELATIONSHIPS

Partnerships and effective working relationships are critical to the capacity of the CRCs to receive and make appropriate referrals within the mental health sector and across a range of other sectors. The CRC service model supports a collaborative approach between CRC staff and consumers and carers, particularly in the care planning and review processes. It is also important that the CRCs have effective working links with other services in the SA mental health system, and particularly with Key Workers and Support Workers. The evaluation has focused particularly on the latter relationship, and survey findings about that relationship are mixed. As discussed in *Section 4.6.2*, there was a trend for CRC staff to regard these workers as valuable but those workers do not see themselves as being valued by CRC staff. Other findings that raise concern and indicate the need for specific strategies to enhance this relationship follow.

- Nearly half (47.8%) of the CRC staff considered Key/Support Workers only 'somewhat effective' in contributing to the overall rehabilitation process, and a further 21.7% provided essentially negative assessments. Only 26.0% were positive in their ratings ('very' or 'extremely' effective).

✓ By contrast, most Key/Support Workers felt their role was effective in contributing to the rehabilitation of consumers, with over half (56.1%) stating their role was 'very' or 'extremely' effective.

⚑ A number of Support Workers noted the need for respect for their positions and for the knowledge they possess about a client's wellbeing. They felt they had valuable non-clinical information to contribute regarding the functional status of their clients, but reported that the CRCs did not always consider this information to be important. The lack of CRC initiated contact regarding the client's status was seen as impeding their capacity to support consumers' transition back into community life.

⚑ The ratings indicate concern by CRC staff regarding the effectiveness of Key/Support Workers. However it should be noted that poor role delineation and communication difficulties have been cited by both CRC staff and Key/Support Workers. Amelioration of these systemic difficulties may support an increase in actual and perceived effectiveness of Key/Support Workers.

⚑ 43.5% of *CRC staff* surveyed believed that the Key/Support Workers role could be improved or enhanced, in particular by –

   ⚑ Increasing the frequency of contact and communication with residents and primary workers

   ⚑ Providing more training for them in rehabilitation

   ⚑ Improved coordinated planning

   ⚑ Ensuring consistency of Key/Support Workers

   ⚑ Broadening the role of the Key/Support Worker

⚑ 56.8% of *Key/Support Workers* felt their role could be enhanced, in particular by –

   ⚑ Improved collaboration and communication between stakeholders in the rehabilitation process, including ensuring that information about any changes that have occurred at the centres is disseminated to those outside of the CRCs

   ⚑ Improved or more frequent training and professional development

   ⚑ Delineated roles, policies and procedures for consistent service delivery

   ⚑ Greater support for the Key/Support Worker role

   ⚑ More frequent consumer contact.

The evaluators note that both groups have identified areas for enhancing the Key/Support Worker role but the only strategies which they both suggest relate to –

⚑ Increasing the amount of contact with consumers, or at least better tailoring the amount of contact to the changing needs of consumers

⚑ providing Key/Support Workers with more training, particularly in relation to rehabilitation.

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Recommendation 5

It is recommended that the Adelaide Health Service CRC Project Implementation Committee (AHS CRC PIC) and the Mental Health Unit ensure that partnership arrangements between service providers are clear and consistent by clarifying relative roles and responsibilities and developing agreed communication processes. It is expected that AHS PIC will develop operational protocols regarding partnership with stakeholders which will apply across all 3 CRCs.

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The 2010-2011 South Australian State budget proposed to transfer day to day CRC management and provision of psychosocial rehabilitation services to the non government organisation (NGO) sector by 2012/13. This will occur after a procurement process. Clinical mental health services will continue to be provided by publicly funded mental health services.

It is not clear to the evaluators why such a significant change to the nature of CRC management and service delivery has been initiated as a budgetary measure, and prior to this independent evaluation being completed, but it nevertheless underscores the need for CRCs to address the issues identified in **Recommendation 5.** Additional discussion on challenges associated with CRC partnerships is contained in *Section 7.6,* and includes a suggested strategy for structuring working relationships with NGO service providers while enhancing current activities provided for consumers – see **Recommendation 12.**

5.3   STAFF TRAINING AND PREPARATION

In response to a question seeking information about rehabilitation training provided during induction to the CRC, 53.5% of CRC staff indicated that they had received such training at this time while 41.9% indicated that this had not been provided.

⚐   Given the rehabilitation focus of CRCs this is a concern that needs to be addressed.

Respondents were asked to provide feedback about other rehabilitation- focused training received during their employment at the CRC. Staff survey findings indicate that only **58.1%** have received this training and that the remaining **41.9%** had not been provided with this training.

⚐   Again, this is very concerning and needs to be addressed.

✓   By contrast, 74.2% of Key/Support Workers surveyed indicated that they had received rehabilitation focused training.

⚐   Given the rehabilitation focus of CRCs the relatively lower rate of training for CRC staff is a concern that needs to be addressed. However, the evaluators note that the term 'rehabilitation training' was not defined in the survey and therefore respondents may be reflecting different perceptions of this term in their ratings.

✓   Most of the 23 CRC staff who received this training rated it positively, with 65.2% regarding it as 'very' or 'extremely' adequate.

✓   Similarly, most of the 25 CRC staff who received training during the course of their employment rated it positively, but less positively than that provided during induction.

✓ Most of the 98 Key/Support Workers who had received this training rated it positively, with 69.3% regarding it as 'very' or 'extremely' adequate.

✓ When rehabilitation focused training has been provided it is valued by most, in both groups of stakeholders.

These findings indicate that CRC staff and Key/Support Workers are satisfied with the induction and subsequent training they receive, but that this training is not being provided to all workers, and this raises serious concerns about consistency in capacity and ensuring rehabilitation expertise that fulfils the requirements of the CRC model.

The evaluators are recommending that a dedicated staff development budget is developed for all CRCs that includes provision of backfill to enable staff participation in training, and that supports consistent and evidence-based a) generic psychosocial training and b) clinical rehabilitation-focused training, applied at induction and at agreed intervals thereafter for CRC staff, Community Key Workers and NGO Support Workers. This should be part of a planned approach to training based on consultation with Key Workers, NGO Support Workers and CRC staff and managers. It could be operationalised through an annual Staff Training Calendar, the costs of which would be shared across CRCs, hopefully achieving efficiencies in resource allocation for training and staff development. It is envisaged that all three groups of workers would be able to participate in the same training program. The new partnership arrangements with the NGO sector, discussed above in *Section 5.2.2* would be strengthened by such an arrangement, as would the implementation of the two new rural CRCs (see *Section 7.4.1*).

Recommendation 6

It is recommended that a consistent and evidence-based rehabilitation focused training program is developed for all CRC staff and Key Workers and Support Workers, and contains both induction and ongoing training. This program would build on existing training activities and be applied consistently across all CRCs, and its design would be based on consultation with CRC staff, Key Workers and Support Workers. It would be supported by a dedicated staff development budget that includes provision of backfill for staff participating in training.

5.4   STAFF ALLOCATION, SUPERVISION & SUPPORT

5.4.1   PERCEIVED EFFECTIVENESS OF CURRENT RESOURCE ALLOCATION FOR STAFFING

While the majority of CRC staff surveyed regard the current mixture of staff types and disciplines as being optimal, most do not believe there are sufficient staff to meet demand.

⚐ Slightly more than half of CRC staff surveyed perceived that current allocation of resources for staffing was less than optimal (52.4% of responses), while 45.2% regard the allocation as appropriate.

Additional comments provided identified –

⚐ shortages of staff generally and in relation to specific professions (limiting the capacity to provide rehabilitation)

⚑ the need for backfill staff to cover those absent on leave, particularly sick leave (noting that some of those commenting on rostering processes perceive a link between shift work and increased sick leave among staff).

'Need provisions for backfill when staff on ARL. I suggest creating a couple of backfill positions to work across all sites, covering ARL and long term sick leave or position vacancies. Agency staff are not useful as backfill because they are not rehab trained.'

✓ CRC staff surveyed were asked if they regard the current *mixture of staff types and disciplines* as optimal, and 60.5% believe that this is the case, while 27.9% do not hold this view.

5.4.2 PERCEIVED ADEQUACY OF SUPERVISION, GUIDANCE AND PROCEDURES

CRC staff surveyed were asked to rate the adequacy of supervision, guidance and operational procedures and policies in assisting staff to undertake their defined work role. The average ratings indicate that CRC employees find the level of supervision, guidance and support to be *somewhat adequate* - see *Figure 7.*

⚑ **This indicates scope for improvement in these three areas, although the documentation of the service model will provide clarity about operational procedures and policies. It will be important for CRC Managers to seek further feedback from their staff about ways in which supervision and guidance can be improved.**

Figure 7: Average ratings of perceived value of supervision, guidance and procedures
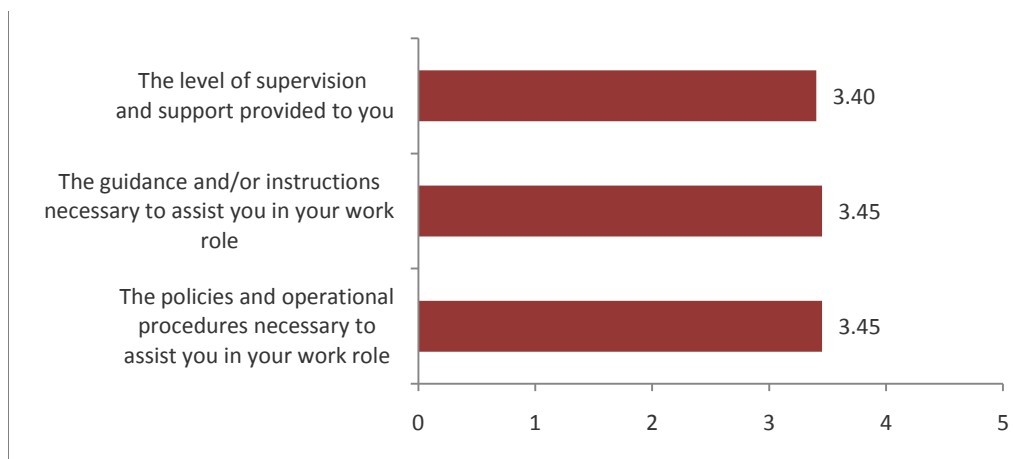
5.4.3 PERCEIVED EFFECTIVENESS OF CRC TEAM WORK

'All I can say is I feel CRCs are filling a major need to consumers and I am very happy to be part of a team at a CRC, and feel it is an important role.' (CRC staff member)

✓ CRC team work was rated positively by most staff, with 58.2% of survey respondents perceiving this to be 'very' to 'extremely' effective. Only 9.4% provided negative ratings. *Figure 8* provides details.

Figure 8: Perceived effectiveness of CRC team work
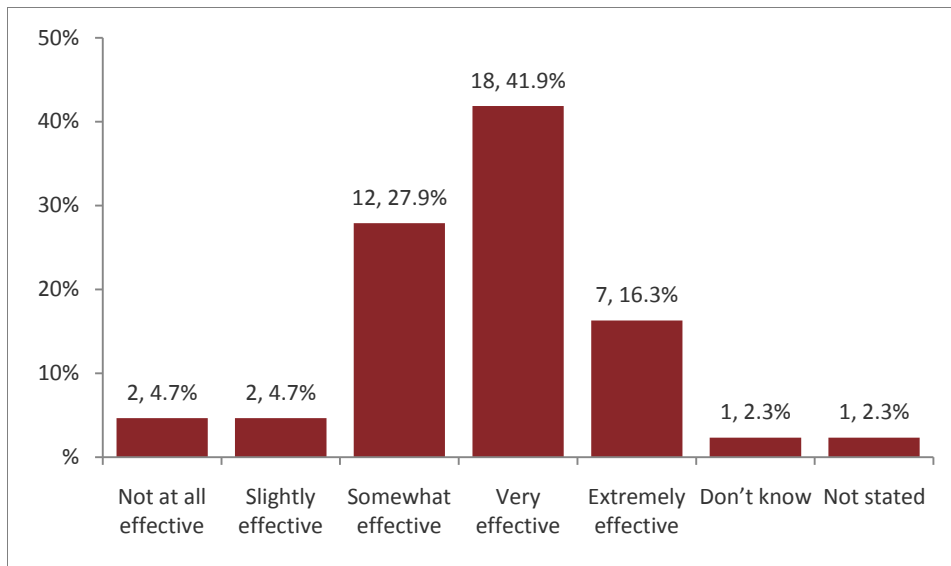
'The team here is great we all work together for the best outcome. Even if the manager is short staffed will support a resident in an appointment or cleaning or anything. We all value each other's role.'

5.5 ASSESSMENT OF GOVERNANCE ARRANGEMENTS

REVIEW REQUIREMENT: Assess the extent to which the governance arrangements for the program promote effective work practices and facilitate desired outcomes

At the time of the evaluation, the CRCs did not have individual management committees and the CRC Steering Committee was created as a forum to bring them together. The Steering Committee was guided by this Aim and accompanying Objective –

Aim: *'to ensure the development of a consistent, statewide service model for CRCs, informing operational procedures and protocols for SA.'*

Objective: *'to utilise expert advice and input to ensure that service modelling is congruent with planning for the operation and implementation of CRCs in South Australia, within the context of SA mental health services.'*

The Committee had these five expected outcomes as its terms of reference:

1. The establishment of a service model that ensures continuity of care and enhanced outcomes for consumers.

2. Development of operational procedures aiming for a high degree of consistency across the CRC sites.

3. A service model which sits in context with other components of the mental health service.

4. Supported continued development and evolution of the CRC service model.

5. Supporting and engaging with evaluation of the CRC service model.

The evaluators had previously expressed concern about the absence of a formal link between the CRC Steering Committee and the Mental Health Unit. There was no formal requirement for the Manager of Rehabilitation and Recovery Services to be a representative; instead she has been co-opted.

However, restructuring in the metropolitan region has brought the two metropolitan regions together and in the process supported the CRCs being considered as an integrated program. Governance of the CRCs has become clearer and the evaluators understand that there is now a formal link between the Mental Health Unit and AHS. This is a positive outcome.

A second governance issue arises from the recently announced shift to a partnership model with NGOs. It will be important as the CRC model changes to a partnership with NGOs that governance remains clear.

Finally, with the recent announcement of the establishment of two new CRCs in rural locations, it will be important as the CRC Program expands to include CRCs in Country SA that governance is clear and that there are connections with the metropolitan CRCs to ensure a common service model and to support peer learning across CRCs – see **Recommendation 7**.

Recommendation 7

It is recommended that metropolitan CRCs and Country CRCs collaborate to ensure that there is consistency in the application of the underpinning service model.

5.6 ANALYSIS OF BUDGET ARRANGEMENTS

REVIEW REQUIREMENT: Analysis of Budget arrangements - based on an overview of relevant documentation and on interviews with service managers, identifying the degree to which individual CRCs have been operating within or out of budget, and reasons for this.

It is the evaluators' understanding that all three CRCs were allocated the same budget, given they provide the same number of places (20 each).

⚐ It is difficult to understand then, why this has not occurred in practice, with a significant disparity between the budgets of Elpida and Wondakka (which had been part of the former CNAHS region) and that of Trevor Parry (which had been part of the former SAHS region).

In the financial year 2009/10, Elpida House expended $1.716 million while Wondakka expended $1.6million. Trevor Parry expended $2.083 million.

As the bulk of the CRCs' budget is allocated to staffing, it is evident in *Table 3* that inequitable budget provision (as opposed to allocation) is reflected in different staff resources. Trevor Parry has been operating with the equivalent of 28.53 FTE positions while the other two CRCs have been operating with 20.2 FTE positions. This is mainly due to the provision at Trevor Parry for backfilling of staff which is not provided at the other two CRCs.

It is assumed that this is due to the lower budget provisions of these two CRCs. **The implications of this disparity in terms of equity for consumers, and burden for staff are of significant concern.**

Table 3: Staff resources across the 3 CRCs

Category	Classification	Position	Elpida	Wondakka	Trevor Parry
Admin	AS02	Admin Support Officer	1.00	1.00	1.08
Allied Health	PO02/AHP2	Clinical Psychologist	0.80	0.80	1.08
	PO02/AHP2	Occupational Therapist	2.00	2.00	2.48
	PO02/AHP2	Social Worker	1.00	1.00	1.24
	PO04/AHP4	Manager	1.00	1.00	1.08
Nursing	RN1	Registered Nurse	2.00	2.00	
	RN2	CN	3.00	3.00	
Operational Services	OPS2	Community Rehab Worker	8.40	8.40	12.29
	OPS2	Consumer Specialist Worker	1.00	1.00	1.08
Other	RNO2	Assoc Clinical Services Coordinator			6.29
	MD02	Salaried Medical Officer			1.05
	WHA3	Patient Service Assistants			0.86
Total			**20.20**	**20.20**	**28.53**

The evaluators' consultation with key stakeholders identified the potentially useful collection of data relating to hospitalisation (eg 6 months prior) and in particular Emergency Department (ED) presentations, before and during residency. The CBIS does not collect ED presentations and does not collect prior hospitalisation unless the person is a prior mental health client. However, progress with data linkage may address this gap in data collection.

SA Health stores information about Community Mental Health consumers, and the services they receive, in the CBIS system (for metropolitan-based services) and the CCC system (for country-based services).

A significant time investment was required by the Evaluators and by SA Health to identify and obtain relevant data for the Evaluation from these systems. This process began in February 2010 and ended with receipt of the final pieces of information (CCC data) at the end of February 2011.

The key file from which CRC consumers were identified was extracted by SA Health on 15th September 2010. This means that the scope of the analysis is the **238** consumers who had entered a CRC at some time up to 15th September 2010.

A total of nineteen separate datasets were supplied from CBIS. Together these datasets covered all domains relevant to the evaluation –

> ➢ Community residential episodes
> ➢ Ambulatory episodes
> ➢ Inpatient episodes
> ➢ Consumer details (i.e. demographics)
> ➢ Legal orders
> ➢ Care plans
> ➢ Services/contacts
> ➢ NOCC scores.

In undertaking statistical comparisons, non normality of distributions and inequality of variances meant that non parametric tests provided the most valid and reliable means of determining statistical significance. Tests used included the Chi-square test, Kruskal Wallis test and Mann Whitney test.

Results from the analyses were compared where appropriate with other published information from various sources such as the Australian Institute of Health and Welfare, the South Australian Social Inclusion Board, and The University of Adelaide (Social Health Atlases).

6.1   FINDINGS RELATING TO CONSUMER PROFILE

6.1.1   AGE AND GENDER

The age profile shows that CRCs provided a service to mostly younger adults. Almost half (48.7%) of all consumers were aged less than 30 years at the commencement of their first CRC stay. A further 29.5% were aged in their thirties and 15.5% were in their forties. Only twelve consumers in their fifties and two consumers aged 60+ utilised a CRC. The average age was **32.1 years.**

The Trevor Parry Centre has the youngest age profile of the CRCs, while Elpida House has the oldest profile. On average the age of consumers who attended the Trevor Parry Centre is around 5 years younger than for Elpida House and around 4 years younger than for Wondakka. The significantly younger age profile of consumers attending the Trevor Parry Centre is most likely to be a consequence of the younger age profile of people residing in the Southern Adelaide region (Glover *et al*, 2006).

Around three quarters (74.8%) of these consumers were **male**. The age profile of male and female consumers using the service was very similar.

The proportion of consumers who were female ranged from 19.0% at Elpida House to 35.5% at Wondakka.

The age profile of CRC consumers appears somewhat **younger** than the wider group of all adult Community Mental Health consumers. According to the SA Social Inclusion Board (2007), 66% of adult Community Mental Health consumers are aged under 44 years, however 86% of CRC consumers were aged 44 or under. In addition, female consumers appear to be relatively underrepresented in CRCs (25%) compared with all adult Community Mental Health consumers (44%) as reported by the Social Inclusion Board.

These demographic characteristics may at least in part be a reflection of the diagnostic profile of CRC consumers (see *Section 6.2*), which shows a predominance of schizophrenia and related illnesses, but also may reflect an appropriate targeting of younger consumers relatively early in the course of their illness.

6.1.2 CULTURAL DIVERSITY

➢ Eleven consumers (4.6%) identified themselves as being of Aboriginal or Torres Strait origin.

➢ Only three consumers (1.3%) spoke a language other than English. The languages identified were Italian and Chinese.

➢ Nearly 90% of CRC consumers were born in Australia or New Zealand (2 consumers), with almost all of the remainder born in Europe or Asia. The ethnicity stated by consumers essentially mirrored the birthplace results.

Indigenous status, language, birthplace and ethnicity profiles did not differ significantly between CRCs.

The issue of cultural diversity has already been identified in findings from the evaluation surveys and stakeholder interviews. Overall there appears to be less cultural diversity among CRC consumers compared with the wider group of adult Community Mental Health consumers, according to statistics presented by the Social Inclusion Board (2007). For example, data sourced by the Board indicated that 9% of mental health consumers are Aboriginal, as compared to less than 5% of CRC consumers. However, in terms of representativeness among the wider South Australian population, the proportion of Aboriginal consumers is over-represented.

6.1.3 LOCATION

The majority (**88.7%**) of CRC consumers reside in the **metropolitan** area (defined as the Adelaide Statistical Division) and 7.9% reside outside the metropolitan area, with 3.4% unable to be coded to a location due to missing postcode information –which may indicate a lack of permanent address.

Of those residing outside of the metropolitan ("Major City") area, 4.6% of CRC consumers reside in an Inner Regional Area (11 consumers), 2.1% (5 consumers) in an Outer Regional Area, and only 1.3% (3 consumers) in a Remote Area, according to their postcode – see *Figure 9.*

Figure 9: Remoteness Area of CRC consumer residence
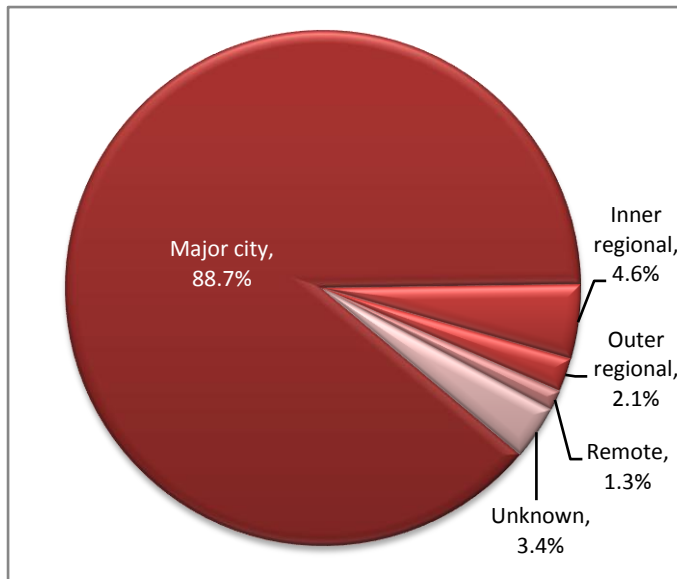
The slight difference across CRCs in the proportions of consumers residing outside of the metropolitan area was not statistically significant.

With an estimated 25% of all SA Community Mental Health clients residing in country areas (according to the Social Inclusion Board, 2007), these results illustrate the barrier that people from regional, rural and remote areas face in accessing a metropolitan-based CRC service.

6.2   FINDINGS RELATING TO DIAGNOSTIC PROFILE

6.2.1   PRIMARY DIAGNOSIS

Analysis of consumers' primary diagnosis, as recorded at their first CRC stay, revealed that the vast majority of CRC consumers (80.3%) had been diagnosed primarily with *a schizophrenic, schizotypal or delusional disorder*. This was followed by *mood (affective) disorders* (12.2%)

The diagnostic profile of consumers did not differ significantly between CRCs.

For the 24 consumers with more than one CRC stay, primary diagnosis was mostly stable across subsequent CRC episodes - see *Figure 10.*

Figure 10: Primary diagnostic profile of CRC consumers – ICD-10 blocks
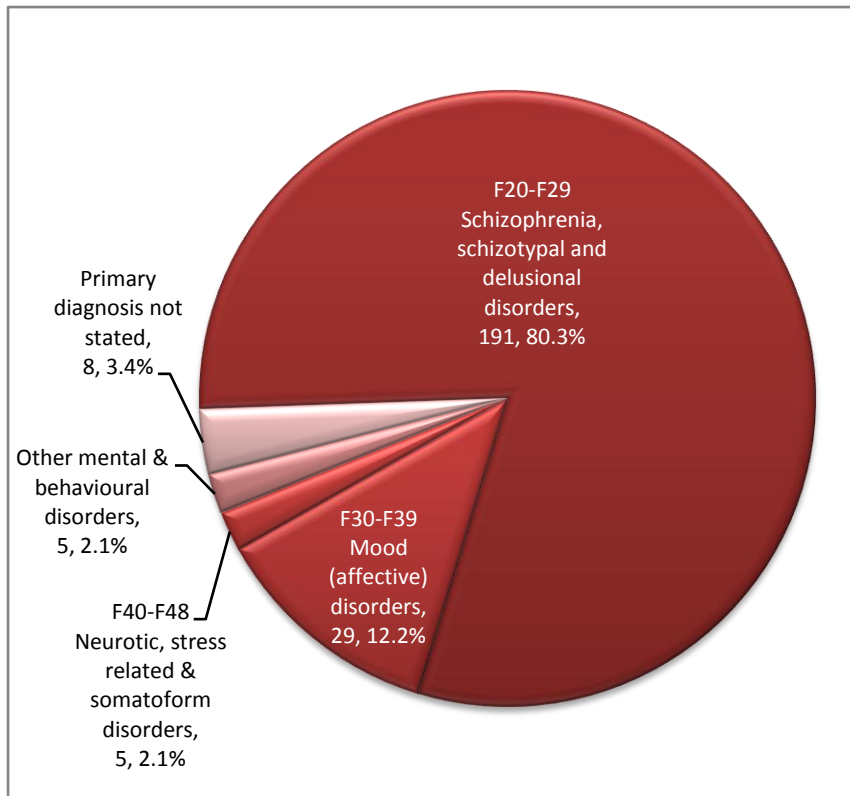
6.2.2   CO-MORBIDITIES

6.2.2.1   SECONDARY DIAGNOSIS

The most common secondary diagnoses recorded for CRC consumers were *neurotic, stress-related and somatoform disorders* (21.3% of secondary diagnoses) and *mental and behavioural disorders due to psychoactive substance use* (14.8% secondary diagnoses) – see *Figure 11.*

Figure 11: Secondary diagnoses recorded for CRC consumers
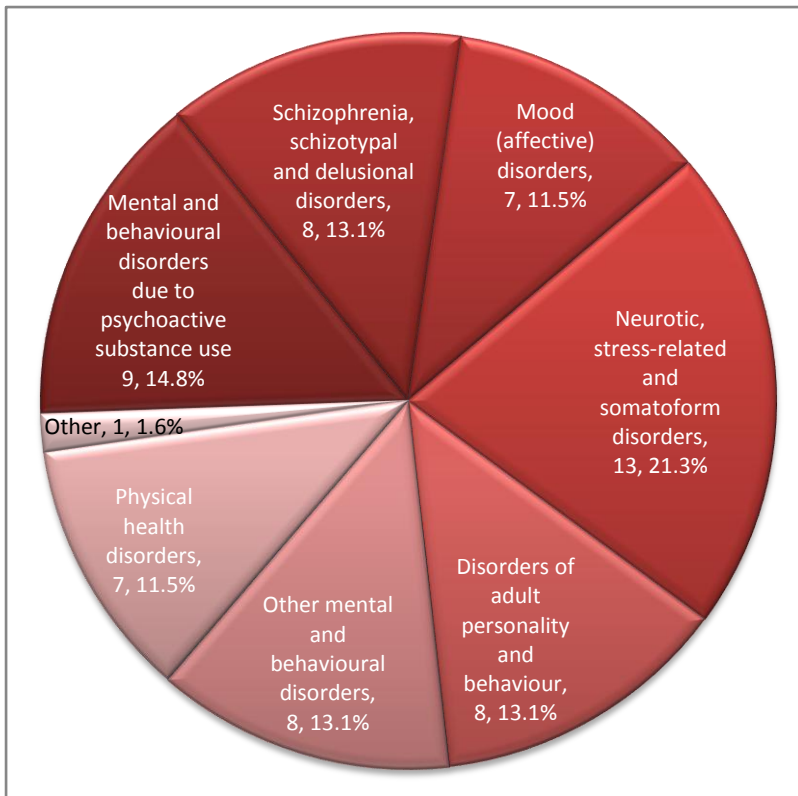
6.2.2.2   CO-MORBIDITY RATES

A quarter (25.2%) of the 230 consumers with a stated primary diagnosis had at least one secondary diagnosis. Overall, 5.7% of the 230 consumers with a stated primary diagnosis had a comorbid *neurotic, stress-related or somatoform disorder,* and 3.9% had a comorbid *mental or behavioural disorder due to psychoactive substance use* – see *Figure 12.* These comorbidity rates are consistent with Australian mental health comorbidity data (AIHW, 2005).

Figure 12: Comorbidity rates for consumers with a stated primary diagnosis

Disorder	Rate
Neurotic, stress-related and somatoform disorders	5.7%
Mental & behav disorders due to substance use	3.9%
Disorders of adult personality and behaviour	3.5%
Schizophrenia, schizotypal and delusional disorders	3.5%
Mood (affective) disorders	3.0%
Disorders of psychological development	1.7%
Diabetes mellitus	1.3%
Organic, including symptomatic, mental disorders	0.9%
Episodic and paroxysmal disorders (e.g. epilepsy)	0.9%
Behav & emotional disorders onset in childhd/adoles	0.4%
Mental retardation	0.4%
Obesity and other hyperalimentation	0.4%
Disorders of the thyroid gland	0.4%
Potential hazards re circumstances (e.g. psychosocial)	0.4%

6.2.3   MENTAL HEALTH LEGAL STATUS

According to the CBIS data, a small number of CRC consumers (17, 7.1%) were classified as involuntary clients at the time of their CRC episode. There were no notable demographic or diagnostic characteristics of this group when compared with voluntary CRC clients.

6.3   FINDINGS RELATING TO CRC EPISODE PROFILE

CRC episodes are discrete stays at a CRC. They comprise the consumer's entire stay, including any days of leave taken during the stay. The entry date is first day of the consumer's stay, and the exit date is the last day of the consumer's stay.

Analysis of data was undertaken to generate a profile of CRC episodes covering –

> ➢ number of episodes per consumer and per CRC,
> ➢ a snapshot of occupancy rates at the time of data extraction,
> ➢ sources of referral to the CRCs,
> ➢ reasons for exit from the CRC,
> ➢ exit destination,
> ➢ length of episodes, including and excluding leave days, and
> ➢ services provided at the CRCs.

Where relevant, differences between the CRCs and differences between particular consumer groups were also examined.

6.3.1   CRC EPISODES PER CONSUMER

A total of 238 consumers had entered a CRC at some time up to 15th September 2010. Twenty four consumers (10.1%) had more than one CRC stay over the reference period, and three of those (1.3% of all CRC consumers) had attended more than one CRC. Number of CRC stays per consumer is shown in *Figure 13*. This illustrates that 21 consumers (8.8%) had two stays, however more than two stays was a rare occurrence.

Figure 13: Number of CRC stays per consumer
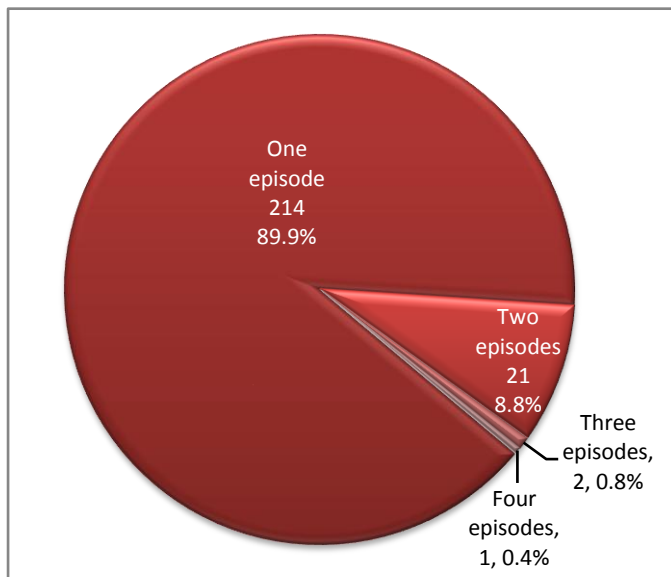
These additional stays meant that the total number of CRC episodes which commenced up to 15th September 2010 (when the data was extracted) was **266**.

6.3.2   NUMBER OF EPISODES PER CRC

Episodes at Elpida House comprised nearly half (47.4%) of all CRC episodes in scope, due at least in part to its earlier commencement date (June 2007). The Trevor Parry Centre and Wondakka started later – December 2007 and July 2008 respectively – and this is reflected in the proportion of CRC episodes at those locations – see *Figure 14*.

Figure 14: Number of episodes per CRC
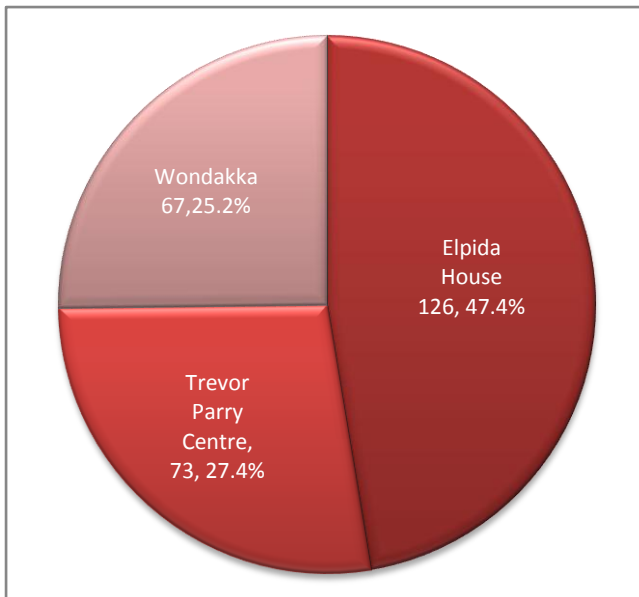
6.3.3   SNAPSHOT OF OCCUPANCY RATES

At the time that the data were extracted 216 episodes had been completed (closed) and 50 were still open, meaning that there were a total of **50** consumers in CRCs at that time. These 50 consumers were spread evenly across the CRCs, with 16 consumers at Elpida House and Trevor Parry Centre, and 18 consumers at Wondakka.

Assuming that each CRC has a total capacity of 20 places each, the occupancy rates at this time appear to have been **80-90%.** Note that a certain number of places may be held at any one time for clients who have just exited, or for new clients who are expected to arrive.

6.3.4   LENGTH OF EPISODES

The length of CRC episodes, based on total number of days between entry and exit dates, was examined for the 216 episodes which had been closed. Around **60%** of those episodes had been completed **within six months**, with **29.6%** completed **within three months**. Most of the remainder had ended within twelve months, with only 6.5% of episodes extending past one year - see *Figure 15.*

The **average** length of completed CRC episodes was **169.4 days**, which equates to between five and six months. "Around six months" is the generally accepted target for length of stay at a CRC. **Median** length of episode was less than 5 months at **140.5 days**, which is a reflection of the skewed distribution of this data.

Length of episode was examined against key consumer related variables such as sex, age, location and diagnostic group. No significant differences were found.

Figure 15: Length of closed episodes – broad categories
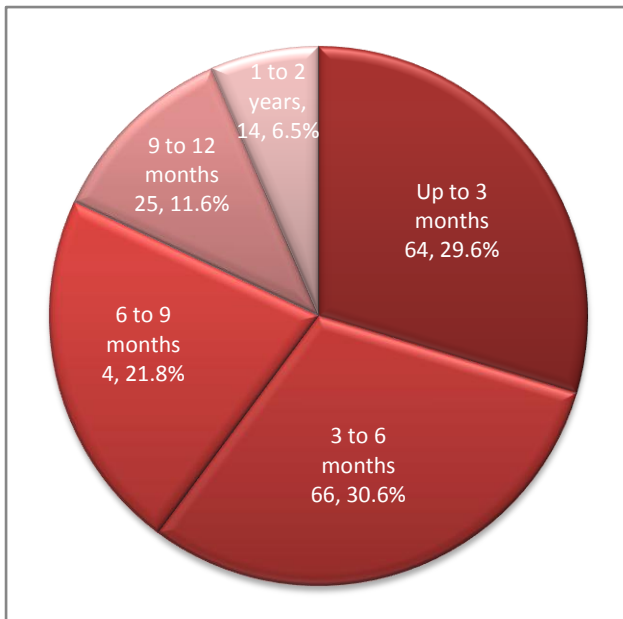
6.3.4.1 LENGTH OF EPISODES BY CRC

Figure 16 illustrates the mean and median length of stay for consumers at each of the three CRCs. While episodes at Elpida House appear to be somewhat shorter than at the other two CRCs, differences were not statistically significant.

Figure 16: Length of closed episodes by CRC – mean and median days
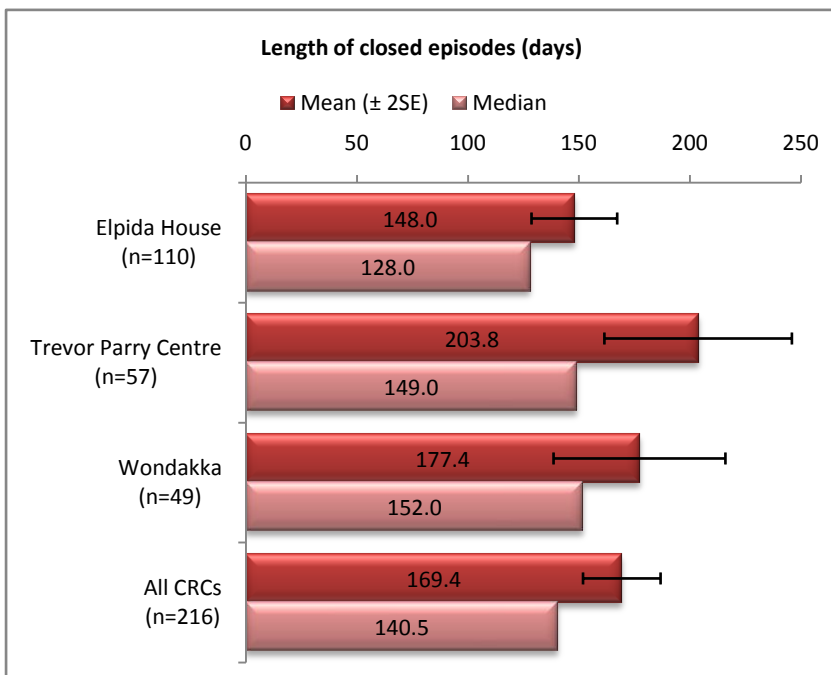
6.3.5 LEAVE

Some consumers take leave from the CRC during their stay, for example as part of their transition to home. According to the data, only nineteen consumers (8.0%) took leave while at a CRC. There were no particular consumer characteristics associated with the use of leave.

In terms of episodes, leave occurred within only nineteen (7.1%) of all CRC episodes. All of those episodes had been closed. The number of leave days taken during a CRC episode ranged from 2 days to 120 days. The amount of leave taken represented anywhere from 1% of the total length of episode (e.g. 4 days leave out of a total stay of 277 days) up to 51% of the total length of the episode (e.g. 120 days out of a total stay of 236 days).

6.3.6 LENGTH OF STAY EXCLUDING LEAVE, BY CRC

When leave days were excluded from the total length of closed episode, the **mean** and **median** length of stay dropped slightly to **167.4 days** (from 169.4 days) and **135.0 days** (from 140.5 days) respectively. Differences between CRCs were not statistically significant. See *Table 4* for statistics.

Table 4: Statistics for length of stay in days (length of closed episode excluding leave days), by CRC

	N	Mean	Standard error of mean	Median	Minimum	Maximum
Elpida House	110	144.4	9.5	123.5	0	460
Trevor Parry Centre	57	203.8	21.1	149.0	11	675
Wondakka	49	176.7	19.4	152.0	6	691
Total	**216**	**167.4**	**8.7**	**135.0**	**0**	**691**

6.4 FINDINGS RELATING TO REFERRALS AND EXITS

6.4.1 REFERRAL SOURCES

The main source of referral into the CRCs was the Community Mental Health Service's CT/CCT/MACS teams. Referrals from this source comprised **52.6%** of the referrals which resulted in CRC episodes. Most of the remaining episodes had been initiated by referral from a mental health inpatient facility (13.5%), a psychiatric/mental health service facility (10.2%) or a General Practitioner (8.3%). *Figure 17* presents these findings.

Figure 17: Main sources of referral to CRCs
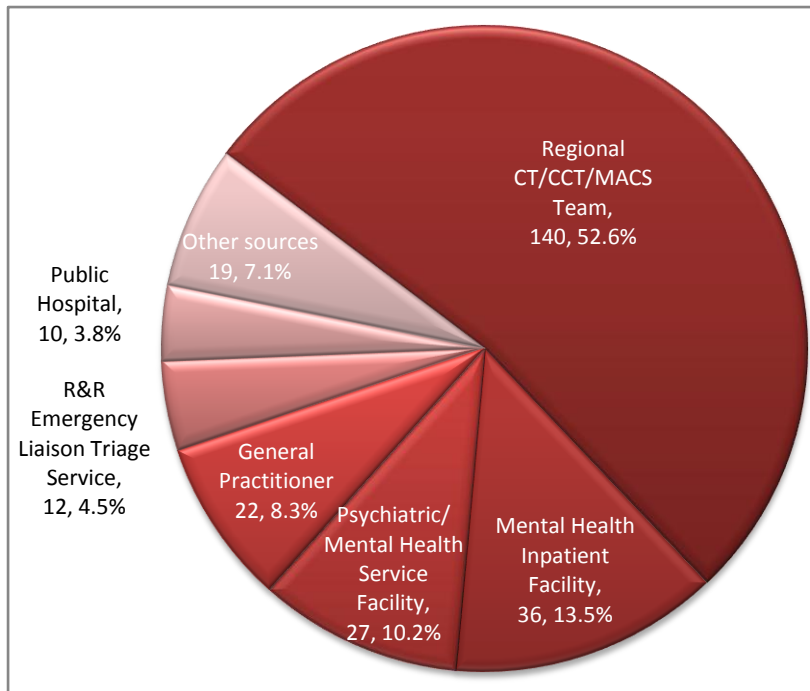
6.4.1.1 REFERRAL SOURCES BY CRC

Main referral sources differed somewhat across CRCs, as illustrated by Figure 18. Over three quarters (76.7%) of referrals to Trevor Parry Centre came from CT/CCT/MACS teams, compared to 53.7% of referrals to Wondakka and 38.1% of referrals to Elpida House. Referrals from Psychiatric/Mental Health Service Facilities comprised 17.5% of referrals to Elpida House, but only 2.7% and 4.5% respectively for Trevor Parry Centre and Wondakka. Elpida House was the only CRC to record referrals from General Practitioners (17.5%).

Figure 18: Referral source, by CRC
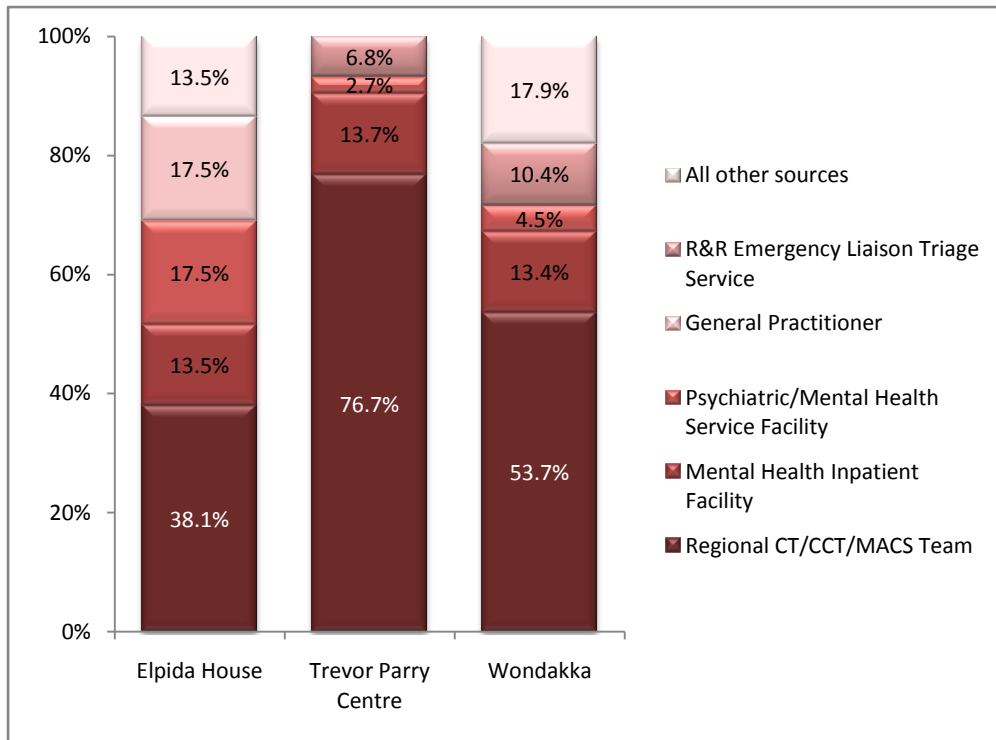
With its predominance of referrals from CT/CCT/MACS teams, the referral profile for Trevor Parry House differed significantly to that for Elpida House and Wondakka (p<.05).

6.4.2   EXIT REASON

The data on reason for exit indicated that most of the 216 CRC consumers who exited the service had a **planned** exit. It was unusual for consumers to leave against clinical advice (8 consumers, 3.7%) – see *Figure 19.* One of the consumers who left against clinical advice returned some months later for a second stay at the same CRC, however none of the others returned.

Figure 19: Reason for exit from CRC
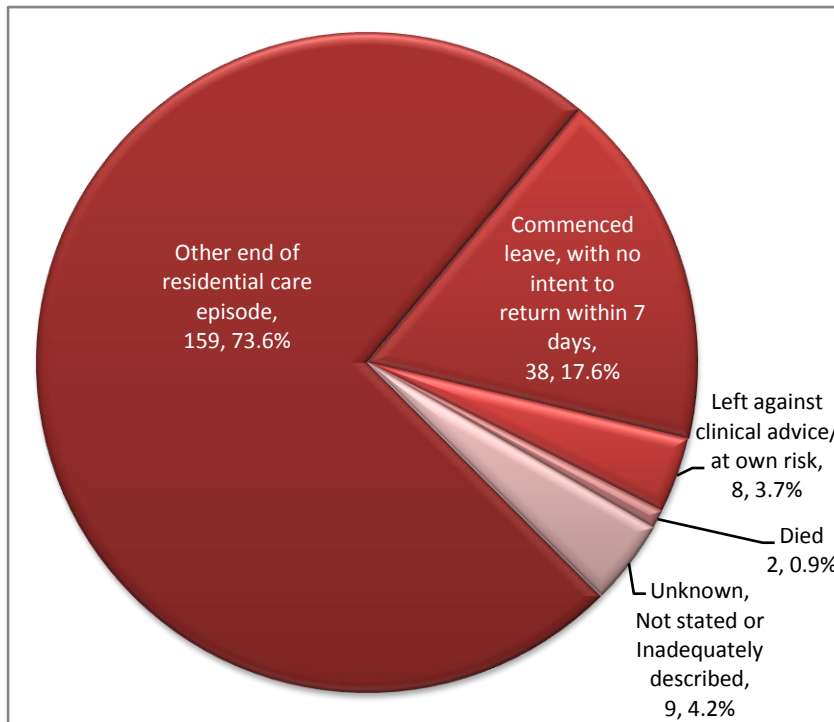
6.4.3 EXIT DESTINATION

As *Figure 20* illustrates, upon exit from the CRC most consumers (68.1%) were referred to the ambulatory mental health service, which presumably comprises the local CT/CCT/MACS teams in the region of their residence. A small number of consumers exited the CRC to enter either specialised mental health inpatient care (5.6%) or a specialised residential mental health care facility (3.7%) – these exits would reflect acute or chronic needs which could not be managed appropriately in the CRC environment. Other exit destinations included private psychiatry, GP and other care.

Only 3.7% of consumers were coded as having *not* been referred to any other service upon their exit from the CRC. However in practice this figure may be somewhat higher considering the 9.3% of consumers for whom information on exit destination was not provided.

Figure 20: Referral destination after exit from CRC
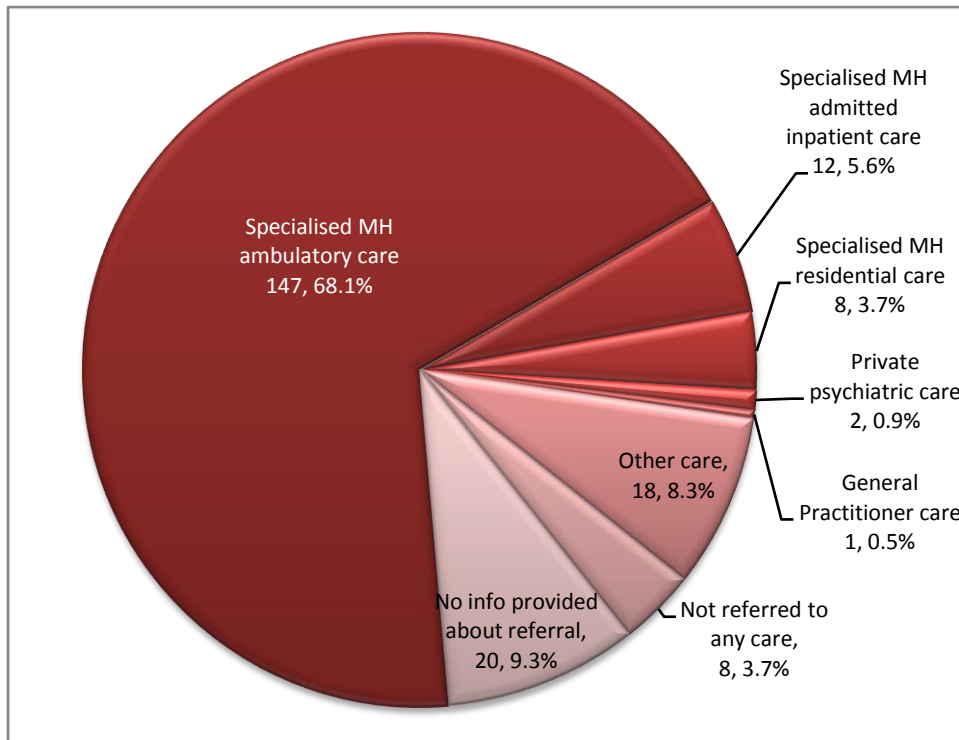
Exit destinations were essentially the same no matter what the original source of referral or the stated reason for exit – the majority of consumers were referred to mental health ambulatory teams upon exiting the CRC.

However there were significant differences (p<.05) between CRCs in terms of the proportion referred to specialised ambulatory mental health care. As *Figure 21* shows, 93.0% of consumers exiting the Trevor Parry Centre were referred to a mental health ambulatory care team, compared with 73.5% from Wondakka and only 52.7% from Elpida House.

Figure 21: Exit destination by CRC

Legend:
- Not referred / No information provided about referral
- Other Care
- Private psychiatric or GP care
- Specialised MH residential care
- Specialised MH admitted inpatient care
- Specialised MH ambulatory care
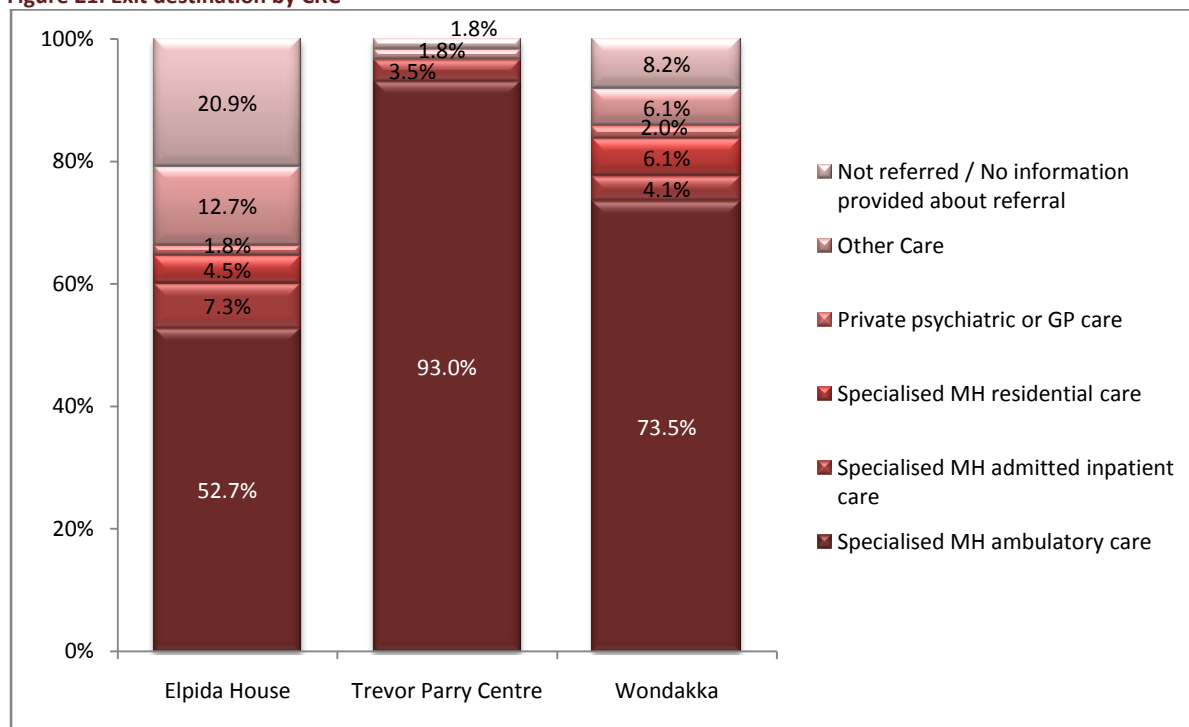
6.5   FINDINGS RELATING TO SERVICES PROVIDED BY CRC TEAMS

6.5.1   NUMBER OF APPLICABLE EPISODES AND SERVICES

This analysis of services involves CRC episodes which had closed **on or before 31st March 2010**, as the Evaluators were provided with a CRC services dataset which extended to 31st March 2010 only. Looking at *closed episodes* allows us to gain the most accurate picture of the number and frequency of services provided within entire episodes.

All types of service provided by the CRCs were included in the analysis, with the exception of NOCC assessments, which are examined separately in relation to Outcomes achieved. Of the 180 episodes which had ended by 31st March 2010, **158** had at least one non-NOCC service.

For these 158 closed episodes, a total of 25,798 non-NOCC services to CRC consumers were reported by CRC teams. Services provided within episodes that were still *open* on 31st March 2010 are not included in this total, therefore the overall service output over the period studied will be higher than this figure.

6.5.2   NUMBER OF SERVICES PROVIDED BY EACH CRC

Of the 25,798 services provided by CRCs to 31st March 2010, 72.9% were provided by Elpida House. Most of the remainder (26.7%) were provided by Wondakka, and only a very small number of services in this dataset had been provided by the Trevor Parry Centre.

The data were carefully examined at both unit record level and aggregate level in an attempt to ascertain potential reasons for Trevor Parry Centre's marked underrepresentation in the service data. Around half of all applicable episodes at Trevor Parry Centre had no service occasions reported, and the Trevor Parry episodes which *did* have service occasions had an average of only 3.9 services attributed to them. In contrast, 100% of

episodes at Elpida House and Wondakka had service occasions reported, and the average number of services per episode was 193.9 and 186.5 respectively.

We know that there must have been services provided by Trevor Parry Centre, but based on the data supplied to us these do not appear to have been recorded in CBIS.

6.5.3   MODE OF SERVICE

According to the data available, the majority of services (86.0%) provided by CRCs were face to face services – see *Figure 22*.

Figure 22: Mode of services provided by CRC teams
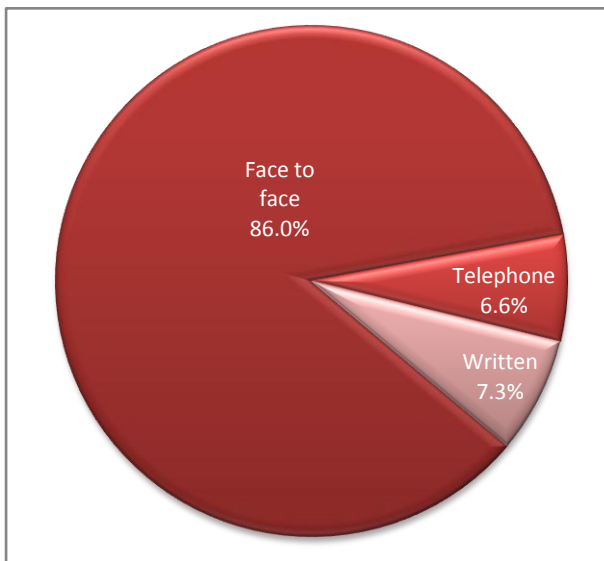
In terms of the amount of time associated with different modes of service, face to face contact comprised 88.8% of total service delivery time – see Figure *23*. As would be expected, telephone contacts were of shorter duration than other modes.

Figure 23: Proportion of total service delivery time associated with modes of service
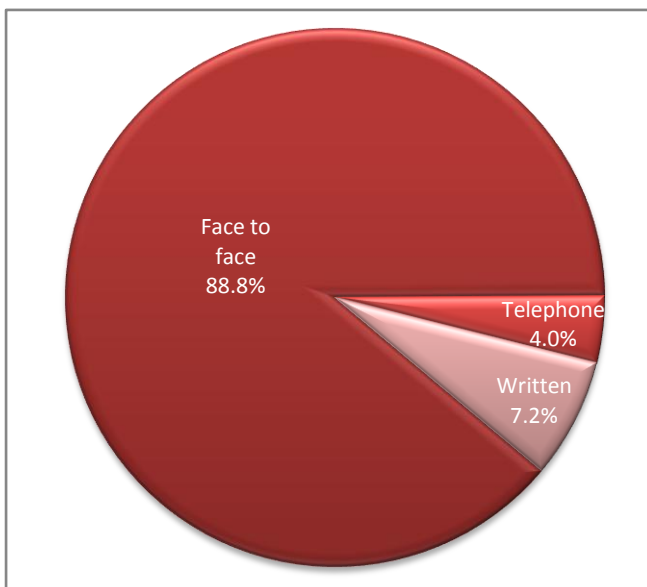
6.5.4 TYPE OF SERVICE

Just under two thirds of all services provided by CRCs were classified as care and treatment services (61.6%), a further 28.7% were medication related services and 8.7% focussed on education or information – see *Figure 24.*

Figure 24: Types of services provided by CRC teams
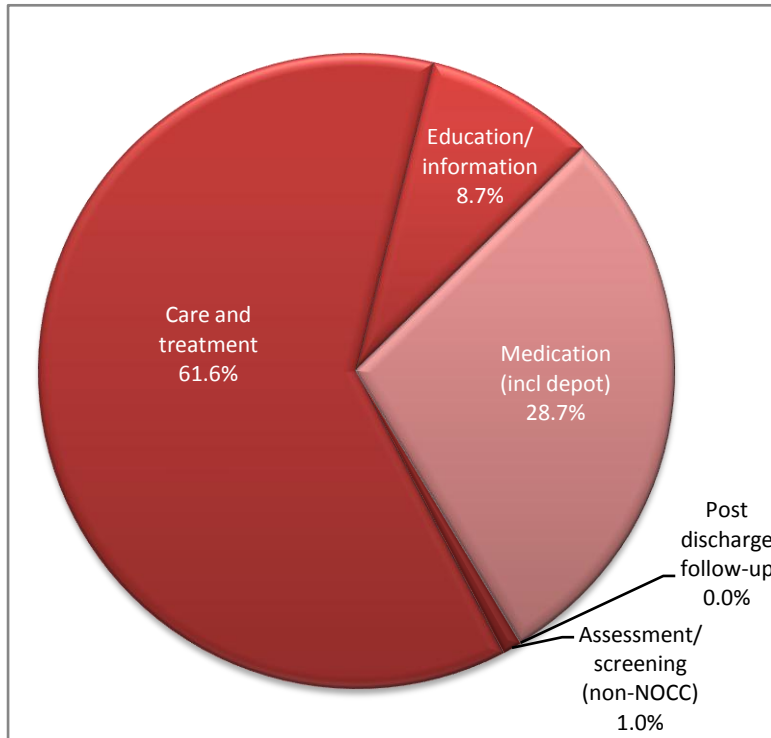
In terms of the amount of time associated with each type of service, care and treatment services as a whole comprised 74.8% of total service delivery time – see *Figure 25*. As would be expected, individual assessment/screening services (non-NOCC) tended to be the most time-intensive, and education/information and post discharge follow-up services were the least time intensive.

Figure 25: Proportion of total service delivery time associated with types of service
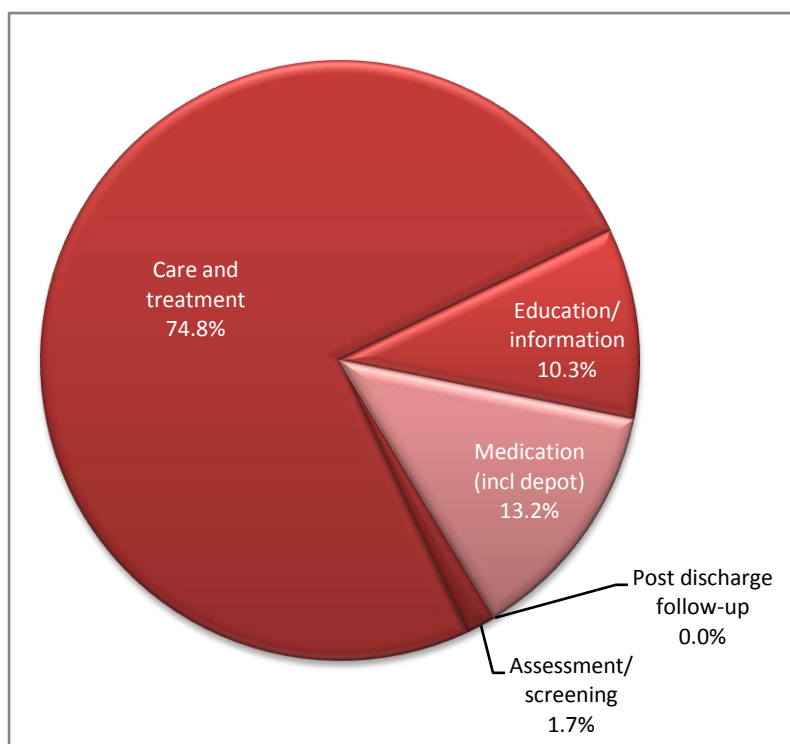
6.5.5   FREQUENCY OF SERVICES PROVIDED

Looking at all services regardless of mode or type, according to the data it appears that on average the CRCs provide around **1.5 services per day** (mean 1.51, median 1.35) **to each consumer** during their stay. This equates to around 46 services per calendar month for each consumer. *Note that this can vary considerably between individual episodes, with some episodes averaging only one service every ten days or so, and others averaging 5 or more services per day.*

Shorter episodes tend to involve the provision of more services per day on average. There was a statistically significant negative linear relationship between length of episode and number of services per day (r=-.286, p<.05).

For episodes of less than 3 months duration there were on average up to two service occasions per day (mean 1.94, median 1.77), whereas for episodes of 9 months or longer there were on average much fewer service occasions per day (mean 1.17, median 0.78). This is probably the result of the lessening of service intensity towards the end of longer stays. *Table 5* illustrates this relationship.

Table 5: Statistics for number of services per day within episodes, by length of episode

Length of episode	N	Mean	Standard error of mean	Median	Minimum	Maximum
Up to 3 months	48	1.94	0.17	1.77	0.12	5.29
3 to 6 months	41	1.29	0.13	1.09	0.17	4.21
6 to 9 months	28	1.29	0.11	1.14	0.28	3.06
9 months or more	17	1.17	0.19	0.78	0.28	2.44

On average over a one month period, each CRC consumer will receive nearly 39 face to face services. There will also be 3 telephone communications and 4 written communications regarding that consumer during that month – see *Figure 26*.

Figure 26: Mean number of CRC services in an episode per month, by mode
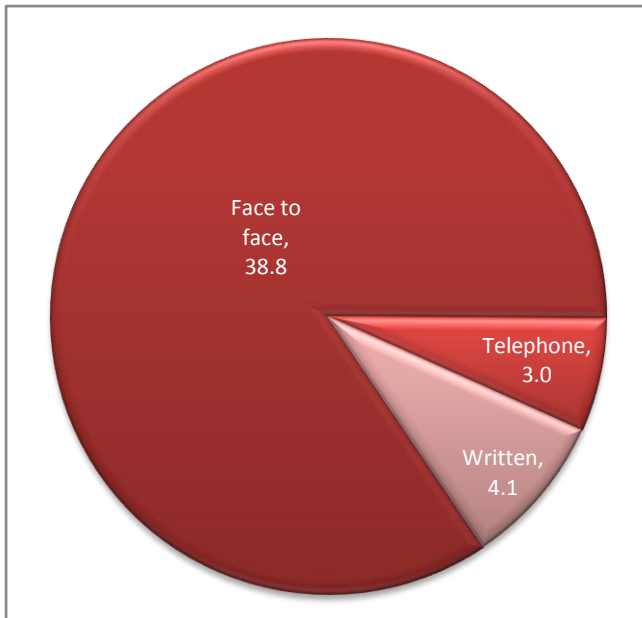
In terms of types of service, in an average month of stay each consumer will receive around 28 care and treatment services, 5 education/information services, 12 medication services, and one non-NOCC assessment/screening service. These findings are illustrated in *Figure 27*.

Figure 27: Mean number of CRC services in an episode per month, by type
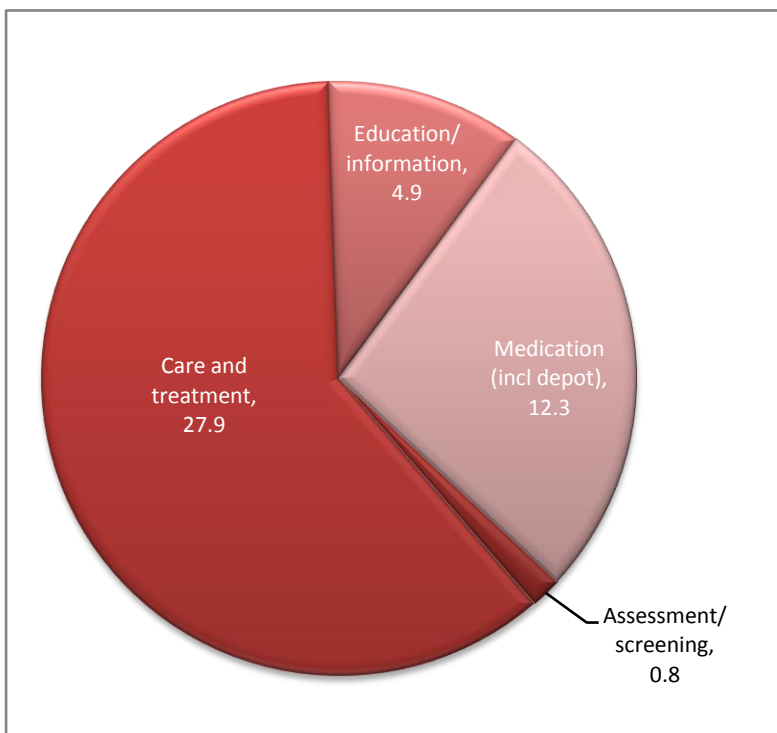
6.6 FINDINGS RELATING TO CONTINUITY OF CARE

6.6.1 CONTINUITY WITH AMBULATORY MENTAL HEALTH TEAMS

Ambulatory mental health teams can play a significant role in assisting CRC consumers to make a successful transition back into the general community. In an ideal situation, Community Key Workers from ambulatory mental health teams would maintain some contact with their consumers while those consumers are residing at a CRC. Maintaining engagement is important, as ambulatory teams are a crucial source of ongoing support and mental health services after a consumer leaves the CRC.

Evidence for engagement with ambulatory mental health teams before, during and after a CRC stay was gathered from records of services undertaken by ambulatory teams across metropolitan areas (CBIS data) and country areas (CCC data). For simplicity, this analysis focussed on the *most recent closed CRC episode* for each consumer (197 episodes).

Service occasions occurring *from 30 days prior to entry* to the CRC through to *30 days after exit* from the CRC were selected for this analysis. Restricting the analysis of pre-entry and post-exit services to 30 day periods allowed us to examine engagement with ambulatory services at those crucial times of transition.

Four of the 197 episodes (2.0%) had no ambulatory services recorded during the period of interest. Furthermore, there were –

➢ 25 episodes (12.7%) with no ambulatory services in the *30 days prior to CRC entry*,
➢ 7 (3.6%) episodes with no ambulatory services *during the CRC stay*, and
➢ 14 (7.2%) with no ambulatory services within *the first 30 days after exit from the CRC*.

While this may suggest lack of continuity in ambulatory services for a subset of consumers, note that these consumers may have been receiving services from *non-ambulatory* areas of the mental health system, e.g. other residential (non-CRC) service teams, inpatient teams, or possibly private health providers. Indeed, consumers without ambulatory services during these periods were more likely to have been referred to the CRC from a source *other than* ambulatory teams, suggesting that their main contacts within the mental health system may lie elsewhere.

No other consumer related factors appeared to be associated with lack of ambulatory services before, during or after a CRC stay. Consumers from both metropolitan and country areas were represented in this group, and there was the expected mix of demographic characteristics, mental health diagnoses and lengths of stay.

Statistics for the number of ambulatory services provided per consumer per month before, during and after CRC stays indicate that -

⇒ On average, each consumer received around 12 ambulatory services in the month before entering the CRC (mean 11.84, median 9.0). Taking both the mean and median into account, this would equate to two to three services per week on average.

⇒ During CRC stays the level of ambulatory service provision dropped somewhat, as would be appropriate. However it was still quite high at around 9 ambulatory services per month per consumer (mean 9.19, median 7.61).

⇒ In the month after exiting the CRC the level of ambulatory services increased slightly, though not quite to the pre-CRC-entry level. After exit consumers received on average 10.49 ambulatory services (median 7.0) per month.

Statistics for the number of ambulatory services provided per consumer per month before, during and after CRC stays are presented in *Table 6.*

Table 6: Statistics for number of ambulatory services per consumer per month around closed CRC episodes

Timeframe	N	Mean	Standard error of mean	Median	Minimum	Maximum
In the 30 days prior to CRC entry	197	11.84	0.79	9.00	0.00	64.00
During CRC episode	197	9.19	0.54	7.61	0.00	43.49
In the 30 days after CRC exit	197	10.49	0.68	7.00	0.00	49.00

6.6.2 AMBULATORY SERVICES REFLECTING ONGOING DIRECT CARE

CRC consumers who received ambulatory services generally received services from more than one ambulatory team. However the service data does not allow us to ascertain which ambulatory team contains the consumer's Community Key Worker, and therefore it is difficult to understand true continuity of care in terms of the ongoing, consistent involvement of one main mental health worker.

In an attempt to address this issue, we focussed on just those types of service and types of team that are likely to reflect the delivery of *ongoing direct care* to individual consumers.

In terms of *types of service,* for the purpose of this analysis we included only the 88.9% of service occasions which related to the direct care of consumers. These were care and treatment services such as supportive care, therapeutic services, education and information services, medication services and country-based care services. Assessment, screening and examination services were excluded, as were services involving travel, missed appointments and unsuccessful contact attempts.

In terms of *types of ambulatory teams* providing services, examination of the data indicated that around the time of their CRC stay individual consumers tended to receive ongoing services from a small number of teams within the following types –

- ➢ Mobile assertive care (MAC) teams
- ➢ Community treatment (CTT) teams
- ➢ Assessment and treatment service (ATS) teams
- ➢ Ongoing client support (OCS) teams
- ➢ Rehabilitation and recovery teams
- ➢ Collaborative shared care teams
- ➢ Collaborative specialist care teams
- ➢ Transitional care teams
- ➢ Brief intervention teams
- ➢ Nurse practitioners
- ➢ Homeless service teams
- ➢ Country-based mental health teams.

Services from these teams comprised 85.5% of all services provided to consumers around the time of their CRC stay. The remainder of services were provided by ACIS, Triage teams, Emergency Departments, Outpatient Departments, Liaison teams, Transfer teams, and Group program activities. These types of team were not considered to be main sources of ongoing direct care to individual consumers, and therefore were excluded from further analysis.

Analysis of the resulting subset of services – the *services most likely to reflect ongoing direct care of consumers* – is outlined below. Naturally these results give a less positive picture of continuity of ambulatory care than the results based on *all* services regardless of type and team. However we believe it is important to recognise that not all ambulatory service activity associated with CRC consumers is necessarily a true reflection of ongoing direct care service provision. This is our attempt towards gaining the most accurate picture possible.

Twelve of the 197 episodes (6.1%) had no ongoing direct care ambulatory services recorded during the period of interest. Furthermore, there were –

- 35 episodes (17.8%) with no ongoing direct care services in the *30 days prior to CRC entry*,
- 18 (9.1%) episodes with no ongoing direct care services *during the CRC stay*, and
- 25 (12.7%) with no ongoing direct care services within *the first 30 days after exit from the CRC*.

Again, consumers without ambulatory services were more likely to have been referred to the CRC from a source *other than* ambulatory teams, suggesting that their main contacts within the mental health system may lie elsewhere. There were no other defining characteristics of episodes lacking in ambulatory services.

Analysis of statistics for the number of ongoing direct care ambulatory services provided before, during and after CRC stays found that on average –

⟹ the number of services provided per consumer per month was around two or three services less than when all service types and teams were considered.

⟹ Each consumer received around 9 ongoing direct care ambulatory services in the month before entering the CRC (mean 9.0, median 7.0).

⟹ During CRC stays the provision of ongoing direct care ambulatory services dropped by around two services per month (mean 7.13, median 5.56). However it still represented more than one contact per week on average, which is a very acceptable level of engagement during this period.

⟹ In the month after exiting the CRC the ongoing direct care ambulatory service activity stayed much the same as it was during the CRC stay, with consumers receiving on average 7.81 services (median 5.0) per month.

Statistics for the number of ongoing direct care ambulatory services provided before, during and after CRC stays are presented in Table 7.

Table 7: Statistics for number of ongoing direct care ambulatory services per month per consumer around closed CRC episodes

Timeframe	N	Mean	Standard error of mean	Median	Minimum	Maximum
In the 30 days prior to CRC entry	197	9.00	0.68	7.00	0.00	64.00
During CRC episode	197	7.13	0.49	5.56	0.00	43.49
In the 30 days after CRC exit	197	7.81	0.55	5.00	0.00	40.00

This appears to provide evidence of ambulatory service continuity before, during and after CRC stays for the majority of consumers. Changes in service frequency across those periods were not statistically significant. Furthermore, the number of ongoing direct care ambulatory services provided to consumers before, during and after their CRC stay appeared to be at an acceptable level, equating to between one and three services per week on average.

6.7 FINDINGS RELATING TO CARE PLANS

Mental health care plans are an important tool for supporting continuity of care. A three-monthly review of care plans is considered to be appropriate within the SA community mental health care system. Reviewing care plans periodically and also when consumers' needs or circumstances change, can be useful to the consumer and to the mental health workers involved in their care.

In order to examine the timing of care plan reviews for CRC consumers, a dataset containing the start date, end date and latest revision date for care plans held in CBIS was combined with datasets containing the latest revision date for care plans held in CCC (the only data available).

Five (2.1%) of the 238 consumers who had entered a CRC during the period studied did *not* have a care plan recorded in the CBIS and those five consumers had all exited the CRC.

Three of those five consumers had exited after a recent short stay at the CRC, therefore there would have been little opportunity to generate a CBIS-based care plan for those consumers. The other two consumers resided outside the metropolitan area. It is possible, particularly for the latter two consumers, that a CCC care plan may exist but has not yet been revised. The existence of unrevised CCC care plans could not be determined from the data available.

For the majority (83.5%) of consumers who had *exited* the CRC, their care plan had been revised at some time since their exit – see *Figure 28.* A small number (10.6%) of exited consumers last had their care plan revised *during* their stay at the CRC, and a further 3.2% had not had their care plan revised since *prior* to entering the CRC. The latter subgroup had short, recent stays at the CRC, offering little opportunity for care plan review since entry.

Figure 28: Timing of last care plan revision – consumers who had exited the CRC
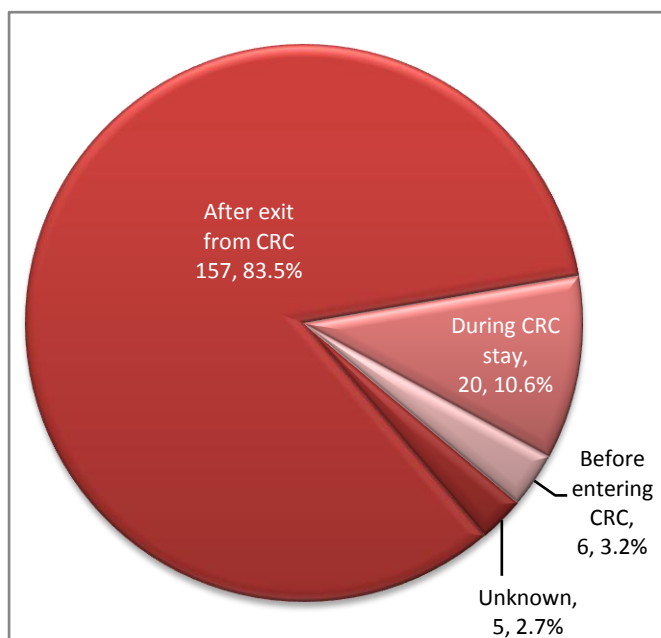
The majority (84.0%) of the 50 consumers who were *still residing* at the CRC at 15th September 2010 had their care plan revised during their stay – see *Figure 29.*

The remaining 16.0% of consumers still residing at the CRC had last had their care plan revised prior to entering the CRC. Three of those 8 consumers had only been in the CRC for around a month, giving little

opportunity to complete a care plan review. A further three consumers had their care plans reviewed shortly before entry to the CRC. Only two consumers had an unexplained delay in review.

Figure 29: Timing of last care plan revision – consumers who were still residing at the CRC

During
CRC stay
42, 84.0%

Before
entering
CRC
8, 16.0%
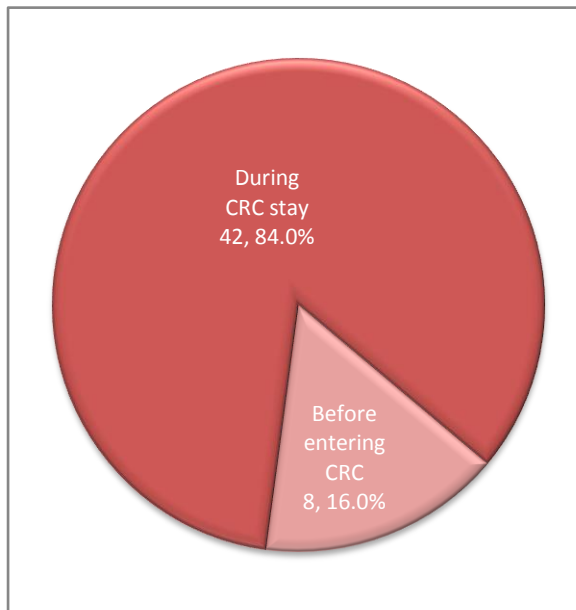
Despite the limitations of the data, it is clear that care plan reviews are taking place for a substantial proportion of CRC consumers. Furthermore, the results suggest that care plan reviews are mostly being undertaken at appropriate phases in the service pathway of CRC consumers.

6.8   OUTCOMES

6.8.1   IMPACT OF CRC STAYS ON USE OF INPATIENT MENTAL HEALTH SERVICES

In order to determine whether CRC stays had an impact on consumers' use of inpatient mental health services, the total number of days that CRC consumers spent within inpatient mental health services in *the 6 months (180 days) prior to their first CRC entry* and the *6 months (180 days) after the end of their last CRC stay* was derived from the inpatient data recorded in CBIS.

The analysis was restricted to the **152** CRC consumers who had exited from their most recent CRC episode at least six months prior to 15th September 2010. This ensured that a time frame of at least six months after exit could be considered for every consumer in the group. Inpatient episodes which overlapped with CRC episodes were carefully managed to ensure that only days outside of the CRC episodes were counted.

There were large individual differences in the number of days that consumers spent in inpatient care in the six months before and after their CRC stays. Some consumers had no inpatient stays recorded, while others spent all or almost all of the six months before or after CRC exit in inpatient facilities.

There was a **large increase after CRC exit in the percentage of consumers using no (nil) inpatient services,** and a **reduction across all other categories** was also evident – see Table 8.

Table 8: Total number of days spent by CRC consumers in inpatient facilities in the 6 months before/after their CRC stay

Total number of days spent by CRC consumers in inpatient facilities	In the 6 months BEFORE first entering a CRC		In the 6 months AFTER the end of their last CRC stay	
	No.	%	No.	%
Nil	54	35.5%	110	72.4%
1 to 30 days	37	24.3%	21	13.8%
31 to 60 days	24	15.8%	8	5.3%
61 to 90 days	10	6.6%	6	3.9%
91 to 120 days	10	6.6%	3	2.0%
121 to 150 days	6	3.9%	3	2.0%
151 to 180 days	11	7.2%	1	0.7%
Total	**152**	**100.0%**	**152**	**100.0%**

Over half (55.9%) of consumers showed a decrease in the total number of days they spent in inpatient facilities. Most of those consumers reduced their inpatient days to nil after their CRC stay.

However there was a small group of consumers (13.8%) who showed an *increase* in the number of days they spent in inpatient facilities, and 29.6% of consumers had no inpatient stays recorded either before or after their CRC stay. See *Figure 30* for details.

Figure 30: Change in total inpatient days between the 6 months before and after CRC stay - categories
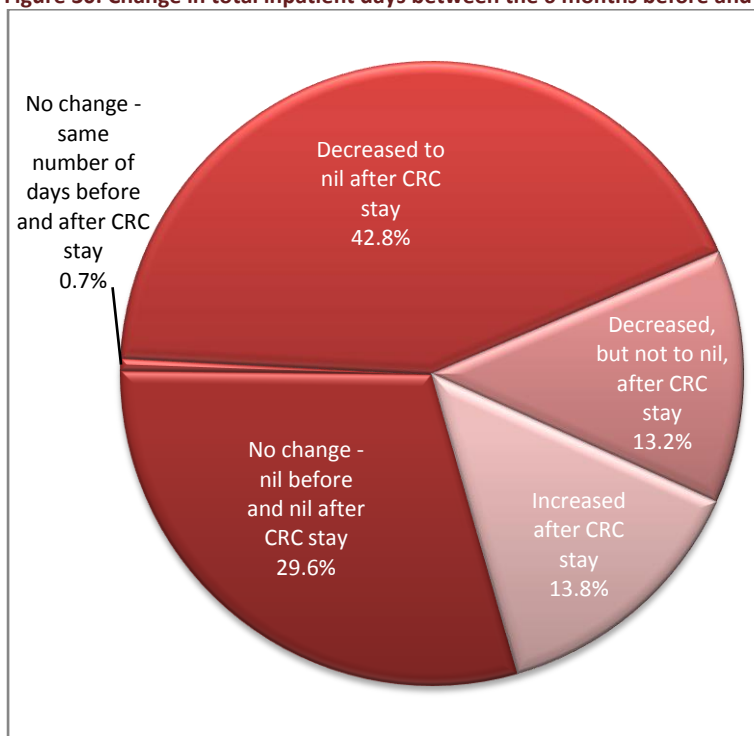
No particular characteristics differentiated consumers who had increased their usage of inpatient services after CRC exit from those whose inpatient service use had decreased.

Overall, the use of inpatient services by CRC consumers **decreased from an average of 41.2 days per consumer before CRC entry** (median 21 days), **to an average of 13.0 days after CRC exit** (median 0 days) – see

Figure 31. This was associated with an overall decrease over more than two thirds in the *total number of inpatient days* used by this group of consumers, from 6,263 days in the 6 months prior to CRC entry to only 1,981 days in the first 6 months after CRC exit – see *Table 9.*

Figure 31: Change in total inpatient days per consumer before and after CRC stay – means and medians
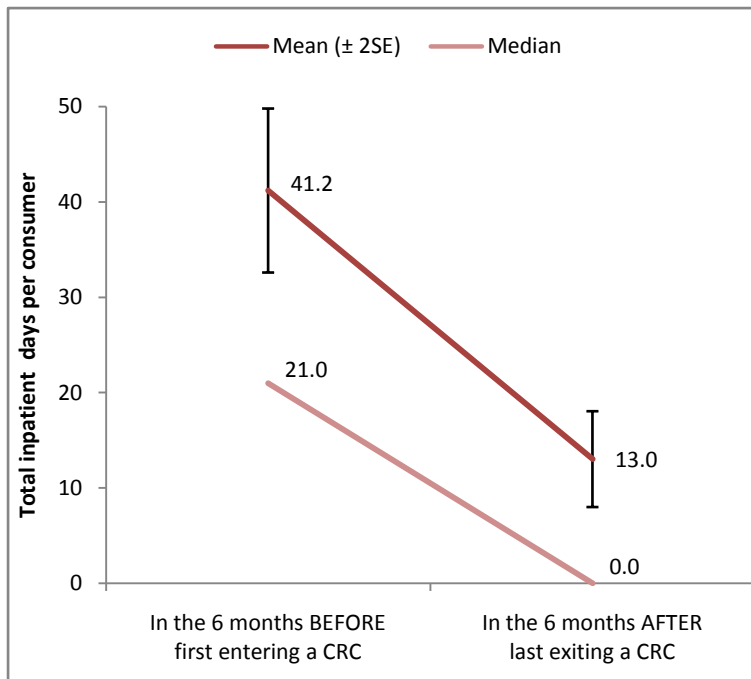
Table 9: Statistics for total inpatient days per consumer before CRC entry and after CRC exit

	N	Mean	Standard error of mean	Median	Minimum	Maximum	Total number of inpatient days
Total inpatient days in the 6 months BEFORE first entry to a CRC	152	41.2	4.3	21	0	180	6,263
Total inpatient days in the 6 months AFTER last exit from a CRC	152	13.0	2.5	0	0	180	1,981

Statistical testing revealed that overall, **after their last CRC stay, consumers experienced a highly significant reduction in the number of days they spent in inpatient mental health facilities** (p<.01), compared to the six months prior to their first CRC stay.

While these results are indicative of a strong reduction in the use of inpatient services after a CRC stay, some caution should be exercised when attributing a direct causal connection. Firstly, there are potential data coverage issues relating to inpatient data for CRC consumers, as outlined in *Section***Error! Reference source not found.** *3.4.1* of Accompanying Report 4. Secondly, there may be other factors influencing the apparent outcomes of consumers over time, such as the contribution of other services including non-CRC residential care services, unrelated changes in consumers' life circumstances, and the natural course of the consumer's illness.

6.8.2   IMPACT OF CRC STAYS ON HONOS SCORES

6.8.2.1   THE HONOS SCALE

The Health of the Nation Outcome Scale (HoNOS) is a 12-item clinician-rated scale designed to measure the present severity (within the last two weeks) of a client's difficulties across a range of aspects of health and functioning.

Each of the 12 items is scored on a 5-point rating scale where zero represents "No problem" and 4 points represents a "Severe or very severe problem". The scores are summed to produce a Total HoNOS score. Therefore the minimum possible Total HoNOS score is zero, which would equate to *no* problems in any aspect of health and functioning, and the maximum possible Total HoNOS score is 48, which would equate to *severe* problems in *every* aspect of health and functioning.

Improvements in health and functioning would be reflected in a *decrease* in the Total HoNOS score.

There are four Subscales within the HoNOS –

1) The **Behaviour Subscale**, comprising 3 items (overactivity/aggression, non-accidental self-injury and problem substance use), with a maximum score of 12
2) The **Impairment Subscale**, comprising 2 items (cognitive problems, physical illness or disability problems), with a maximum score of 8
3) The **Symptoms Subscale**, comprising 3 items (hallucinations/delusions, depressed mood, other mental/behavioural problems), with a maximum score of 12
4) The **Social Subscale**, comprising 4 items (problems with relationships, problems with activities of daily living, problems with living conditions, problems with occupation and activities), with a maximum score of 16.

Scores from these subscales can highlight particular areas of difficulty experienced by consumers. In terms of change over time, these subscales can also reveal differential improvement/deterioration in different domains of health and functioning.

6.8.2.2   DATA USED FOR THIS ANALYSIS

Data from HoNOS assessments undertaken in *ambulatory settings* was available from both the CBIS and CCC systems for CRC consumers. The Total HoNOS score, plus the four subscale scores (Behaviour, Impairment, Symptoms and Social) were available from both systems.

HoNOS data from *residential episodes* was not provided to the Evaluators. Therefore we selected the ambulatory HoNOS assessment occasions that occurred as close as possible *on or before the first CRC entry date* and *on or after the last CRC exit date* for each consumer. Assessments occurring beyond 180 days from either time point were excluded from consideration as proxy entry and exit assessment occasions.

Ambulatory HoNOS assessments within 180 days of entry or exit were available for 215 of the 238 CRC consumers who had entered a CRC at some time up to 15th September 2010. A total of **126** consumers had such assessments around the time of *both* entry and exit. Those consumers are therefore the focus of this analysis.

The majority of these 126 consumers had been assessed *within 30 days prior* to their first CRC entry and *within 60 days after* their last CRC exit.

The *last* recorded HoNOS assessment available from the ambulatory dataset for these consumers was also selected for analysis. In most cases this assessment was more than 6 months after the consumer's last exit from a CRC.

It is important to note that using HoNOS scores collected by ambulatory teams rather than HoNOS scores collected by CRC staff has the *advantage* of being sourced from assessments that are *independent* of the service being evaluated.

6.8.2.3   TOTAL HONOS SCORES AROUND CRC ENTRY AND EXIT

The average Total HoNOS score for CRC consumers around the time of their first **entry** to a CRC was **16.5 points** (median 16.0 points). This appears to be somewhat higher than the National average of 11.3 points reported for consumers entering residential settings in 2007-08 and 2008-09 (the latest data available).

Similarly, the average Total HoNOS score reported for CRC consumers around the time of their last **exit** from a CRC was **12.8 points** (median 12.5 points). This appears to be slightly higher than the National average of 10.1 points reported for consumers at discharge from residential settings in 2007-08 and 2008-09 (the latest data available).

These results suggest that the overall severity of mental health related problems experienced by consumers around the time of their first CRC entry and their last CRC exit may be somewhat greater on average than for clients entering and exiting other residential mental health services. However the differences are unlikely to be statistically significant.

6.8.2.4   CHANGE IN HONOS SCORES

As illustrated in *Figure 32*, the mean HoNOS Total score and the four HoNOS Subscale scores decreased between entry and exit for this group of 126 consumers. Furthermore, this downward trend appeared to continue past exit through to the last ambulatory HoNOS assessment recorded for these consumers.

The apparent reduction in Total HoNOS scores between entry and exit was statistically significant (p<.05). There was also a statistically significant reduction in three of the four Subscale scores, with the exception being the Behaviour scale. In other words, there was –

➢   a **significant improvement in Total HoNOS scores between entry and exit** (p<.05), and
➢   a **significant improvement in Subscale scores, except for the Behaviour subscale, between entry and exit** (p<.05).
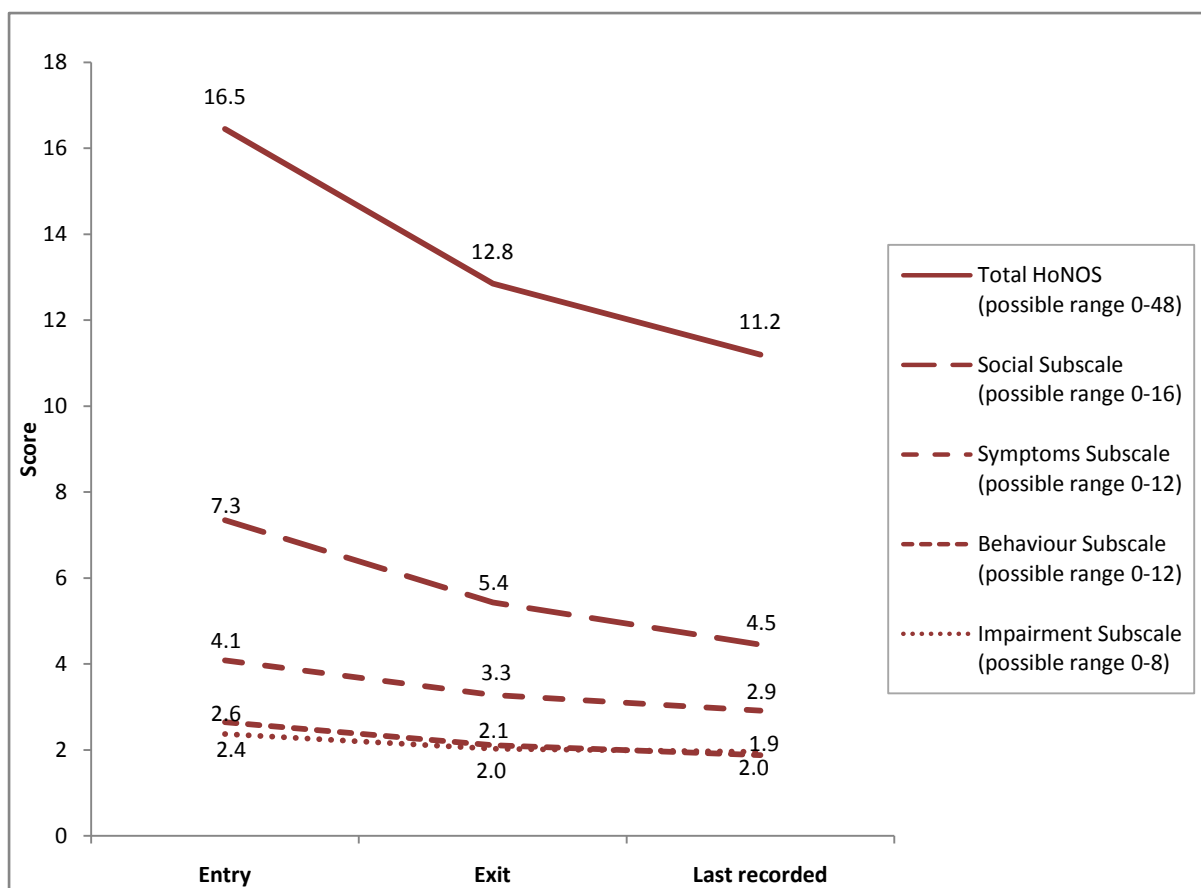
When Behaviour subscale scores from around the time of *first CRC entry* were compared with scores from the *last recorded ambulatory assessment,* the difference reached statistical significance ($p<.05$). It is reassuring that **given a longer time period, a statistically significant improvement can be seen on the Behaviour scale**. Problems in the areas covered by this scale (overactivity/aggression, non-accidental self-injury, substance use) can greatly compromise successful community living.

Comparing scores at *CRC exit* with scores at the *last recorded ambulatory assessment* showed that scores on the **Social subscale continued to improve significantly after exit** ($p<.05$). However the small improvements after exit seen in the Total score and in the other subscales did not reach statistical significance. Stable scores between exit and the last recorded assessment can be seen as indicating that CRC consumers had **maintained the gains they had achieved between entry and exit**.

6.8.2.5 DIRECTION OF CHANGE EXPERIENCED BY CONSUMERS BETWEEN ENTRY AND EXIT

Of the 126 consumers who were assessed around the time of their first CRC entry and their last CRC exit –

➢ 61.9% recorded an **improvement** based on their Total HoNOS score,
➢ 5.6% recorded **no change** in their Total HoNOS score, and
➢ 32.5% recorded a **deterioration** based on their Total HoNOS score.

The only consumer or service characteristic found to be related to these broad outcomes was the CRC that the consumer first attended. Analysis by CRC found that 70.6% of consumers who attended the Trevor Parry Centre showed an improvement in their Total HoNOS score between entry and exit, compared with 60.7% of

consumers attending Elpida House and 54.8% of consumers attending Wondakka. These apparent differences are discussed further in the following section.

6.8.2.6 CLINICAL SIGNIFICANCE OF CHANGE BETWEEN ENTRY AND EXIT

The change in the **average** HoNOS Total scores between CRC entry and exit was **3.7 points**. According to Parabiaghi et al (2005), a change of **8 points** in an individual consumer's total HoNOS score would be the minimum needed to be confident that a *clinically significant change* had occurred for that consumer.

A quarter (**25.4%**) of consumers who were assessed around their CRC entry and exit experienced a **clinically significant improvement** (8 points of more) in their total HoNOS score.

A small number (7 consumers, **5.6%**) experienced a **clinically significant deterioration**.

For most consumers, the degree of change they experienced, as measured by their total HoNOS scores, was not clinically significant (less than 8 points) – *see Figure 33.*

Figure 33: Degree of change in total HoNOS score between entry and exit
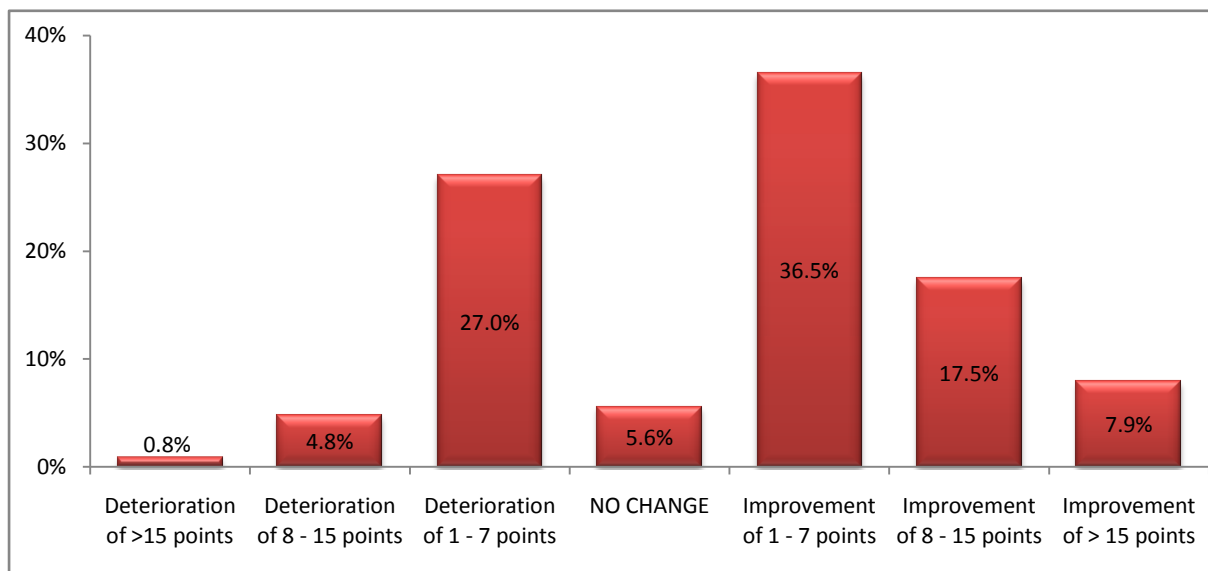
Of course, consumers exit CRCs for different reasons. Some consumers exit after achieving gains in their functional status, while others exit due to acute illness and a need for a more intensive service. Differences between consumers in terms of reasons for CRC exit, reasons for HoNOS assessments, and the focus of care associated with HoNOS assessments, were not significantly related to changes in HoNOS scores in this sample of consumers.

Comparing changes in HoNOS Total scores across the three CRCs revealed that **41.2% of consumers who had attended the Trevor Parry Centre experienced a clinically significant improvement** between entry and exit, compared with 22.6% of consumers attending Wondakka and 18.0% of consumers attending Elpida House – see *Figure 34.*

Figure 34: Degree of change in total HoNOS score between entry and exit, by CRC
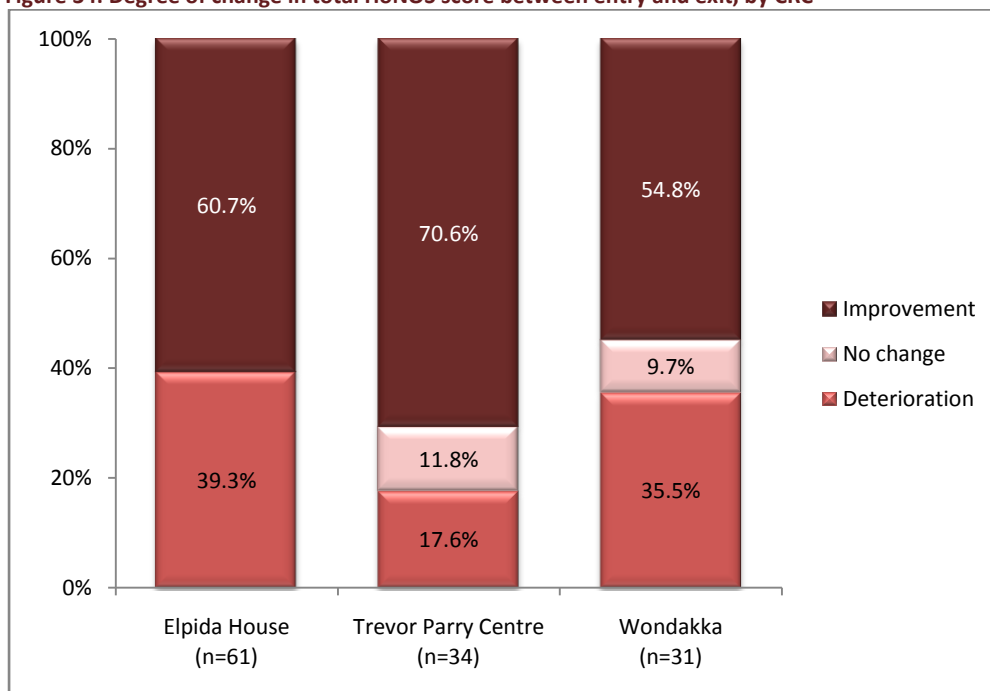
This change profile differed significantly between Elpida House and the Trevor Parry Centre (p<.05), but not across any other consumer, episode or assessment occasion characteristics.

The greater degree of improvement in HoNOS Total scores between entry and exit shown for the Trevor Parry Centre appears to be explained by two main factors. Firstly, consumers at the Trevor Parry Centre had on average higher HoNOS scores at entry than did consumers at the other CRCs, and therefore there was more room for improvement for those consumers. Secondly, the age profile of consumers attending the Trevor Parry Centre was significantly younger than for the other CRCs.

6.8.3   CONCLUSIONS

The findings relating to outcomes achieved for CRC consumers, based on use of non-CRC inpatient mental health services and HoNOS scores prior to and following CRC interventions are encouraging. Although a causal connection with CRC interventions cannot be confirmed (without also analysing the impact of other non CRC variables), the association can be considered to be a positive one.

Analysis of the total number of days spent by CRC consumers in inpatient facilities during the 6 months before and after their CRC stay identified a **large increase after CRC exit in the percentage of consumers using no (nil) inpatient services**. Statistical testing revealed that overall, **after their last CRC stay, consumers experienced a highly significant reduction in the number of days they spent in inpatient mental health facilities** (p<.01).

While a small group of consumers (13.8%) showed an *increase* in the number of days they spent in inpatient facilities, and 29.6% of consumers had no inpatient stays recorded either before or after their CRC stay, overall the use of inpatient services by CRC consumers **decreased from an average of 41.2 days per consumer before CRC entry to an average of 13.0 days after CRC exit**.

Analysis of HoNOS scores found a significant improvement overall in **Total HoNOS scores between entry and exit** (p<.05), and **in three of the four Subscale scores, between entry and exit** (p<.05). Nearly 62% of consumers recorded an **improvement** based on their Total HoNOS score, 5.6% recorded **no change** in their

Total HoNOS score, and 32.5% recorded a **deterioration** based on their Total HoNOS score. A quarter (**25.4%**) of consumers who were assessed around their CRC entry and exit experienced a **clinically significant improvement** (8 points of more) in their total HoNOS score.

6.9 FINDINGS FROM THE ANALYSIS OF OCCUPATIONAL THERAPY ASSESSMENTS

To address the "CRC service delivery information" aspect, in 2010 the CRCs were asked to provide the evaluators with relevant quantitative client information and service delivery information collected at their Centre and stored locally in electronic form. This process identified one particular domain of information which was being collected but was not stored on CBIS – data from functional assessments of CRC consumers undertaken by Occupational Therapists (OTs).

6.9.1 THE ASSESSMENT TOOLS EMPLOYED

From May 2009, on a trial basis, OTs employed at CRCs incorporated two formal standardised assessment tools into their assessments of consumers where possible. These tools were the **Assessment of Motor and Process Skills (AMPS)** and the **Occupational Self Assessment (OSA) tool.**

The AMPS is one of the best known and widely used standardised assessments in occupational therapy, with robust psychometric properties. It involves a formal observational assessment of how a person performs a selection of familiar activities of daily living, with specific examination of the person's *motor skills* (skills in moving the self and objects in order to undertake a task) and *process skills* (skills in selecting and using tools and materials, carrying out individual steps in a task, and modifying actions when problems are encountered).

The OSA is a reliable and valid self-report tool designed to capture clients' perception of their own competence in everyday activities and the value they place on each of those activities. It is used to facilitate collaborative goal setting with clients, and to provide an indicator of change. It covers a wide range of basic everyday activities, such as managing finances, getting along with others, having a routine, and handling responsibilities.

6.9.2 APPLICATION AND ANALYSIS OF THE ASSESSMENT TOOLS

These assessments were intended to add additional information to the comprehensive multidisciplinary assessment of consumers undertaken around the time of their entry to the CRC. Assessment at exit from the CRC, and also at the midpoint of the consumer's stay, were also suggested but were rarely undertaken in practice. The majority of OT assessment data had been collected at the time of admission.

Two of the three CRCs, Elpida House and Wondakka, were able to provide OT assessment data to the Evaluators in electronic form. The time frame covered by those assessments was **May 2009 to March 2010.**

The CRCs advised that only a relatively small amount of data was available due to difficulties in establishing and maintaining sufficient OT staffing at the CRCs, particularly OT staff who had been trained in using the AMPS tools.

The data provided by the CRCs was consolidated into a single dataset for analysis. The small number of cases with assessment data at more than one time point were analysed descriptively on a case-by-case basis, as there was insufficient data for reliable time series analysis.

6.9.3 SUMMARY OF FINDINGS

A complete report on the analysis of AMPS and OSA data can be found in ***Accompanying Report 3, Report of Analysis of OT Assessment Data from the CRCs***.

6.9.3.1 FINDINGS FROM THE AMPS ASSESSMENT

There were 41 cases where the AMPS had been administered at Admission.

⇒ Just over half of the clients (58.5%) assessed at Admission scored below the cut-off score of 2.0 on the AMPS Motor scale, indicating some difficulty with motor aspects of tasks associated with independent living. However no clients scored at the extreme low end of the scale.

⇒ Half of the clients (51.2%) assessed at Admission scored below the cut-off score of 1.0 on the AMPS Process scale, indicating difficulties with process aspects of tasks associated with independent living.

⇒ As would be expected, there was a close relationship between most individuals' scores on each of the two AMPS scales, with low Motor scores generally associated with low Process scores.

⇒ According to the AMPS, 41.5% of the clients had both Motor and Process skill deficits at Admission. A further 17.1% had a Motor skill deficit only, and 9.8% had a Process skill deficit only. Nearly a third of clients had no skill deficit at Admission, according to the AMPS.

⇒ Three clients had an AMPS assessment at both Admission and Review. Two of those three clients showed an improvement on the AMPS Motor scale, and one of these clients had improved their score by a clinically-significant 1.2 points between their Admission and their Review 6 months later.

⇒ All three clients showed improvement on the AMPS Process scale, however at Review they still had not reached the cut-off level for that scale. Furthermore, none of these improvements would be considered clinically significant as they all represent change of less than 0.5 points.

⇒ One client was assessed on the AMPS at both Admission and Discharge, and showed improvement on both the Motor and Process scales during their four month stay at the CRC.

6.9.3.2 FINDINGS FROM THE OSA ASSESSMENT

Forty two consumers had completed the OSA at Admission.

⇒ Most of these consumers scored around the midpoint of the Competence Measure, which can be interpreted as consumers perceiving their ability to undertake activities of daily living as being only just adequate.

⇒ Four consumers completed an OSA assessment at both Admission and Review. These assessments were undertaken between one and six months apart. Three of these consumers showed minimal change on the Competence Measure between Admission and Review, and one consumer showed a (not statistically significant) decrease of 11 points.

⇒ Four consumers completed an OSA assessment at both Admission and Discharge. These assessments were undertaken between three and ten months apart. Two of the consumers showed a statistically significant (p<.05) increase in their Competence score between Admission and Discharge. These increases are also likely to represent a clinically significant increase in these consumers' perceptions of their own competence in activities of daily living. The Competence scores for the other two consumers

remained relatively stable, indicating that these consumers did not perceive much change between Admission and Discharge in their own abilities to undertake the everyday tasks covered by the OSA.

Furthermore, analysis revealed that the scores from the AMPS and OSAtools were *independent* for this sample – there was no correlation between the OSA Competence Measure and the AMPS Motor and Process scores at Admission (r=-.035 and r=.016 respectively).

6.9.4 CONCLUSIONS

It is apparent from this analysis that assessing mental health consumers' actual and perceived functional status using tools such as the AMPS and the OSA can deliver useful information for individual rehabilitation planning, monitoring and tracking of outcomes.

Based on available data from AMPS assessments, it appears that around two thirds of the consumers entering a CRC may have a measurable deficit in the skills required to effectively perform activities of daily living. This finding is consistent with the main aim of the CRCs – to assist mental health consumers to develop or regain skills required for successful independent living.

It should also be noted that according to the AMPS assessments, nearly a third of the consumers entering a CRC did *not* have an objectively measurable deficit in skills required to perform activities of daily living. Clearly there are needs specific to the rehabilitation of mental health consumers which are not necessarily measurable via tools such as the AMPS. These needs would include time to develop a sense of stability and confidence, and opportunities to learn specific strategies to best manage their own mental health.

For a successful return to independent living, consumers require not only actual skills but confidence in their ability to use those skills consistently and effectively. This is why tools measuring the *consumer's* perception of their own competence, such as the OSA, are an essential companion to tools which assess competence objectively. Each type of assessment provides distinct but complementary information about functional ability.

With independent living as a key outcome for CRC residents, ADL-focussed tools such as the AMPS and OSA are an invaluable addition to the more mental-health-focussed assessment tools such as the HoNOS. The lack of an association found in this analysis between consumers' scores on the OSA and the AMPS underlines the need for CRCs to continue to undertake both objective assessments (e.g. AMPS) and consumer self-assessments (e.g. OSA) where possible, in order to gain a balanced view of consumers' needs, progress and outcomes. This also highlights the importance of CRCs employing Occupational Therapists and ensuring that this occurs as part of multidisciplinary service provision.

Recommendation 8

It is recommended that the AMPS and OSA assessment tools continue to be used to measure consumer outcomes relating to activities of daily living, and that an amount be set aside each year to pay for training in the use of the AMPS so that all Occupational Therapists working in CRCs are able to administer both of these tools. The information yielded should be used to inform Care Planning and Review processes.

6.10 REFERENCES FOR SECTION 6

AIHW (2005) *National comorbidity initiative: A review of data collections relating to people with coexisting substance use and mental health disorders,* AIHW Cat No PHE 60 (Drug Statistics Series No 14), Australian Institute of Health and Welfare, Canberra

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7 BARRIERS AND CHALLENGES

REVIEW REQUIREMENT: Identify the barriers associated with the design, planning and implementation of the service provided by the CRCs

A number of barriers relating to the design, planning and implementation of the CRCs have been identified through the consultation process.

7.1 RESOURCE CONSTRAINTS

Barriers arising from **resource constraints** were identified from the consultation process, and given the less advantageous budgets of Wondakka and Elpida House compared with Trevor Parry, this is not surprising (although the CRC Managers did not draw the evaluators' attention to this disparity during our consultations with them). In relation to staffing the main concern was that available resources were 'tight' for supporting 20 residents and limited the type of interventions that could be offered. In addition, the provision of a 24 hour service without dedicated night staff was seen as an issue in terms of continuity of care between day and night staff. This is discussed further in *Section 7.2.*

7.2 PROVIDING A 24 HOUR SERVICE AND ROSTERING ISSUES

CRCs are designed to offer a 24 hour service, and this feature was identified as one of the strengths of the model by those consulted for the evaluation because it enables -

- o More effective engagement with consumers;
- o Provision of support through critical phases in the consumer's condition;
- o Identification of early warning signs;
- o The ability to better support self-management.

However, while this is of great benefit to consumers it may bring costs for its staff in terms of physical, social and emotional well being unless managed appropriately. The survey asked staff to identify issues associated with rostering, and, some highlighted the impact on their well being while others expressed concerns about the way rostering is being applied, suggesting approaches that would address the negative impact on health – such as, changing the length of shifts, and paying more attention to the sequencing of early and late starts. The comments that follow illustrate these two issues.

Impact on staff well-being

> *'I feel constantly tired as a direct result of working the shifts that are required.'*

> *'Shifts are draining and you feel tired all the time unable to focus.'*

Planning and management of rostering

> *'Due to a seven day rotating roster that has 5 different starting times ranging between 0700hrs and 2230hrs with little if no consistency from day to day, I find that I have a higher usage of sick leave than ever before in any other position I have previously worked in. I find that this is not isolated to myself and that there is a high level of sick leave amongst my peers. Because there are so many start times as well as internal shift swaps the roster is not an accurate reflection of who might or might not be on for any given shift hence there is then concern that we may not have enough staff at any given time on any given day. '*

'I feel that the shift length for Community Rehabilitation Workers is too short. If the workers worked longer shifts tasks that were started in the morning or planned for could be undertaken by the same worker in the afternoon, ensuring minimal confusion to the consumer and continuity of care. Longer shifts would also mean that worker have more days off per roster period, this would increase the opportunities for activities outside of work, and could potentially be more family friendly and increase morale.'

'Working a late shift and then early shift the next day is VERY difficult. There is not enough time to get home and have a reasonable amount of time to wind down and get to bed to get enough sleep. I would think that a minimum of 7 hours time for sleep should be allocated for sleep but often myself and my co-workers only achieve 5 hours sleep. This I would think contravenes the Occ Health and safety requirements for staff health. We preach 'sleep hygiene' to our residents and then are unable to achieve this ourselves.'

Recommendation 9

It is recommended that CRC Managers consult experts on the design of rostering and shifts that support a 24 hour service without compromising the health and well-being of staff. CRC Managers should also consult with staff on the challenges being faced and strategies for managing those issues. A uniform approach across the three CRCs to rostering for shift work should then be designed and implemented.

7.3 STAFFING CHALLENGES

A number of issues were identified in relation to building a **multidisciplinary CRC staff profile**. In particular, *Occupational Therapists* were described as difficult to recruit and retain and their key role in rehabilitation has not been acknowledged in documentation of the service model. While a CRC may have an OT it also needs to use them in a coordinating role, and this was described as leading to confusion about that role. *Psychologists* were also identified as being difficult to recruit but with a critical contribution to make. Yet some stakeholders described those in employment as having their skills under-utilised or sometimes used for other roles, for example, case management.

Another barrier concerns **insufficient training of staff**. This was seen in relation to understanding rehabilitation processes, in orienting new staff and in time off for training, with backfilling, to maintain and develop new skills. Planning and training days across CRCs were seen as providing valuable peer learning, but not occurring beyond one day, at the time of reporting. These issues are addressed in **Recommendation 6.**

7.4 ACCESS AND EQUITY IN SERVICE PROVISION

7.4.1 EQUITABLE ACCESS FOR CONSUMERS IN RURAL LOCATIONS

Different stakeholders consulted identified barriers in relation to access to and provision of services for people living in rural areas. At the time of the evaluation's interview and survey processes, all three CRCs were located in the metropolitan area, making it difficult to prepare clients for living in their communities and for retaining connection with their families (which can be important to recovery). Although a significant proportion of rural clients are reported as staying in the city – and therefore having access to more services and more work opportunities – for those wishing to return to their rural origin, the model is more difficult to apply.

Survey feedback from both CRC staff and Key/Support Workers (see *Section 4.2.5*) gave poor ratings of the CRCs' capacity to provide accessible services for consumers in rural locations.

There were a range of criticisms levelled at current processes for servicing rural clients. At the time of reporting, Country Community MH Teams provide a general continuity of care service (continuous care teams - CCT) and anything else is referred to NGOs. However, CRC representatives argued that NGOs in rural locations do not have sufficient staff with rehabilitation skills. They also identified wide disparities in country Mental Health Teams' understanding of the role of CRCs.

Rural workers argue they are not being given the opportunity to participate in care planning while a client is in the CRC, and that they are not receiving discharge information. One worker gave the example of a resident who came into Downey after 11 months in a CRC with no information, and when the CRC was asked to provide information they received a 6 dot point summary. Rural workers also expressed dissatisfaction with communication processes, resulting in them not being sufficiently informed about their clients' progress and needs when returning to their community. Rural Key/Support Workers also point to a lack of understanding about the impact of distance on their capacity to physically participate in meetings with CRC staff.

Analysis of CBIS and CCC data quantifies and supports these findings, showing a significant under-representation of people living in rural and remote locations among CRC consumers – see S*ections 6.1.3* and *7.4.1*. Clearly, people from regional, rural and remote areas face significant barriers in accessing a metropolitan-based CRC service.

A number of strategies have been suggested by those consulted to enhance access for rurally located consumers and their carers. These include:

o Quarantining a proportion of CRC funding for rural consumers, using population data to determine this.

o Centres in major regional centres like Mt Gambier have been suggested as a means of increasing access, but it was acknowledged that these are not necessarily local unless the client has come from that centre.

o Another option proposed is for Mobile Country Teams, while another involves 'Service Hubs', such as are being proposed for ICCs.

o Better and more strategic use of video-conferencing (to link with country workers and family) was also suggested, noting that this is currently not available at CRCs.

The evaluators are aware that a Communication Plan has recently been developed for the CRCs and that this includes specific strategies focused on people living in rural South Australia. For example, a DVD that clearly describes the services of CRCs and includes footage of the three CRCs has been made available, and is also provided in a condensed version on the internet. This should assist country based stakeholders to make more informed decisions about becoming a CRC client. A brochure about the CRCs has also been developed and distributed widely in hard copy, and can be downloaded from the SA Health website.

The evaluators believe that multiple strategies will be needed that address the issue of distance, including making use of electronic communication technologies that address this issue. Video conferencing is an expensive solution, but Skype is not and should be explored as an option for CRCs and the organisations with whom they work in partnership.

At the time of preparing the final report it was announced that two CRCs are to be established in country South Australia, each with 10 places. This is an extremely important provision that acknowledges the inequity of current resource allocation. It is a beginning and the evaluators are recommending that the issue of poor access and equity for rural consumers continue to be addressed.

Recommendation 10

It is recommended that SA Health continue to monitor access and equity for rural consumers, including determining whether additional CRCs are needed outside of the metropolitan area.

7.4.2   EQUITABLE AND INCLUSIVE CULTURAL ACCESS

As discussed in *Section 4.2.5,* the CRCs' capacity to provide culturally inclusive and accessible services for people from culturally diverse backgrounds, and for people from Indigenous backgrounds, were among the most poorly rated features of the implemented CRC service model. This is a view shared by CRC staff and Key/Support Workers, and was supported by findings from the analysis of demographic data from the CBIS/CCC systems.

There will be a cluster of factors that are likely to affect this perception, and all represent possible strategies to address this situation. No single strategy can be expected to be effective, but a combination of strategies that will be mutually reinforcing is always required when managing cultural diversity.

➢ Cross cultural awareness training of staff that is designed to increase sensitivity to working with different cultures and to enhance understanding of the role played by cultural 'filters'.

➢ Specific training designed to increase cross cultural competence, including appropriate use of interpreters, guided experience in working collaboratively with different communities (separating training that is focused on Indigenous groups from training that is focused on working with people from culturally and linguistically diverse backgrounds).

➢ Training which increases understanding about the interaction between cultural influences and mental health, drawing on the resources of organisations with expertise in this area.

➢ Recruitment of staff and Key/Support Workers from diverse cultural backgrounds and from Indigenous backgrounds (tailoring these choices to reflect local and consumer need).

➢ Strategic working relationships with organisations and communities providing culturally specific or Indigenous specific services (for example, the Survivors of Torture and Trauma Assistance and Rehabilitation Service – STTARS).

Recommendation 11

It is recommended that the Adelaide Health Service PIC develop a series of strategies to enhance the capacity of CRC services to be culturally inclusive for people from Indigenous backgrounds and for people from culturally and linguistically diverse backgrounds, paying particular attention to cross cultural awareness raising training and strategic working relationships with organisations with specific cultural roles.

7.5   UNDERSTANDING THE ROLE OF CRCS IN THE MENTAL HEALTH SERVICE SYSTEM

CRC Managers and the majority (76.7%) of CRC staff surveyed believe that the role of CRCs is not understood by others in the mental health service system, including those who refer consumers to them. This issue needs to be addressed, although it is acknowledged that when all steps of the reformed mental health system are in place, there will be better understanding of the role of each and their interrelationship. Nevertheless, prior to this occurring there is a need to improve current levels of understanding.

> *'Referrals tend to come from the same clinicians/teams who have come to understand the process and value the service. However, for many the service is still largely unknown. I phoned the team leader of a country community mental health team about arranging a time to speak with the team about the CRCs. I was shocked to find out that he knew nothing about the service. Consumers in that particular town are missing out on opportunities because the mental health team knows nothing of the service.'*

In identifying areas where the CRCs could be improved, CRC staff most frequently cited the need to clarify the rehabilitative role of CRCs to referral sources and the needs of consumers that can be addressed by them. This was seen as promoting more accurate referrals.

Key Workers and Support Workers surveyed agree with this perception. The referral and eligibility criteria were identified as being unclear in open ended feedback, and some observed that changes to referral rules and eligibility criteria were not disseminated to the referring agencies. They also identified the need to better inform consumers and the wider community about the role of CRCs and their place in a reformed mental health system.

7.6   PARTNERSHIP CHALLENGES

CRC services and other components of a stepped mental health system face the ongoing challenge of coordinating with other providers in the mental health system and externally, particularly those in the non government sector. Consumers will have multiple needs that are addressed by different sources of support, both formal and informal. Taking a holistic approach to addressing those needs faces the challenge of working within different paradigms, policies and procedures and the evaluators are aware of how complex this can be.

The evaluation findings have identified that CRC working relationships with Key Workers in the community mental health system and Support Workers in the NGO sector are developing and working well, but with scope for improvement in communication processes, frequency of contact and consistent rehabilitation-focused training (see **Recommendation 5**). Another finding is that both consumers and carers are seeking more structure in the daily activities of CRC residents, arguing that the current approach is too unstructured and leads to boredom (see *Section 4.3 and 4.4)*.

The opportunity exists to address both of these issues by a more structured partnership with NGO providers that would see a range of organisations working with CRC staff to provided planned activities that assist transition to independent community living. Sometimes the problem is simply one of awareness of programs and facilities already in existence as illustrated by the comment: -

> *"It would be good if staff made suggestions as to what to do, because sometimes we don't know what is around".*

Measures to address this issue could include:

o   employment preparation (through employment service organisations) – for example, job seeking skills

o vocational skills development (through Registered Training Organisations) – which could include literacy and numeracy skill development, computer skill development and other pre-employment training opportunities),

o programs offered by Adult Community Education (ACE) providers that cover a range of skills and interests but can also build a supported pathway to vocational education and higher education. Some of these providers are also Community and Neighbourhood Centres and could be selected for their proximity to the consumer's local neighbourhood;

o services offered by housing providers, to assist in obtaining a range of accommodation opportunities;

o awareness of programs of community services and facilities available;

o programs that assist in developing skills in daily living.

If a range of working relationships or partnerships are developed with different NGOs, clinical rehabilitation and day programs with a view to designing a range of activities delivered either on-site or at the partnering organisation's site, these could be tailored to individual Care Plans and stepped to lead to increasing levels of self sufficiency. This approach provides more structure for existing collaboration with the NGO sector but also supports the implementation of a partnership service model that was proposed in the recent South Australian budget.

At the same time, the evaluators are not suggesting that CRCs reduce their role in linking consumers to different community services – simply that those provided in house are strengthened to maximise the impact of CRC services as a whole.

Recommendation 12

Recovery principles and rehabilitation principles should be embedded further in any further service model development. It is recommended that CRCs look at how they can partner with other agencies in order to provide recovery focused rehabilitation activities both on and off site. These activities may be group or individually focused and should be integrated into individual Care Plans and Reviews.

A key strength of the CRC model is seen in its filling of a gap in the mental health service system, with nothing like this available previously. As the findings of the evaluation indicate, this strength brings the challenge of achieving understanding by other parts of that system and by the wider community, of the role of CRCs and the boundaries of that role. Such a challenge can be expected to be at its greatest in the early stages of implementation, which is when this evaluation has taken place, exacerbated by other 'steps' of a reformed mental health service system not having been implemented at the same time.

The implementation of the CRC model has faced, and will continue to face, a number of challenges that can be expected given the complexity of most consumer need, and the intricacies of a mental health system that is undergoing reform. These have been explored in *Section 7.*

However, there have been numerous achievements to date, (evident from the number of ✔ symbols preceding findings throughout this report). To summarise those achievements, they include:

✔   Implementation of three CRCs which have been found to **reflects the underlying principles of the CRC model**. The 7 Key Principles identified have all received positive ratings from the majority of CRC staff and Key/Support Workers surveyed. They have also been endorsed by consumers and their carers.

✔   There has also been consistent support across all stakeholder groups for the **integrity of the underpinning CRC service model**.

✔   In rating the extent to which the CRC in which they work **reflects the goal of supporting the recovery** from mental illness of people with high and complex needs, there was a trend for respondents to provide positive ratings. **58.1%** have rated the CRCs as 'very much' to 'extremely' successful in fulfilling the recovery goal.

✔   In pursuit of a multidisciplinary CRC workforce, the **current mixture of staff types and disciplines** has been rated as being optimal. CRC **team work** has also been rated positively.

✔   Most of the staff and Key/Support Workers **understand their specific role** in the CRC, and believe that this role is valued.

✔   Although there is a need for training to be provided more consistently, when **training** has been provided, either as part of induction or ongoing employment, it has been rated positively.

✔   Consumers and carers perceive the CRCs as **filling a much needed gap**, and while there have been some areas identified for improvement, most believe that CRC services have had a positive impact on those receiving these services. This gap includes providing a **rehabilitation focused** service which operates **24 hours a day**.

✔   Analysis of the total number of days spent by CRC consumers in inpatient facilities during the 6 months before and after their CRC stay identified **a highly significant reduction in the number of days they spent in inpatient mental health facilities after their CRC stay** (p<.01). There was a **large increase after CRC exit in the percentage of consumers using no (nil) inpatient services** in the six month timeframe.

✔   While a small group of consumers (13.8%) showed an *increase* in the number of days they spent in inpatient facilities, and 29.6% of consumers had no inpatient stays recorded either before or after their CRC stay, overall the use of inpatient services by CRC consumers **decreased from an average of 41.2**

days per consumer in the six months before CRC entry to an average of 13.0 days in the six months after CRC exit.

✓ Analysis of HoNOS scores found a significant improvement in **Total HoNOS scores between entry and exit** (p<.05), and **in three of the four Subscale scores, between entry and exit** (p<.05). Nearly 62% of consumers recorded an **improvement** based on their Total HoNOS score, 5.6% recorded **no change** in their Total HoNOS score, and 32.5% recorded a **deterioration** based on their Total HoNOS score. A quarter (**25.4%**) of consumers who were assessed around their CRC entry and exit experienced a **clinically significant improvement** (8 points of more) in their total HoNOS score.

✓ The findings relating to outcomes achieved for CRC consumers in terms of their use of non-CRC inpatient mental health services and their HoNOS scores prior to and following CRC interventions are encouraging. Although a causal connection with CRC interventions cannot be confirmed (without also analysing the impact of other non CRC variables), the association can be considered to be a positive one.

✓ The recommendations made by the evaluators reflect the findings of consultation with all stakeholder groups and are designed to build on these achievements while also addressing the challenges involved in the continued implementation of the CRC service model.

The extension of CRC services to rural locations is a welcome development, not only because of the access and equity issues addressed, but because the two new centres will strengthen the existing network of CRCs. This creates significant opportunities for peer learning and support for staff and NGO partners and possible opportunities for resource efficiencies – for example, by sharing training and development costs. It will be important to design governance structures and communication processes in such a way that this linkage is supported and that the underpinning model is applied consistently, while being sufficiently flexible to enable local adaptation. This evaluation was conducted at a time of transition which brought its own challenges. Nevertheless, the outcomes can be used to inform future developments and avoid problems encountered during the early developmental stages. A number of specific recommendations have been made as well as suggestions flagged throughout regarding areas that would benefit from further investigation or attention. While the majority of ratings were positive, there could be further investigation into negative staff, key community and support worker feedback. It is expected that other suggestions without specific recommendations will be addressed within Recommendation 1 about reviewing the Service Model as a matter of priority. This would include issues such as length of stay of residents.

As the CRCs transition to a government/NGO partnership, there will be increased scope to provide a wider range of activities and supports for CRC residents that build on the expertise and networks of the partners. To support this partnership it will be important to develop a joint training and development strategy for staff, as recommended by the evaluators and an enhanced approach to rehabilitation training, joint care planning and review processes.

Finally, the CRCs have been implemented in a time of significant change and reform in the mental health sector of South Australia, and this evaluation has been undertaken in the earliest stages of that implementation. This can be expected to bring a range of challenges and it is important to weigh these against the achievements made, both of which are evident in this report. The CRCs have achieved much in a short time and this will provide a solid foundation for their continued development, provided the challenges identified are addressed.

CRC Steering Committee

Ms Amelia Traino, Manager, Rehabilitation and Recovery Services, SA Health Mental Health Unit

Plus other Committee members (see asterisked names below)

CRC Managers

Mr Bill Miliotis, CNAHS Manager, Elpida House CRC*****

Ms Sarah Burden, CNAHS Manager, Wondakka CRC*****

Mr Jamie Ryan, SAHS Manager, Trevor Parry CRC*****

SA Health Regional Directors of Rehabilitation and Recovery

Mr John Strachan, SAHS Acting Director, Rehabilitation and Recovery*****

Ms Barb Wieland, CNAHS, General Manager Rehabilitation and Recovery*****

Regional Allocation Committee representatives

Mr Matt Ballerstrin, Chair SAHS Regional Allocation Committee

Ms Gayle Goodman, Chair CNAHS Regional Allocation Committee

Other

Dr Sue Booth, Senior Research Officer, Mental Health Research & Outcomes Unit

Mr Dan Donaghey, Rural and Remote Mental Health Service, and Rural and Remote representative on CRC Steering Committee*****

Mr Adrian Leet, Rural and Remote Mental Health Service, and Rural and Remote representative on CRC Steering Committee (replacing Dan Donaghey)*****

Ms Ness Wells, Community Key Worker (North)
Mr Rob Underwood, Community Key Worker (South)

The evaluators prepared this consolidated version of the eighth iteration of the CRC Service Model and used it to inform the consultation process.

SA HEALTH COMMUNITY MENTAL HEALTH SERVICES

COMMUNITY RECOVERY CENTRES

Elpida House, Trevor Parry Centre, Wondakka

SERVICE MODEL KEY FEATURES and REQUIREMENTS

FOR DISCUSSION AND FEEDBACK AS PART OF THE AISR EVALUATION OF THE 3 CRCS

The following represents a consolidated version of the Service Model document attached to the RFT for this project as interpreted by the evaluators. It attempts to delineate the Key Features of the Service Model to provide a basis for systematically analysing the following CRC Evaluation Requirement (as outlined in the RFT). It was prepared prior to the Budget announcement and is not considered to be the final version of the revised CRC Service Model which is being undertaken at the time of writing.

Evaluators' comments are provided in italics and in footnotes.

Background

A.   Funding is provided for the delivery of Services in Community Recovery Centres (CRCs) in accordance with the South Australian Mental Health Services Plan endorsed by the State Government in February 2007 (*ref*), under which Service Providers must "*build capacity to assist and support people with mental illness to live full and meaningful lives in the community*[2]."

B.   The CRCs are 20 bed community based residential, rehabilitation facilities and are part of a *stepped model of care* being introduced in SA[3] providing a range of additional options in the continuum of care from support in the community, community recovery centres through to acute care and 24 hour supported accommodation.

C.   Services agree to the Principles, Aims and Outputs as specified in the Service Model.

Service Principles

1.   CRCs are predicated on acceptance by all staff and collaborators of the *concept of recovery* from mental illness, considering both internal and external factors (underlying philosophy)

   a.   Internal or subjective factors such as whether the person has hope for the future, a positive sense of self, meaning and purpose in his/her life, is treated with dignity and respect and feels empowered.

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[2] From Qld Health document: what is over-riding SA goal of MH services?
[3] Stepping Up report, Glenside Masterplan, etc

b. External or objective factors such as whether the person has daily living skills, adequate income and housing; social relationships and supports; meaningful activity and employment and whether he or she experiences prejudice or exclusion.

2. The primary role of CRCs is to support recovery from mental illness of people with high and complex needs (as defined in Target Group) through the *delivery of rehabilitation approaches* that promote self management and encompass hope and a belief in the capacity of all individuals to take their own recovery journey.

3. All CRC residents will have a *MHS Care Plan developed within a recovery framework*, addressing both internal and external aspects, and *delivered in partnership* with consumers, carers and other care providers including the CMHS key worker and where involved, the NGO Individual Psychosocial Rehabilitation Support Services (IPRSS) worker. The plan will reflect and be reflected in the CRC programme[4].

4. CRCs will have a written rehabilitation programme[5] that is recovery focussed and identifies specific approaches or interventions that support both internal and external aspects of recovery.

   a. Specifically the programme will *promote healthy lifestyles* and include aspects such as nutrition, exercise and an ordered day that considers a balance of meaningful social, recreational, vocational activity and personal and home management

   b. The CRC rehabilitation programme will actively address the notion of *"connectedness"* through socially and community focussed interventions.

   c. Programmes will identify the roles and responsibilities of each of the partners, and demonstrate[6] a *coordinated and integrated* approach that assists and supports the person's recovery.

5. Each consumer receiving a CRC service will have a *nominated CRC worker and a CMHS key worker*.

6. Participation in the CRC programme is *voluntary*. While participation is voluntary, it is acknowledged that some people will, at times, need active, even assertive encouragement to engage with the CRC program[7].

7. As a 24 hour service, all CRC staff will be expected to have knowledge of and be involved in any consumers CRC program[8].

8. *Consumers* of the CRC are *encouraged to be as involved as possible in all aspects of the service* they are receiving, including the development and review of an integrated service plan in collaboration with CRC staff, their community key worker, carers and NGO service providers. Consumers are also encouraged to express their level of satisfaction in a number of ways e.g.verbal, written, consumer feedback forms, complaints, resident meetings.

9. *Carers and family members are encouraged, where the client is in agreement, to be involved* with plans for the care of their family member etc. Carers and family members are also encouraged to be involved in Carer meetings at the CRC and as part of evaluation processes.

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[4] What does this mean and how can it be measured?
[5] Is this reasonable ie that a written program exists?
[6] Rather than 'to ensure'
[7] What does this mean in practical terms?
[8] Does this mean ALL staff need to know about ALL resident consumers? Reword; eg All CRC staff will ……….

10. Additionally the following **Principles** apply that are consistent with other MHS components of the stepped system of care:

   a. Consumers are respected as citizens and their participation in, and contribution to the life of the community is supported and promoted.

   b. Needs of consumers from culturally and linguistically diverse (CALD) backgrounds or from Aboriginal or Torres Straight Island (ATSI) backgrounds and people living in rural and remote communities will be acknowledged, respected and accommodated as far as possible.

   c. Consumers are provided with choices and opportunities to develop and maintain skills and to participate in the activities that enable him or her to achieve valued roles in the community.

   d. etc[9]

Target Group

The CRC program is aimed at people suffering mental illness with high and complex needs[10] Typically they will have some or all of the following features[11]:

o Adults aged 18 years or older.

o Need for assessment, intervention and support cannot be met by a less restrictive option.

o An assertive community Mental Health Service has been trialled but has not been able to meet the consumers' needs in intensity or structure.

o Trials of alternate forms of community support (NGO) have not been able to meet the consumers' needs.

o Consumers' needs not able to be met by above approaches due to unsuitability of usual living environment.

o Assessments indicate significant functional disabilities in the areas of life or social skills and self care. This may be in conjunction with forms of social disadvantage such as unemployment, homelessness or risk of exploitation.

o Have been clients of other parts of the mental health service (such as high and medium secure or an acute inpatient unit) and require an intensive period of rehabilitation to assist in their transition to community living.

o Consumers who will participate voluntarily. Orders under the Guardianship and Administration Act (1993) or the Mental Health Act (1993) do not impact on eligibility.

o Risk assessment indicates the person does not pose a significant risk to themselves or other residents of the CRC.

o Consumers who accept the terms of the Residential Agreement or are willing to participate with CRC staff at least in a tentative form of engagement.

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[9] This is a long list and will be difficult to measure. Can it be summarised in terms of respect and dignity and the detailed list included as an appendix?

[10] Is there a succinct definition of 'high and complex needs'?

[11] Does this list need review? Clarification? Ie a list that can be referred to when listing criteria for referral or entry

o   Consumers may not have current accommodation but if not will have identified a preferred location. They will have the support of a CMHS team (and possibly NGO provider) to assist with establishing post exit accommodation. This work will begin on entry.

Services Provided by CRCs

The current list in the SERVICE MODEL document is a mix of services as well as features of a CRC (how it feels or looks like). Suggest a review to consolidate and separate those relating to ALL CRCs then additional features? Also the section labelled "Prevention and Early Intervention Aspects of the Model' can probably brought into this section. Some dot points under "Nature of Services/Service Type" could probably be embedded within Principles, eg:

o   CRCs will support the recovery of a person with a mental illness. Areas of focus for an individuals program will be developed and agreed with that person. The process will also draw on relevant assessments.

Alternatively Principles could be shortened and a new section created called "Features of CRCs" that draw together some of the points under Principles and some currently under Services. The Service section would then relate purely to service provision objective features, such as 24 hour service, multi-disciplinary teams and how comprised etc.

Structural Service Links and Partnerships

Below is the extract from current Service Model document. Given experience since document written can this section be reviewed to more clearly define common and other links?

Key structural service links

CRCs are part of South Australian Mental Health Services, and form a step in the continuum of care. The service is available to existing consumers of mental health services as part of a comprehensive, coordinated Mental Health Services support plan. Whist pathways in may be from any other part of the service, they link most strongly with Community MHS, which is the anticipated pathway out.

Partnership arrangements with other services/service types]

The CRC will work closely and collaboratively with the Community Mental health Team, the GP and where involved the NGO worker.

The CRC service plan is developed in partnership with the consumer and where appropriate, the carer.

Could bring in "Partnership approach section" here

Processes of entry and exit for CRCs

Given that the CRCs have been operating for more than a year since the current Service Model document was written, it would be useful for this section to be reviewed and set out more clearly.

Governance and Risk Management

Outputs and data collection Requirements

Eg CBIS, annual reports (to whom?), etc

Example only, extracted from Queensland Health Template for Mental Health Service Agreement available on the internet [12]

"Mental illness" means a condition characterised by a clinically significant disturbance of thought, mood, perception or memory. (*Mental Health Act*, year)

"Milestones" means the tasks undertaken to establish and implement the service agreed by Us and You and/or within stated timeframes including commencement and completion dates of different tasks.

"Non Government Service Provider" means a service provider, other than the State, providing community mental health services.

"Output" means a measurable unit eg. number of hours, number of places, delivered under community mental health service types as defined in the "Queensland Plan for Mental Health Community Services"

"Program" means the program identified in the Service Agreement (Part C). Where required, the term extends to any replacement program administered by Us to meet similar purposes.

"Quality System" means the process approved by the Minister under which a service provider may be certified by an external body.

"Recovery" – "Recovery is the journey toward a new and valued sense of identity, role and purpose outside the parameters of mental illness; and living well despite limitations resulting from the illness, its treatment and personal and environmental conditions." (from "Sharing Responsibility for Recovery", Qld Health, 2005)

"Service Model Guidelines" – a document which contains a detailed description of the design and operation of funded initiatives.

"Service Outlet" means a place at which community mental health services are provided.

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[12] www.community**services**.qld.gov.au/...**service**-**agreement**/.../draft-specific-terms-funding-community-**services**-**mental**-**health**.pdf; http://www.communityservices.qld.gov.au/community/strengthening_ngos/common-service-agreement/