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**Evaluation of the
NSW Mental Health – Community Living
Supports for Refugees Program (2019–21)**

Final Report

June 2022

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Purpose of this document

This report was prepared by Human Capital Alliance (International) Pty Ltd (HCA) for the Mental Health Branch, NSW Ministry of Health (MoH).

It is the Final Report for a process evaluation of the Mental Health Community Living Supports for Refugees (MH–CLSR) program. This report describes and analyses findings across three rounds of data collection carried out over the first two years of establishing the program. The evaluation commenced in late 2019 and was completed in September 2021.

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We acknowledge Aboriginal and Torres Strait Islander peoples as the traditional custodians of Australian lands and waters. We acknowledge the wisdom of Elders past, present and emerging, and pay respect to all Aboriginal and Torres Strait Islander peoples and communities of today.

This report was prepared on Awabakal, Eora (Gadigal), Gumbaynggirr and Ngunnawal Country.

We also acknowledge the lived experience of refugees and asylum seekers and people living with a mental health issue.

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Human Capital Alliance

Human Capital Alliance (International) P/L (HCA) specialises in helping clients align their human resources to their own objectives – whether these be organisational, occupational, industrial or national. We are a Sydney-based management and research consultancy firm, established in 1989. HCA has consulted to public, not-for-profit, Aboriginal community controlled, and private sector organisations. Our methodologies are well-researched, innovative and effective. Our consultancy work has mostly been in the domestic (Australian) market with some international assignments in the Asia/Pacific region and Europe. Two important themes that run through our work are our commitment to:

- understanding and acting on client needs through a strategic research approach, rather than simply operational
- employing the best possible research methodology (within budget constraints) to find answers that meet the unique needs of each client.

HCA has undertaken more than 30 projects in the mental health space. These range from small assignments and service-level evaluations to reviews of large mental health and suicide-prevention projects, including whole-of-government responses to mental health and suicide service demands.

SHORT SUMMARY

ABOUT THE PROGRAM

The Mental Health Community Living Supports for Refugees (MH-CLSR) program was established in June 2019. It is based on the well-established NSW Health Community Living Supports (CLS) program but aims to meet the needs of refugees and asylum seekers. Both programs help people with mental illness to recover and live in the community with as little ongoing help as possible.

Unlike the CLS program, a person does not need a formal mental illness diagnosis to receive support from the MH-CLSR program. The MH-CLSR program is also unique in that it is open to refugees and asylum seekers of all ages within the first 10 years of arriving in Australia, with support for the entire family considered. It is the first program of its kind in Australia and internationally to provide support in this way to this community group.

The MH-CLSR is currently available in seven NSW local health districts (LHDs) where a large number of refugees and asylum seekers live. The NSW Ministry of Health (The Ministry) administers the program and contracts community managed organisations (CMOs) who specialise in mental health and refugee settlement to deliver the program. This occurs in partnership with LHD mental health services. In 2021-22 the program received \$5.1 million in recurrent annual funding.

ABOUT THIS EVALUATION

The Ministry commissioned this evaluation for the first two years of the program (2019 -2021), to assess whether it was being implemented and governed as intended. Data sources included key documents, interviews, surveys and administrative data. Responses from service providers and consumers were included. The analysis involved comparing and combining data collected over three points in time.

By the end of the evaluation period 165 consumers were receiving support from MH-CLSR. This is more than double the number of people CMOs were contracted to support (79). Of those who received support 54% were refugees and 39% were people seeking asylum, with a small number with 'other' or unknown visa status.

The average time consumers remained in the program was 357 days. The most common type of support provided was to help consumers with their mental health, daily living skills and accessing other services. Depression, post-traumatic stress disorder (PTSD), and anxiety were the most common diagnosis for which consumers received mental health support.

There were differences in the support needs and type of support provided depending on where consumers lived. Sometimes this was because other local services were present to help with their needs. There were also differences based on the mix of refugees compared to asylum seekers in the location. Asylum seekers were reported to need more help with basic living needs than refugees.

At a broad summary level, the evaluation has found the strengths of the program are:

- The program has a clear and strong purpose and direction, and in most cases the model of care is being followed.

- There is a high level of trust and satisfaction with the program amongst consumers. Consumers report the program is easy to engage with. They find it flexible and report that it meets their needs.
- CMOs and LHDs also report a high level of satisfaction with the program and with the Ministry's management of it.
- CMOs have recruited a suitable workforce to support delivery of the program, and they have established successful connections with local community organisations.
- Pathways to refer consumers to local health services are in most cases effective.
- Partnership arrangements between CMOs and LHDs are functional and supportive of program needs.
- The program delivers a need for refugees and asylum seekers that is not met by the mainstream CLS program.

AREAS IDENTIFIED FOR FURTHER IMPROVEMENT

To improve CMO practice the Ministry could provide guidance to CMOs on:

- Effective ways to help consumers develop their goals; plan their recovery and exit from the program; and the types of support needed to achieve this.
- How to support a consumer's family members.
- When to help consumers with travel.
- How to best support asylum seeker consumers.
- Adjusting the types of support and hours of support so that consumers can reach their goals more easily.
- Including in the Individual Support Plan (ISP) how a consumer may 'step-down' or transition out of the program in a planned way.
- Introducing good client record management systems so that consumer information can be captured and analysed more easily.
- Using the Living in the Community Questionnaire (LCQ) outcome measures to see if the supports provided to consumers are effective.
- What community engagement means in MH-CLSR and the types of community engagement activities that CMOs should undertake in the program.
- Best practice clinical supervision that CMOs could undertake with their support workers including frequency, amount of time and quality.
- Identifying the training needs of CMOs and developing strategies to meet these.

To improve program operation, partnerships and governance:

- Explore the use of alternative outcome measure tools to the LCQ that may be easier for consumers to complete.
- Distribute examples of excellent shared care practices that are currently in place between some CMO and LHD workers to promote better shared care of consumers.
- LHDs could nominate an operational level contact for CMOs to liaise with to discuss consumer support issues and LHD processes.
- Organise information to CMOs and LHDs about consumer access to income support and health care in specific visa categories.
- Continue to capture CMO expenditure data (six monthly) and share findings with all CMOs that could promote more efficient operational spending.

The above opportunities may be implemented to further improve the program and are set out in more detail at the end of the Executive Summary.

Finally, good practice was evident throughout the evaluation. It shows that MH-CLSR is being governed and delivered according to the intended model of care, and that it is a valuable addition to the existing suite of community based psychosocial support programs delivered by NSW Health.

A future impact evaluation of the program may determine whether the program has resulted in improved mental and physical health and well-being outcomes for refugee and asylum seeker consumers. A proposed methodology for an impact evaluation of this program is provided at Appendix 4.

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ACRONYMS AND ABBREVIATIONS

CALD	Culturally and Linguistically Diverse
CEE	Centre for Epidemiology and Evidence
CLS	Community Living Support (a state wide program which supports people with a severe mental illness to live and participate in the community in the way they want to)
CMH	Community mental health
CMO	Community managed organisation
FIRS	Field Implementation Rating Scale
FTE	Full-time equivalent
HASI	Housing and Accommodation Support Initiative
HCA	Human Capital Alliance
HCIS	Health Care Interpreter Service
InforMH data collection	Minimum Data Set for MH-CLSR
ISP	Individual Support Plan
LCQ	Living in the Community Questionnaire
LHD	Local health district
MoH	Ministry of Health
MH-CLSR	Mental Health Community Living Supports for Refugees program
Program Guidelines	'Mental Health Community Living Supports for Refugees – Program Guidelines'
NDIS	National Disability Insurance Scheme
NSW	New South Wales
SIA	System Information and Analytics
SLA	Service Level Agreement
STARTTS	NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors
TIS	Telephone Interpreting Service
VET	Vocational Education and Training

EXECUTIVE SUMMARY

ABOUT THE PROGRAM

The Mental Health Community Living Supports for Refugees (MH–CLSR) program is unique. It aims to assist refugees and asylum seekers who are experiencing psychological distress, mental ill-health and impaired functioning. The program provides trauma-informed, recovery-oriented, and culturally safe and responsive psychosocial supports

In November 2017, the NSW Government announced recurrent operational funding of \$4.8 million for the program, as a supplement to the NSW Government’s mental health reform strategy, which has been underway since 2014. The program operates through four community managed organisations (CMO) in nine separate sites across seven local health districts (LHD). Process evaluation of the program began in 2019 and covered the first two years of the program implementation. This report details the results of the evaluation.

Objectives of the MH–CLSR program

- Improve the mental health, wellbeing and functioning of program consumers.
- Increase social participation and community integration of program consumers.
- Prevent acute mental health crisis and avoidable admissions to hospital or presentations to emergency departments.

OBJECTIVES OF THE EVALUATION

This evaluation has focused largely on the program implementation process. The evaluation objectives were to:

1. Examine program implementation and governance.
2. Assess the effectiveness of the program in achieving the outputs and selected impacts.
3. Describe the costs associated with program implementation and based on the program reach, provide an estimate of the expected benefits of the program to government in monetary terms.
4. Outline a plan for future performance monitoring, impact and outcome evaluation.
5. Collect relevant baseline data for this future evaluation.

The broad areas of evaluation questioning were:

- service coordination and governance
- model of care
- skills and training of workers
- care planning
- community engagement and partnerships
- outcomes of the program.

METHODS

The evaluation involved three data-collection rounds to assess the implementation and progress of the program – baseline round (August 2020), second round (April 2021) and final data collection round (August 2021). Following data collection and analysis in both the baseline and second rounds of data collection, quality improvement type workshops were held with CMO and LHD managers. Members of these workshops discussed selected findings and determined recommendations between them to be enacted by both CMOs and LHDs.

Mixed methods approach

This approach was used to examine the program from a range of different perspectives and data sources. It was designed to satisfy the evaluation objectives set by the NSW Ministry of Health (MoH). The mixed methods included:

- management audit (including document review and key informant interviews with CMO managers and support workers, LHD managers, partner agencies, relevant community leaders and groups)
- survey of CMO managers
- collection of cost data
- collection of program administrative data (Supported Living Collection Minimum Data Set collected through the InforMH data collection)
- interviews with program consumers.

Analysis of data

Data analysis was conducted through qualitative and quantitative approaches which are described in more detail in the main body of the report and in Ridoutt et al., 2019.¹ Findings derived from the analysis were interpreted through a Field Implementation Rating Scale (FIRS) tool (Rubin et al., 1982) to assess the extent of implementation at each site and across the program as a whole, according to 13 pre-defined implementation criteria. The assessments reviewed the differences of implementation between the sites in terms of their level of variation or compliance with the model of care, as presented in the 'Mental Health Community Living Supports for Refugees – Program Guidelines' (the Program Guidelines).

FINDINGS AND DISCUSSION

Findings from the three data collection rounds indicates that the program complied with the Program Guidelines. Importantly, stakeholders, including consumers, were satisfied with the program. Stakeholder groups reported that the program targeted a need for psychosocial support for refugees that had previously been unmet through the mainstream Community Living Support (CLS) program. Despite this

¹ Ridoutt, L., Cowles, C., Lawson, K., Leary, J. and Stanford, D. (2020). *Baseline report of the evaluation of the Mental Health Community Living Supports (MH-CLSR) program*, Ministry of Health, NSW.

positive assessment, and after acknowledging improvements that occurred after the quality improvement workshops, some areas of possible improvement remained.

Program governance

At each site, structured and functional partnerships between CMOs and the seven LHDs were established and formalised in line with the Program Guidelines. This marked an improvement from the baseline CMO manager survey data. Both CMO and LHD manager interviews indicated that the existing partnership arrangements all functioned sufficiently well to meet higher-level partnership needs.

The arrangements for partnership meetings varied between sites in their regularity, membership, and content. The CMOs/LHDs with better operational relationships tended to have the following characteristics:

- high levels of trust, established from previous experience of working together for other programs, especially the Housing and Accommodation Support Initiative (HASI)
- dual partnership arrangements – at one level senior managers discuss service level agreement (SLA) type issues and, at another level, team leaders and sometimes support workers discuss operational issues and individual support
- an effective LHD resource person (for instance a Clinical Partnership Coordinator) with the role to promote and facilitate liaison between LHD clinical staff and other resources and other relevant services.

Most CMO and LHD managers agreed that a shared care approach to consumers was the ideal, but in most cases a form of 'parallel' care was practised, at best.

Understanding of the model of care

The final data collection round confirmed earlier findings that the program was largely perceived as having clear and strong purpose and direction. This supported the high level of satisfaction of managers (CMO and LHD) with both the Program Guidelines and in the MoH direction of the program, as identified in the baseline data. However, findings showed that continued practice brought providers increasingly into novel situations where the Program Guidelines were open to interpretation at the site or CMO level. In responding to these situations CMOs could at times be uncertain for whether adjustments might be viewed as 'non-compliant' with the model of care or as a 'tolerable' level of variation under the program's general principle of flexibility.

Three areas where uncertainty was prominent and where the Program Guidelines were reported to be unclear were:

- exit of consumers from the program – CMO stakeholders sought more guidance on best-practice pathways to creating recovery-based exit.
- information sharing between clinical partners – CMO stakeholders sought more explicit guidance on appropriate information sharing

- CMO respondents widely supported the ‘whole-of-family’ approach, as outlined in the model of care, because of the flexibility and integration it allowed in terms of service response. However, some CMO interview respondents noted that defining a ‘family’ as the service unit created both administrative (capacity and budget) and practice issues (workforce skill base) that needed clarification.

Service delivery – Fidelity to the model of care

Service volume

Since the program began, the number of consumers receiving a service climbed steadily and plateaued in 2021, at or above contracted levels. Overall, CMOs were contracted to provide support at any one time to 79 consumers, but the final number of consumers was approximately 165 – over double (109%) the number CMOs were contracted to support.

Based on the program data, higher levels of support resulted in:

- less support time being spent, on average, per consumer (41% less than contracted) and their needs being met over a longer support period.
- more support time (24%) than contracted delivered collectively to all consumers; the original contracted hours were always intended to be a minimum.

CMOs contended that the lower average hours of support per consumer did not impact service quality or outcomes.

Service patterns

Fifteen possible types of support were identified in the model of care. One third (33%) of all support hours were spent on two types: ‘Support in accessing other support systems’ and ‘Support in psychosocial intervention’. These together with another three support types – ‘Support preparing support plans’, ‘Support in daily living skills’ and ‘Support in medical/health activities’ – used almost two thirds of total support time (62%).

The different sites varied widely in the way CMOs allocated their available support hours, as anticipated by the flexibility built into the model of care. To some extent, this reflected the natural differences that could be anticipated between sites. These included:

- consumer population needs (e.g., refugees versus asylum seekers)
- service context (e.g., urban versus rural)
- service environment (the availability or not of partner services).

Evidence of the impact of current service delivery decisions on consumer outcomes will be explored in a future impact evaluation of the program.

Development of Individual Support Plans (ISPs)

The development of ISPs was a critical component of the program’s model of care and evidence indicated that all sites approached this task accordingly. Compared to baseline data, recent data (survey and

interviews) revealed that the quality of ISPs improved, and ISP review had become more regular and consistent. There was also an increase in CMO support worker understanding that the ISP is a key tool to direct the selection of support activities. Adoption of electronic formats, as already proposed by some CMOs, will also assist with monitoring and review of progress against goals and outcome measurement into the future.

Completion of the Living in the Community Questionnaire (LCQ)

In the baseline data collection, the LCQ was shown to have been administered infrequently and often incompletely. Despite some improvements in performance and the LCQ having been translated into 18 different and relevant community languages, the final data collection round revealed that the LCQ administration was still not reaching practice levels that supported good program monitoring.

At a workshop to discuss second-round data findings (16 June 2021), CMO managers noted that LCQs that were translated still required an interpreter to navigate with the consumer. This was due to poor literacy in the consumer's own language, and the use of technical terms that did not make sense in translated text and/or that consumers found confronting.

Most CMO managers recognised that less-than-adequate LCQ administration practice impacted the ISP development process and the capacity to measure consumer progress and outcomes quantitatively. If the LCQs were to remain the primary means to achieve these purposes, CMO support workers need more intensive training and development in its use.

Relationship with local community groups and leaders

All sites appeared to find a range of ways to build successful connections with local community organisations and other potential referral agencies.

CMO managers who were interviewed indicated that after the initial phases of the program, progress in advancing community engagement slowed down. The managers reflected on the challenges that they and support workers faced in committing adequate time to community engagement when there were pressures to provide other more urgent forms of support to individuals.

They also noted that the skillset required for effective community engagement was different to that needed by support workers to provide individual support. Most support workers did not naturally possess the two skillsets.

The model of care is focussed on community engagement yet understanding and implementation of this component was varied. Many managers and staff talked about community engagement and development as interchangeable concepts. Further guidance on how to define, undertake and manage this component of the program was requested by many sites.

Relationship between the CMOs and LHDs

In each site, structured and functional partnerships between CMOs and the seven LHDs had been established and formalised in line with the Program Guidelines. This was an improvement on the situation found during baseline data collection. CMO and LHD manager interviews indicated that the existing partnership arrangements all functioned sufficiently well to meet higher level partnership needs.

Most CMO and LHD managers agreed that a shared-care approach to consumers being supported in common was the ideal. However, in most cases a form of 'parallel' care (at best) was practised. Scope for

improvement existed in how the program operated at the service-to-service level between CMOs and LHDs. This included how consumers were referred between services and how information was shared.

Consumer experience

Data collected through individual interviews indicated that consumers unanimously found the program easy to engage with. Consumers also appreciated the flexible and personalised approach that program staff could take in meeting their short- and longer-term support needs. Consumers greatly valued simple communication that created a high level of trust. Consumers and support workers reported that these activities provided a good platform of connection for goal setting and future independence.

Consumers also valued group activities highly and this view was confirmed by CMO managers and support workers in places where group activities had been conducted. Consumers reported group activities to be particularly beneficial as a form of 'lived experience' support network, where trauma did not need to be re-described. The reported value of group activities for establishing ongoing social networks suggested their potential value as part of a step-down approach to gradually exit from the program. The number of support hours devoted to group activities was very limited.

CMO respondents reported that asylum-seeker consumers, compared to refugee consumers, often needed more intensive scaffolding for basic needs of living – at least in their initial phase of engagement with the program.

Workforce and training issues

Since the initial baseline data collection, the workforce had doubled in size and was reaching maturity. There seemed to have been a broad recruitment shift across the CMOs, towards higher reliance on relevant formal qualifications and a secondary focus on lived experience. However, the proportion of the workforce with lived refugee or mental health experience was still considerable (44%) and in keeping with the Program Guidelines.

The one area of concern for recruitment was in relation to community engagement/development activities. Based on cost data, only 7.2% of the workforce was dedicated to these activities. Access to better training and support for CMO support workers to undertake these activities had the potential to improve exit outcomes for consumers.

In the early program stages, training of the workforce was comprehensive and appropriately targeted. In the final round of data collection, manager and support worker interviews seemed to identify a broad shift in training strategy from manager-directed to support worker-directed (that is, support workers tended to report that it was up to them in general to identify their own training needs and request those on an individual basis). It might be time to reconsider MH-CLSR workforce training needs across the program and establish learning interventions that could apply to much of the workforce.

CMO support worker interviews indicated that clinical supervision was reported as being quite variable in frequency and quality across, and sometimes even within, CMOs. According to CMO manager and support worker interviews, the only widely implemented form of regular supervision was administrative in nature and, while this was supportive of on-the-job learning, it tended not to foster active reflection. This is a key area of required improvement.

Cost of implementation

Only minor differences existed between CMOs in the distribution of total expenditure to operational and establishment components. As the program had evolved over time, spending on establishment and capacity building had reduced, as expected. On average, expenditure on workforce (including management) accounted for approximately 80% of the total operational expenditure across the program.

The most significant differences between sites, even between those managed by the same CMO, were in the average cost per consumer. The average cost per consumer was \$1,240 at the program level on average, ranging from a high of \$1,950 to a low of \$583 per consumer.

The approach to economic analysis for this evaluation period focused on implementation and process evaluation. The available data did not allow an assessment of reach, nor an estimate of the expected benefits of the program to government in monetary terms. Insufficient time had passed to observe substantive changes in consumer outcomes (such as reductions in acute service use) that could be attributed to the program. There should be opportunities to do this in the future – once further time has elapsed, and adequate data has been collected. This was proposed in the separate deliverable that outlines an Impact Evaluation method (at Appendix 4).

CONCLUSION

The program appeared to be a valuable and widely welcomed addition to services for NSW refugees and asylum seekers who were experiencing psychological distress, mental ill-health and impaired functioning.

CMOs were progressing well in implementing the program, largely according to the model of care. However, there were notable aspects of the model that had been less well implemented and where improvement was still required. These aspects include:

- development and use of ISPs
- completing LCQs and therefore creating a better record of impact
- engaging at a clinical level between LHD assets and CMO support workers
- re-focusing and maintaining focus on community engagement
- re-focusing and maintaining focus on training and development of CMO staff
- clarifying some aspects of the model of care.

Despite these identified areas for further improvement, CMOs, LHDs, other service stakeholders, and community members had all observed individual case successes and perceived the potential for the program to achieve considerable benefits.

The proposed impact evaluation would determine objectively whether implementation of the program translated into improved health and well-being outcomes for refugees and asylum seekers experiencing psychological distress.

OPPORTUNITIES FOR IMPROVEMENT

A range of opportunities for improvement have been identified through the evaluation in alignment with seven key areas:

Understanding of the model of care	<p><i>Opportunity #1:</i></p> <p>The Program Guidelines could include evidence based ‘best practice’ approaches and criteria to guide CMOs to better develop consumer goals and interventions; plan their supported recovery and to assess the readiness to exit consumers. In the longer term the proposed Impact Evaluation, especially the audit of ISP goal achievement, should provide program-specific ‘best practice’ guidance.</p> <p><i>Opportunity #2:</i></p> <p>Regular workshops (quarterly) could be conducted with CMOs to provide guidance on the approach to specific situations such as the whole of family supports, transport of consumers and supporting asylum seekers who have much broader settlement-related needs because of their ineligibility for services. Where appropriate, Program Guidelines could be updated on the agreed approaches.</p>
Service delivery – Fidelity to the model of care	<p><i>Opportunity #3:</i></p> <p>Hold regular workshops with CMO managers to consider whether certain types of support activity are being under-utilised by the program workforce, so that where needed CMOs can modify the distribution of support hours and support worker approaches in the development of ISPs.</p> <p><i>Opportunity #4:</i></p> <p>CMOs could be encouraged and supported to introduce efficient client record management software platforms to better capture, store and access consumer information including ISPs. This would greatly assist a future Impact Evaluation of the program to access and analyse consumer outcome data more easily.</p> <p><i>Opportunity #5:</i></p> <p>A short interactive training course could be developed for all MH-CLSR support workers to use the LCQ more in their work, and to better use the LCQ outcome measures to obtain feedback about the effectiveness of consumer supports provided.</p> <p><i>Opportunity #6:</i></p> <p>In consultation with CMOs and LHDs, explore the use of alternative outcome measure tools to the LCQ that can be used with consumers (such as Recovery Assessment Scale – Domains and Stages [RAS-DS], Camberwell Assessment of Need [CAN] and the WHO Wellbeing Index). These alternative tools capture similar data on living skills, recovery needs, and independent living outcomes as the LCQ, but are not as arduous to complete and are also available in translated form.</p>
Relationship between the CMOs and LHDs	<p><i>Opportunity #7:</i></p> <p>Capture and distribute across the MH-CLSR program examples of excellent shared care practices that are in place between some CMO and LHD workers to</p>

support consumers. These examples can show case ways that all CMOs and LHDs can overcome cultural and practice barriers to practice genuine shared and achieve better outcomes for consumers.

Opportunity #8:

LHDs could assign an operational level contact person or unit for CMOs to liaise with to discuss consumer support issues and to clarify LHD processes and engagement as needed.

Consumer experience

Opportunity #9:

CMOs could formally including in the ISP how a consumer may 'step-down' or transition out of the program as part of their recovery journey. This will assist the consumer to transition out of the program in a planned way when appropriate to do so.

Opportunity #10:

Some CMOs and LHDs would benefit from information and training about the implications of specific visa categories in terms of access to income support and health care in particular.

Workforce and training issues

Opportunity #11:

The Program Guidelines could clarify what is meant by community engagement and the types of community engagement activities that CMOs should undertake that would satisfy the purposes of the model of care. It should also outline the proportional effort CMOs are expected to make in community engagement, and the types of outcomes expected from this activity. This in turn would inform the types of skill required by the workforce to implement those activities effectively.

Opportunity #12:

Consider undertaking a broad training-needs analysis of the MH–CLSR workforce and identify areas of common learning needs. The Ministry of Health and CMOs could collaboratively initiate a range of strategies to meet these identified training needs including cross CMO shared learning workshops; practical on the job learning activities and online and face to face training courses.

Opportunity #13:

Consider undertaking an audit of current clinical supervision through a survey of MH–CLSR support workers, seeking their views on the consistency and quality of clinical supervision they receive. Following this, the Program Guidelines could include guidance for CMOs on best practice clinical supervision including frequency, amount of time and quality.

Cost of implementation

Opportunity #14:

The Ministry of Health could continue to capture CMO expenditure data (perhaps on a half-yearly basis) using the 'costings survey' used in this evaluation. Analyse and share any positive site expenditure findings with all CMOs that may promote more efficient operational spending.

1. INTRODUCTION

ABOUT THE PROGRAM

In 2014, the NSW Government began a decade-long reform of the mental health system. The reforms included funding for mental health clinical care, together with a range of psychosocial supports for people with severe mental illness. This includes the Housing and Accommodation Support Initiative (HASI) and Community Living Supports (CLS). In November 2017, the Minister for Mental Health announced a further allocation of \$4.8 million in recurrent operational funding to expand psychosocial supports for refugees living with mental health conditions. This was linked to the increased intake of refugees fleeing conflicts in Syria and Iraq.

The Mental Health Community Living Supports for Refugees program, known as the MH–CLSR program (the program) is unique. It aims to provide trauma-informed, recovery-oriented, and culturally safe and responsive psychosocial supports to refugees and asylum seekers who are experiencing psychological distress, mental ill-health and impaired functioning.

The objectives of the program are to:

1. Improve the mental health, wellbeing and functioning of program consumers.
2. Increase the social participation and community integration of program consumers.
3. Prevent acute mental health crisis and avoidable admissions to hospital, or presentations to emergency departments.

Services are provided in the LHD areas in NSW that have concentrated areas of primary and secondary settlement of refugees and/or significant service delivery to asylum seekers. These LHD areas include Sydney, South Western Sydney, Western Sydney, Murrumbidgee, Illawarra Shoalhaven, Hunter New England and Mid North Coast (See Table 1).

The services of the program are provided under contract by four CMOs at nine separate sites across the seven LHDs.

New Horizons has subcontracted 45% of service delivery in South Western Sydney LHD, Mid North Coast LHD and Sydney LHD and 100% of service delivery in Hunter New England LHD to the NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS).

Table 1: CMO providers and LHDs²

CMO	LHD	Sites
Anglicare Sydney	Western Sydney	Western Sydney
Australian Red Cross	Murrumbidgee	Griffith and Wagga Wagga
Grand Pacific Health	Illawarra Shoalhaven	Wollongong
New Horizons and STARTTS	Mid North Coast South Western Sydney Sydney	Coffs Harbour Fairfield/Liverpool Ashfield
STARTTS	Hunter New England	Newcastle and Armidale

The current MH–CLSR Program Logic is published in the Program Guidelines (Appendix 3 in 'Mental Health Community Living Supports for Refugees – Program Guidelines'). The Program Logic is included as Appendix 1 in this report. The Program Guidelines provide guidance for CMOs and LHDs about a wide range of matters, including the aims of the program, its philosophy and model of care (including its basis in recovery orientation, cultural safety and responsiveness, and trauma-informed care), the types of support services that can be offered and its reporting requirements.

EVALUATION OF THE PROGRAM

The evaluation of the program commenced in October 2019 and was undertaken almost simultaneously with the first two years of program implementation.

The objectives of this evaluation were to:

1. Examine the program implementation and governance.
2. Assess the effectiveness of the program in achieving the desired outputs and selected impacts.
3. Describe the costs associated with program implementation and based on the program reach, provide an estimate of the expected financial benefits of the program to government.
4. Outline a plan for monitoring the future performance and impact of the program, and evaluation of outcomes.
5. Collect relevant baseline data for this future evaluation.

The methodology to meet the first three evaluation objectives is provided below. The plan for future performance monitoring, impact and outcome evaluation has been provided separately.

² The Program Guidelines identifies 12 sites in seven LHDs viz.: South Western Sydney, Western Sydney, Murrumbidgee, Illawarra Shoalhaven, Hunter New England, Mid North Coast and Sydney. The InforMH Data Set identifies only 10 separate site entities across the same seven LHDs. Since this data set was a primary means of collecting administrative data, and unlikely to be changed in the future (thus forming a historical and future record of program activity), the starting point for site-based data collection became these 10 sites. Subsequently, when the management audit and CMO Manager Survey was being implemented it was found that two sites, Fairfield and Liverpool, were effectively being managed as a single site (South Western Sydney).

EVALUATION METHOD

Overview of the evaluation design

A mixed methods approach was used to examine the program from a range of different perspectives and data sources. The evaluation consisted of three rounds of data collection, to assess the implementation of the program. Figure 1 shows the timing of commencement of each of these data collection rounds and provides a summary of the methods used at each round.

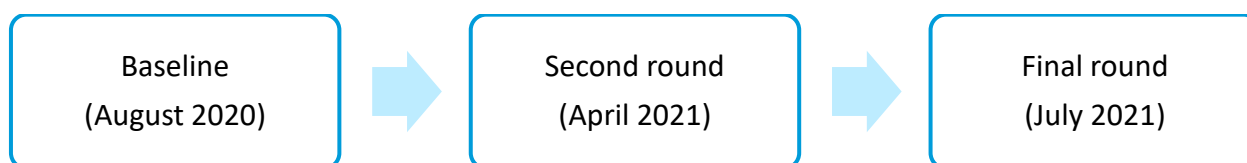


Figure 1: Overview of the evaluation timeline

Data in each data collection round was collected to answer the evaluation questions in each of the evaluation focus areas (see Appendix 2).

The evaluation included the following data collection activities:

- management audit (Chemlinksy, 1985) – a survey of CMO managers; document review; and key informant interviews with CMO managers and staff, LHD managers and team leaders, partner services/ agencies, relevant community leaders and groups
- collection of cost data
- collection of program administrative data – Supported Living Collection minimum data set collected through the InforMH data collection (referred to subsequently as the InforMH Data Set)
- interviews with program consumers.

More detailed information about the evaluation design and data collection processes is available in the Evaluation Plan Version 1.3 (Ridoutt et.al., 2021).

Data collection

Data were collected from all nine sites where the program was delivered (see Table 1) as follows:

- **Baseline data collection:** this round aimed to understand how the program was initially being implemented at each site. It also provided comparative data for future rounds of data collection.
- **Second data collection:** this round focussed on collecting comparative data to assess changes in implementation patterns. This was especially in relation to aspects raised in the feedback workshop following baseline data collection.
- **Final data collection:** this round examined how the program implementation had changed over time at each site.

Table 2 below provides details of the methods, respondents and sample sizes across data-collection activities.

After the first two rounds of data collection, two 'Plan-Do-Study-Act' (PDSA)-style feedback workshops were held to discuss selected findings with CMOs and LHDs. Subsequent data collection rounds included an assessment of whether agreed actions from these workshops were implemented and if there was an improvement in identified areas. Workshops were attended by both CMO and LHD manager representatives with program responsibilities and resulted in a series of agreed changes to program processes.

Table 2: Summary of data collected over each data collection round

Data collection method	Data collection round			
	Baseline round: Sept./Oct. '20	Second/ mid-term round: April/May '20	Final round: Aug./Sept. '21	Total
Management audit:				
<u>Document review</u>	15 program level documents ³ Over 70 site level documents ⁴	–	15 documents provided by CMOs ⁵	> 100 documents
<u>Interviews:</u>				
<ul style="list-style-type: none"> • CMO staff (managers and support workers) 	n = 35 (from 9 sites)	n = 3 (from 3 selected sites who had been identified for follow up at the first feedback workshop)	n = 15 (from 9 sites)	n = 53
<ul style="list-style-type: none"> • LHD staff (managers and support workers) 	n = 17	–	n = 7	n = 24
<ul style="list-style-type: none"> • Partner services and community organisation representatives 	n = 6	n = 10 (from 7 sites)	–	n = 16
<ul style="list-style-type: none"> • MoH personnel 	n = 2	– ⁶	–	

³ Included funding briefs, business plans, tender documents, program guidelines and data specifications.

⁴ Included tender submissions, annual reports, service agreements, acquittals, establishment plans, workforce capacity building plans, subcontracting arrangements, site level policies and procedures.

⁵ Documents described the way community engagement and development activities were approached.

⁶ Separate interviews were not undertaken with Ministry stakeholders after the baseline round of data collection because HCA met regularly (almost fortnightly) with MoH and CEE staff.

Data collection method	Data collection round			
	Baseline round: Sept./Oct. '20	Second/ mid- term round: April/May '20	Final round: Aug./Sept. '21	Total
CMO manager survey	Survey input from 9 sites	Survey input from 9 sites		18 individual surveys
Interviews with consumers	n = 11 (from 7 sites ⁷)	n = 10 (from 5 sites ⁸)	n = 11 (from 7 sites)	n = 32
Costings survey⁹	Survey input from 9 sites	–	Survey input from 9 sites	18 site surveys
Program administrative data (InforMH Data Set)¹⁰	132 unique consumer records analysed (August 2019–May 2020)	213 unique consumer records analysed (June 2020–April 2021)	200 unique consumer records analysed (additional data: April–July 2021)	464 unique consumer records analysed ¹¹

Data analysis

Description of analyses

Analysis of data within each specific data collection activity was undertaken as follows:

- *CMO manager survey data* were aggregated and analysed. This involved descriptive analysis of single variables associated with the implementation process, using frequency and percentage response distributions.
- *InforMH program data* were obtained about consumers who were referred and accepted into the program by the CMOs. Data were analysed through simple descriptive statistical analysis (frequency distributions and cross tabulations) to examine specific variables between and within sites.
- *Management audit and consumer interview data* were analysed through a combination of content and thematic analysis (Ezzy, 2002). This identified common themes and concepts across stakeholder groups and sites. The evaluation focus areas were used as the initial organising themes.

⁷ All consumer interviews were conducted with an interpreter via TIS, except if consumers spoke Arabic or had a stated preference to speak in English.

⁸ Interviews conducted as above.

⁹ Costs relate to establishment, workforce capacity, recurrent expenditure and time for governance meetings.

¹⁰ Monthly program data was provided by System Information and Analytics (SIA) Branch of the MoH to the evaluation team as unit record data in a CSV file format.

¹¹ The records for some consumers were included in more than one data round, representing people remaining in the program between data collection rounds.

- *Costings survey data* was analysed through a descriptive approach. This involved estimating costs of implementing the program in relation to costs associated with program establishment, workforce capacity, recurrent expenditure and time for governance meetings.

A Field Implementation Rating Scale (FIRS) (Rubin et al., 1982) was also used to assess the extent of implementation at each site according to predefined criteria. Assessment focussed on the extent that implementation was or was not achieved.

For this evaluation, a feature of the FIRS tool was that program managers and service providers and other stakeholders (including consumers) contributed to in the construction of the criteria and rating scales. The evaluation team used data collected from the surveys, the document review and interviews with stakeholders to subjectively construct FIRS ratings on each criterion at each site. FIRS criteria developed for this evaluation were as follows:

1. Readiness for implementation
2. Leadership and commitment to the program
3. Access and intake to the program
4. Individual Support Plans (ISPs)
5. Workforce composition of the program and professional development
6. Use of interpreters
7. CMO relationship with the local community (e.g., refugee, religious leaders, etc.)
8. CMO relationship with other local partners and services
9. Appropriateness of the service agreement
10. Effectiveness of the local partnership meetings
11. Working relationships between CMO and LHD
12. Clarity of purpose and direction of the program
13. Referral mechanisms to other services.

Detailed information about the FIRS method is provided in Appendix 3.

Interpretation of findings

All data from each data collection round (Table 2) were analysed separately. The information from each data collection round was then combined and interpreted using a triangulation approach (Jick, 1979). Where contradictions in interpretation of findings occurred (for instance where interview and CMO manager survey data disagreed on the current state of clinical supervision), the weight of evidence for a particular conclusion was adopted or the contradiction was acknowledged.

Approach to economic analysis

The economic analysis focused on the cost of implementation, variation between sites and the distribution of key expenditures. This included costings for:

1. establishment and capacity building
2. operational expenditures to run the program
3. governance to manage the program.

This analysis aligns with the aims of the process evaluation and provides information for future program investment, including the expenditure needed for operational and governance activities. It also provides an opportunity to understand variation between sites.

Although included in evaluation objective 3 (see section *Evaluation of the program*), it was not possible in this phase of the evaluation to assess reach or provide an estimate of the expected benefits of the program to government in monetary terms. This was because insufficient time had passed to observe substantive changes in consumer outcomes – such as reductions in acute service use which could be attributed to the program. It may be possible to include a return-on-investment or cost-benefit analysis in future evaluation phases, as detailed in the proposed Impact Evaluation Methodology (see Appendix 4).

2. FINDINGS

OVERVIEW

This section presents information and findings collected from three stages of data collection of the evaluation. This includes:

- a description of the characteristics of program consumers and service delivery outcomes.
- findings for key evaluation question grouped under key focus areas of the evaluation (Appendix 2).
- three additional areas of focus ('Use of interpreters' and 'Living in the Community Questionnaire (LCQ)', 'Description of implementation costs') that have been added to aid the presentation of findings.

Throughout the report, CMO sites have been identified to enable appropriate comparisons between sites and to support quality improvement efforts. All other information has been presented in aggregate format and interview participants are only identified by participant type and as per the conditions of ethics approval.

Where appropriate and available the data has also been presented according to the data source and data collection round. In some instances, data for the most recent data collection round is presented on its own to provide a more up to date view of the program characteristics or stakeholder views.

DEMOGRAPHIC CHARACTERISTICS OF PROGRAM CONSUMERS

Since its commencement in August 2019 until the end of the final data collection period in July 2021, 464 individuals have been supported by the MH-CLSR program. The key demographic characteristics of the program consumer population are:

- Age – just under half (47%) are over 40 years old
- Gender – there are more female consumers than males (55.3%)
- Immigration status – there are more refugees (54%) than asylum seekers (39%) with a small number with 'other' or unknown visa status
- Years since arrival – 49% had been in Australia for more than five years, 85% for more than two years.

Two consumer population characteristics were found to be most influential on program operation – mental health diagnosis and preferred language. These are discussed in more detail below.

Mental health diagnosis

Nearly half of consumers included within the final data collection round had a diagnosis of depression (53.0%), while almost a quarter (23.0%) had not been diagnosed with a mental health condition. Other common mental health diagnoses amongst program consumers included post-traumatic stress disorder

(PTSD) (33.0%) and anxiety (27.0%) (see Table 3). There was little variation in the prevalence of diagnoses between baseline and final data collection rounds, except for the incidence of schizophrenia, which increased from 1.5% to 6.0%.

While this information is collected as part of support planning for consumers, it is important to note that a diagnosis of mental ill health is not a prerequisite for referral to the program.

Table 3: Distribution of current consumer population by type of diagnosis, April-June 2021 (n = 200) (Source: InforMH Data Set)

Diagnosis	Count MH-CLSR consumers	% of total MH-CLSR consumers**
Depression	106	53.0
Post-traumatic stress disorder (PTSD)	66	33.0
Anxiety disorder	54	27.0
No diagnosis	46	23.0
Schizophrenia	12	6.0
Personality disorder	5	2.5
Schizoaffective disorder	4	2.0
Bipolar affective disorder	3	1.5
Eating disorder	2	1.0
Other*	37	18.5

* 'Other' diagnoses included acute stress reaction, complex trauma, deep depressive disorder, intellectual disability, alcohol other drug dependence, complex trauma and psychosis.

** Diagnosis can change after an encounter with the service, so the percentage calculations are estimates only (given a possible variable n).

The prevalence of anxiety and depression amongst MH-CLSR consumers was higher than that amongst the broader NSW community mental health (CMH) consumer population¹². However, the reverse was true for the prevalence of schizophrenia. In this regard, the community mental health population is much like that of HASI consumers where the most common diagnosis (65%) in a 2012 evaluation was schizophrenia (Bruce, et al., 2012). This was consistent with the views of several LHD stakeholders who felt CMH and HASI consumers generally experienced more acute levels of mental ill health than MH-CLSR consumers.

Preferred language and interpreter services requested

Program consumers requested interpreter support for a wide range of languages, with 31 languages identified as 'preferred' by consumers. The most common of these were Arabic (22%), Kurdish (9%) and

¹² Broader NSW community mental health (CMH) consumer population sourced from Mental health services in Australia: State and territory community mental health services, 2019-20'; AIHW

Tamil (8%) (see Table 4). Nearly a fifth (18%) of program consumers preferred to speak English and did not require an interpreter. Interpreters for the most prevalent languages were required at most sites, however at some sites interpreters were required for relatively rare languages.

Table 4: Distribution of consumers from by type of language preferred to speak, April-July 2021 (Source: InforMH Data Set)

Preferred language nominated by consumers	No. of consumers	% total consumers (n = 213)
Arabic	46	21.6
Kurmanji	20	9.4
Tamil	16	7.5
Farsi	14	6.6
Dari	12	5.6
Persian	11	5.2
Burmese	4	1.9
Swahili	3	1.4
Hazaragi	2	0.9
No interpreter requested	38	17.8
Other	36	16.9

SERVICE DESCRIPTION

Number of consumers supported

Since the program started, the number of consumers who have received a service at least once a month has grown steadily¹³ (see Figure 2). The number of consumers being supported across all sites plateaued at between 160 and 170, which is higher in total than the originally contracted number of 79.

¹³ Note that this data does not indicate individual occasions of service. A consumer might be seen or supported multiple times in a month but still generate only a single report for that month.

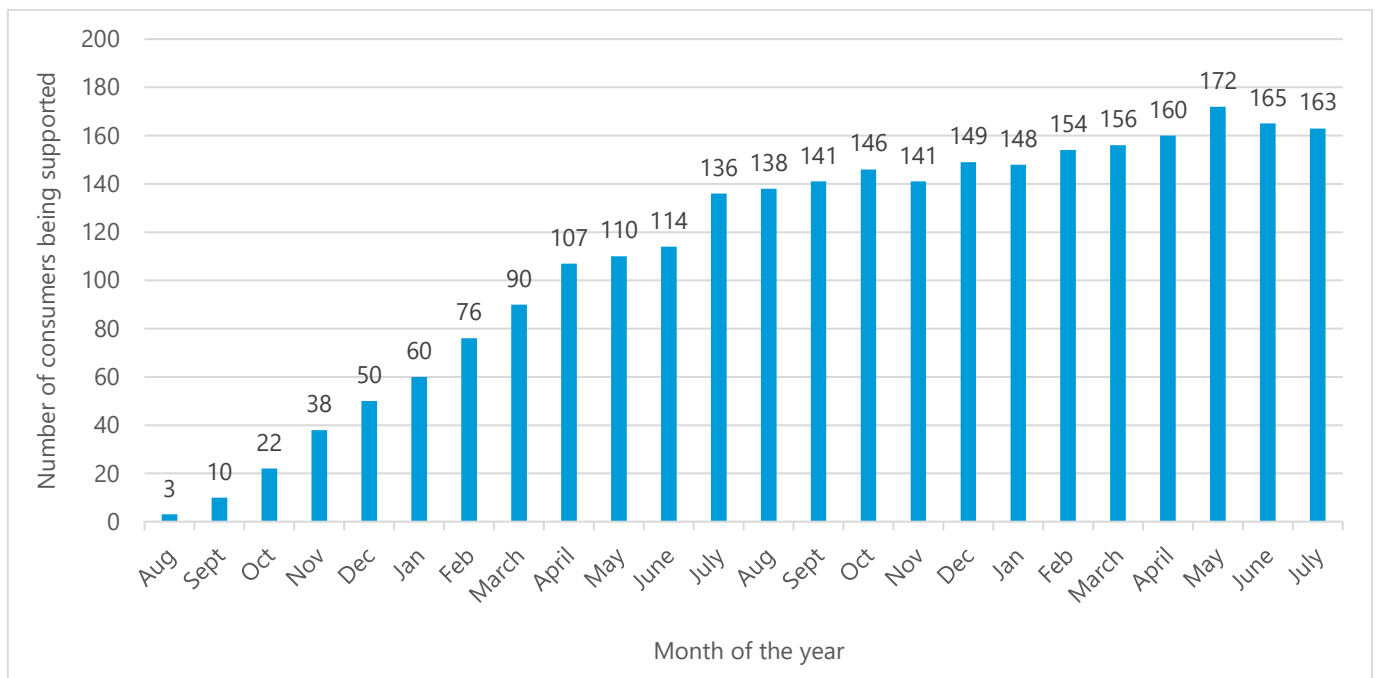


Figure 2: Growth in program activity, from program commencement, August 2019–July 2021 (Source: InforMH Data Set)

Table 5 below shows the distribution of total consumers by site location. This table is based on data analysed from the most current data collection period (April 2021–July 2021). It notes that all sites had more consumers in their service than they were contracted to manage.

Hours of support provided

CMOs supported more consumers than contracted by offering less hours of support per consumer per month. CMOs are required to provide, on average, 2.2 hours of support per consumer per month, yet the final round data collection indicated that they provided 1.3 hours per consumer. This is less than the contracted hours, however, available support hours were spread across more consumers. CMO managers inferred that this level of support served the needs of the ‘average’ consumer. As one CMO manager observed:

“No-one is saying there is not enough hours ... there are more customers currently than the quota, but we are still able to accommodate demand. It helps that we can adjust delivery of hours from week to week.” (CMO manager #5)

Table 5 indicates that the estimated daily support hours provided in six out of the nine sites exceeded the number of contracted daily hours. In two of the sites, the estimated actual support hours provided were less than that contracted.

Table 5: Number of consumers by contracted versus actual at each site, final round data, April-July 2021
(Source: InforMH Data Set)

MH-CLSR provider	Site	Contracted consumer number*	Actual average consumer number / month**	Contracted daily number of support hours	Estimated actual daily number of support hours
Anglicare	Western Sydney	16	50.0	36	29.4
Grand Pacific Health	Wollongong	10	13.0	23	20.1
New Horizons	Newcastle	6	8.3	14	29.3
	Coffs Harbour	6	21.3	18	23.9
	Fairfield***	20	4.0	43	9.5
	Liverpool***	-	28.5	-	48.9
	Ashfield	8	14.3	15	13.6
	Armidale	4	9.3	6	16.2
Red Cross	Wagga Wagga	9	6.5	20	10.5
	Griffith	-	10.0	-	15.6
Total		79	165.2	175	217

* Number of unique consumers being supported by the service and provided at least one occasion of service within a one-month period.

** Number of consumers being provided a service on average each month. Calculated over 4-month period April–July 2021.

***Fairfield and Liverpool are managed by New Horizons as one site.

A comparison between sites of the average number of support hours provided per consumer per month over the three data collection periods is illustrated in Figure 3. The total hours support per consumer varied substantially between sites and within sites over time. For the final period of data collection round support hours ranged from 11.8 hours per consumer per month to 70.5 hours per consumer month.

After the second feedback workshop (where comparative data on levels of support hours per consumer were first produced), the Western Sydney site investigated the possibility that data was not being collected properly. It was concluded that this was not the case and instead, it was believed that the low average support hours per consumer was due to a greater number of consumers participating in the program than contracted. It was contended by staff at the site that this was possibly due to the urban location of the site where there were other service options that for consumers. In the case of the other outlier (Newcastle site) which had a very high average number of support hours per consumers, similar investigations were not carried out. However, this site had a very high proportion of support staff who were working casually.

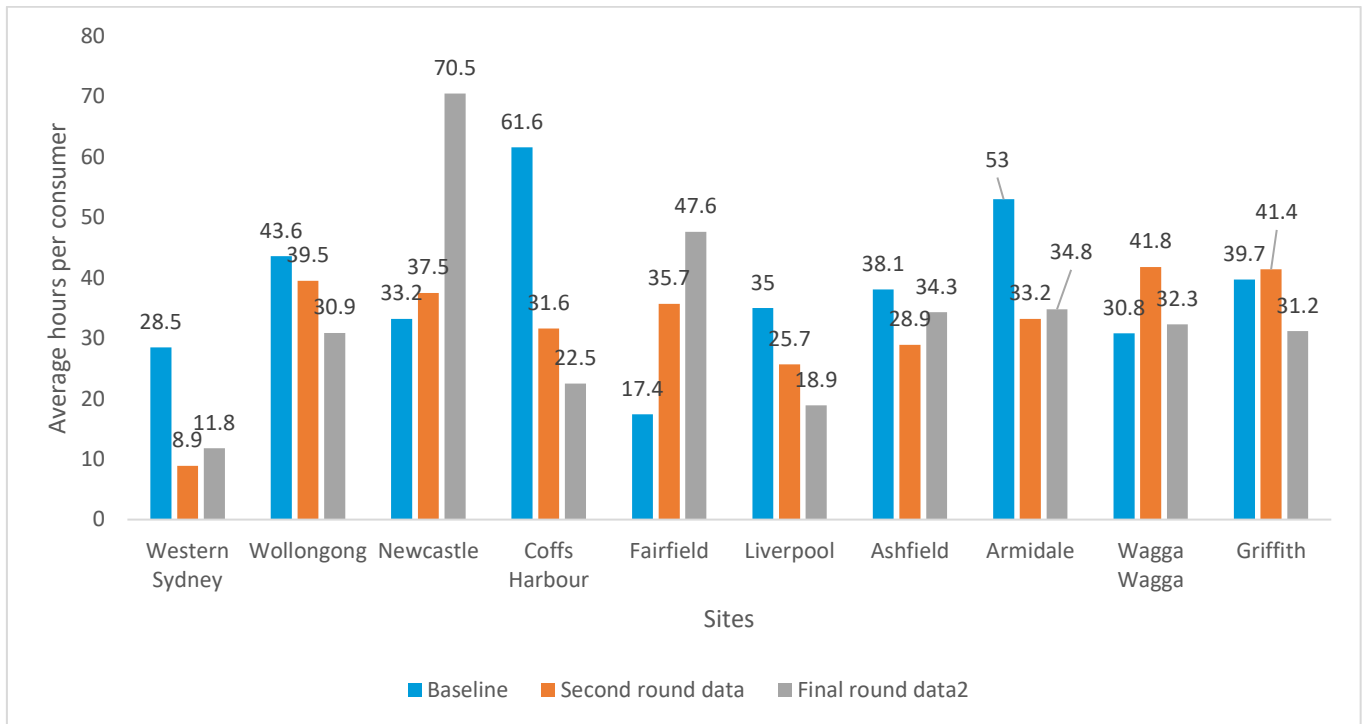


Figure 3: Number of hours spent per month per consumer in providing support activities by program sites and by round of data collection (Source: InforMH Data Set)

Duration of support

Further analysis of the data from the final collection period (April 2021–July 2021) revealed:

- 61.2% of consumers had been in the program before the start of the data collection period.
- Just under half the consumers (48.8%) had been in the program for over one year.
- Just over one quarter (25.9%) had been in the program since inception.

The average duration of consumers being actively supported in the program increased from approximately 130 days at the baseline data collection to 357 days during the final data collection round.

Consumer exit from the program

During the final data collection round, 30 consumers exited the program (13.8%). That is less than half the proportion of consumers exiting the program in the previous (second round) data collection period (32.4%, June 2020–March 2021) and represents a return almost to the proportion exiting during the baseline data collection (10.6%) in the early days of the program. The reduced exit rate was accompanied by an increase in the average duration of consumers being actively supported in the program – from approximately 130 days at baseline data collection to the most recent 357 days. Most of the recent exits were planned, as shown in Table 6.

Table 6: Proportion of consumers exiting the MH-CLSR program over different data collection periods (Source: InforMH Data Set, April-July 2021)

Data collection period	% of consumer exiting	% planned exits	Main reasons for exiting
Baseline n=132	10.6 n=14	64.3 n=85	Exited on own request –no alternative support arrangements Relocated – no alternative support arrangements
Second round n=213	32.4	62.3	Exited to alternative community support – higher intensity arrangements Support needs reduced – no alternative support arrangement Exited to alternative community support – lower intensity arrangements
Final round n=200	13.8	93.3	Support needs reduced – no alternative support arrangement Exited to alternative community support – lower intensity arrangements Exited on own request – no alternative support arrangements

Most of the recent (final-round data collection) consumers that exited to support did so to the Jesuit Refugee Service, House of Welcome (a refugee housing service) or a refugee settlement service.

SERVICE COORDINATION AND GOVERNANCE

MoH Program Guidelines

Relevant evaluation question/s:

- *Are the MoH Program Guidelines useful in assisting with the coordination of services and are changes required? Is the level of detail appropriate to ensure good governance locally?*

Most interview respondents reported satisfaction with the management of the program at a state-wide level. A few LHD or CMO respondents suggested improvements, including:

- CMOs regarded the program guidance documentation as useful and ‘fit for purpose’. However, thought it would be helpful if there were regular opportunities for CMOs and the MoH (e.g., through workshops) to share experiences and learnings so that the Program Guidelines can be updated to cover emerging issues.
- LHD managers similarly considered it important to have opportunities to share experiences and challenges with staff from other LHDs involved with the program. This would facilitate shared learning regarding change in practice to:
 1. better work with the MH-CLRS model within LHD organisational structures
 2. more active and responsive support for preventing suicide within broader national policy shifts and reform.

CMO and LHD formal relationships

Relevant evaluation question/s:

- *Have LHDs and MH–CLSR service providers developed service level agreements, and what are the key elements?*
- *How are all formal and informal partnerships with MH–CLSR service providers working? Are strategies being designed to fill gaps or improve functioning?*

Service Level Agreements

During the Baseline data collection Service Level Agreements (SLAs) for six sites were available for review by the evaluation team, and there was interview evidence that suggested they existed in one or two other sites. The development of some SLAs was delayed due to agreement and sign-off by LHDs. In the second round of data collection, it was verified that all SLAs had been completed and accepted by the LHDs. Further review of the SLAs was not conducted for the final data collection round as per the evaluation method.

Overall, the SLAs were considered by LHD and CMO manager to helpful to establish the scope of the program. All SLAs were developed in accordance with the template provided in the program guidelines, with some exceptions related to mental health assessments and partnership meetings.

Partnerships between LHDs and CMOs

All sites held local LHD and CMO partnership meetings, most commonly monthly. Some sites initially combined with existing Housing and Accommodation Support Initiative (HASI) and Community Living Support (CLS) meetings. However, this changed to separate meetings to allow for more focused MH–CLSR discussions.

Local partnership meetings also varied across the sites in terms of:

- purpose – discussion of governance and/or operational issues (e.g., clinical discussion of new referrals and existing consumers)
- attendees – managerial staff (senior and middle managers) and/or operational staff (frontline managers, LHD mental health and non-mental health staff, case support workers, refugee clinic or multicultural health staff).

Overall, respondents from both partnership sides reported that these meetings were a critical component of the program. At a small number of sites, the local partnership meetings were the only practical opportunity for clinical discussion. CMO staff members at these sites reported that this arrangement was not ideal as meetings often focused on formal governance issues, time was constrained, or operational level personnel were not sufficiently represented. As one operational level person noted:

"... we are not setting collaborative goals ... discussions are not happening." (CMO support worker #5)

Local partnership meetings were also reported to provide an opportunity to address the barriers to providing support such as inflexible processes in clinical liaison, referral, and information sharing between CMOs and LHDs.

Clinical partnerships and pathways

Relevant evaluation question/s:

- *Have clinical partnerships and pathways been established and used and how are they functioning?*

Clinical liaison

The model of care emphasises that straightforward and efficient clinical liaison between partner agencies is important for effective care and positive consumer outcomes. CMOs reported that support workers getting advice on clinical strategies from LHD CMH was 'variable'. It was sometimes achieved by liaison between frontline managers rather than in clinical and support worker interactions.

In general, interviews with CMO and LHD stakeholders indicated that effective working relationships existed between the partners to make the program work for consumers. However, some CMO support workers and team leaders reported that normal working protocols for the LHD presented obstacles to their work. CMO support workers who wanted to discuss individual consumer management issues reported that some LHD mental health staff were unresponsive to calls for support. Some respondents reported that relationships between staff at the frontline level were dependent on the personalities and partnership skills of those involved, leading to inconsistent approaches, even within an LHD.

Instances of shared care were reported at some sites, although a few stakeholders considered this to be more like parallel care than best-practice shared care. There was one site where both partners acknowledged a good practice approach to shared care, with MH-CLSR staff working with the LHD early psychosis program.

Several stakeholders noted that established relationships could facilitate better functioning. Where a CMO had been operating in the mental health sector in a local area for some time, such as through other funded programs like HASI, the individuals involved were familiar with one another and there was often trust, respect and operational knowledge established between the agencies. At two sites, the CMO and LHD had not worked together in mental health before MH-CLSR was established and were just starting to establish these relationships.

Mental health assessments

Mental health assessments were an integral component of the program to inform eligibility, care planning, and clinical risk management. The Program Guidelines stipulate that mental health assessments can be obtained by CMOs from a range of possible suppliers, including the LHD.

Initially, in the baseline data collection round, obtaining mental health assessment was identified as a key concern by CMOs as assessments were not being undertaken by the LHD in several sites, especially where LHD referrals to the program were low. However, LHDs reported having varying capacity to conduct assessments. To address this issue, CMOs agreed to obtain assessments from other practitioners (e.g., in-house resources and bulk-billing psychiatrists and GPs) for referrals outside of the LHD.

Subsequent data collection phases indicated that this was largely an effective strategy for obtaining mental health assessments with minimal negative impact on CMO budgets. While at one LHD, most

mental health assessments were conducted by the LHD CMH service, all other LHDs only conducted assessments for consumers referred to the program by CMH. If consumers were referred from another part of the LHD, the assessment was not necessarily conducted by the LHD. CMOs reported that, in such cases, mental health assessments were obtained either in-house or through private practices.

Referrals into and from the MH-CLSR program

Relevant evaluation question/s:

- Are referrals being prioritised by LHDs?
- How have the referral and/or transition systems been working?

Referrals into the MH-CLSR program

During the final data collection round, most referrals were from the public health system. These were made up of referrals from CMH (18.4%, n = 201), 'other' LHD services (16.9%) and inpatient/ acute care services (3.9%). The other major source of referrals during that period was a settlement service (27.7%) (see Figure 4). 'Other' sources of referral contributed an average (of all program sites) of over one in ten referrals to the program and included self-referrals, referrals by friends and family, referrals from homelessness services and referrals from alcohol and other drug services. The distribution of consumers by source of referral changed little after the early stages of the program.

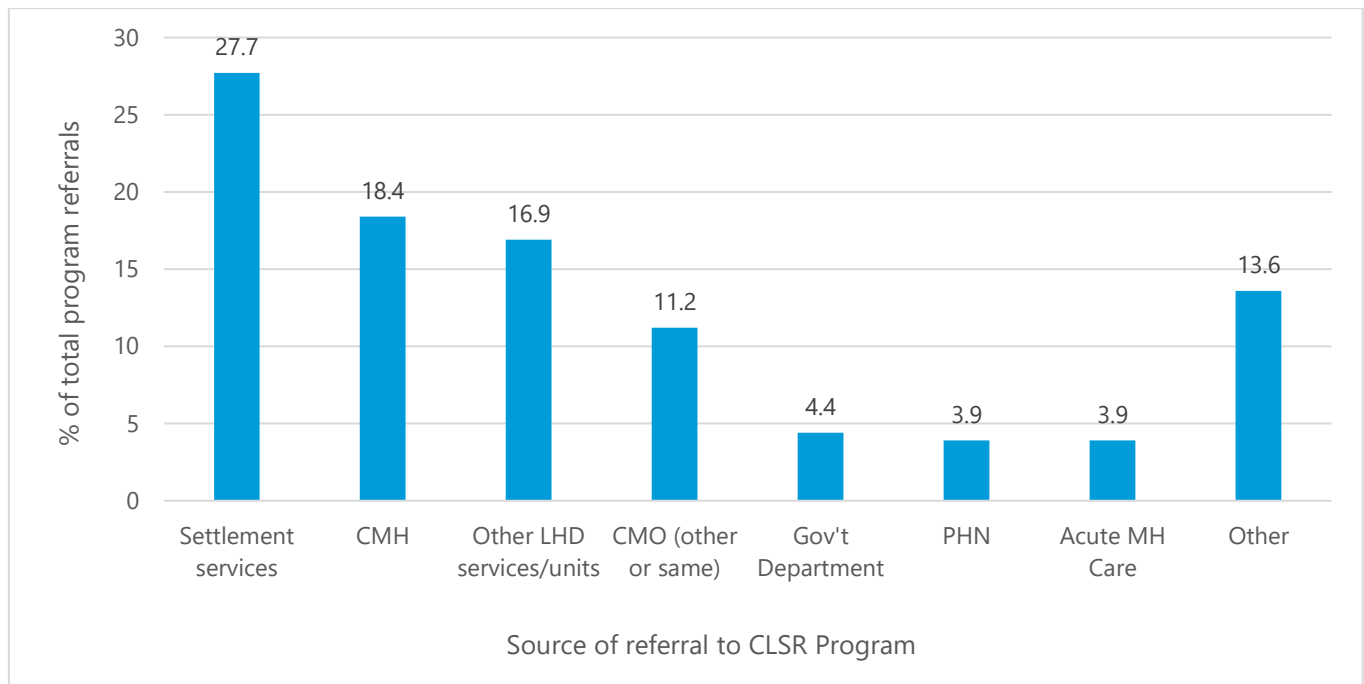


Figure 4: Current distribution of source of referrals to the MH-CLSR Program by type of referral source (April to July 2021 n=201) (Source: InforMH Data Set)

Table 7 provides details of referral sources by program site. In seven sites, 25–56% of referrals into the program came from LHD Mental Health Services, but there were additional substantial referrals from other LHD services in many sites. Referrals from LHDs were prioritised by CMOs in accordance with the Program Guidelines.

Table 7: Current distribution of consumers by source of referral by program site (%) (Source: InforMH Data Set, April-July 2021)

Source of referral	MH-CLSR program sites									
	Western Sydney	Wollongong	Newcastle	Coffs Harbour	Fairfield	Liverpool	Ashfield	Armidale	Wagga Wagga	Griffith
Settlement service	<u>24.6</u>	<u>20</u>	<u>54.5</u>	<u>37.5</u>	<u>50</u>	<u>18.8</u>	<u>34.3</u>			<u>40</u>
LHD community mental health	10.1	<u>15</u>	<u>27.3</u>	12.5	<u>25</u>	<u>50</u>	6.6	<u>40</u>	<u>28.6</u>	<u>40</u>
LHD acute care mental health	1.4			<u>20.8</u>		6.3	2.9			
Other LHD services *	14.5	<u>60</u>				6.3	<u>11.4</u>	<u>40</u>	<u>28.6</u>	<u>20</u>
CMO (same program provider)	8.7			4.2		6.3	5.7			
CMO (different program provider)	<u>15.9</u>					6.3	2.9			
Primary Health Network	1.4	5.0		<u>16.7</u>			5.7			
Private health service	3			4.2			2.9	10		
Govt department	10.1						2.9	10		
Self	4.3								14.3	
Carer / friend	1.4		<u>18.2</u>				2.9			
NDIS							2.9			
Homelessness service									<u>28.6</u>	
Drug and alcohol					<u>25</u>					
Other	4.3			4.2		6.3	<u>17.1</u>			

Top three sources of referral for each site are underlined.

* Includes Refugee Health and Multicultural Health services

Referrals from MH-CLSR to LHD Mental Health Services

CMO respondents reported that referrals to LHD Mental Health Services from MH-CLSR were for consumers with more complex mental health needs. At most sites, the LHD required the CMO to utilise the formal referral pathways of the Mental Health Line, which was seen by CMO support workers as inappropriate and frustrating. In their view, this pathway was inconsistent with the SLA approach, which was meant to remove obstacles and promote cooperation between partners. From the CMO perspective, using the Mental Health Line could hinder potential 'warm referrals'¹⁴ because this process introduced a third party to triage a consumer with complex needs.

MODEL OF CARE

Relevant evaluation question/s:

- *Has a flexible model of care been developed and implemented?*

CMO respondents mostly considered that the model of care was appropriate and flexible enough to facilitate good practice for staff and good outcomes for consumers. LHD respondents, similarly, considered the model of care to be a good adjunct for their services.

One LHD clinical manager reported, however, that there was limited cross-over with their services due to differences in the level of acuteness and severity of mental illness between the consumers of the respective services. Many respondents in both CMOs and LHDs reported that the Program Guidelines was a good reference point for making decisions locally about the model of care.

Despite the general positive perspective on the model of care, specific issues were raised that caused concern or confusion for some providers and service partners. Some issues called for more detail in the model of care for and more consistency across sites. These are discussed in the subsequent sections.

Supporting consumers to exit the program

The Program Guidelines do not impose a requirement for consumers to be exited from the program other than in consideration of their support needs. However, several stakeholders (LHD and CMO managers, CMO support workers) suggested the need for more active and strategic exit planning. They questioned whether enough was being done in terms of individual support planning to ensure that consumers had a network of trusted supports for the range of needs that remained after being in the program. It was reported that a small number of consumers were transferred to National Disability Insurance Scheme (NDIS)-funded services and other types of supports, and collaboration with NDIS services in general were seen to improve exit rates and the model of care.

¹⁴ A warm referral process is recommended for vulnerable consumers when a referral is being made to an unfamiliar third party service – see <http://communityindustrygroup.org.au/wp-content/uploads/FACT-SHEET-Effective-Referrals.pdf> for further information.

One stakeholder suggested it would be valuable for CMOs to collaborate with the MoH to assist in preparing examples of typical [planned] consumer journeys that could be shared between sites. The need for further guidance was echoed by several other respondents.

Information sharing

CMO and LHD respondents reported that effective information sharing enabled good care planning and helped to mitigate risks. At most sites, information sharing was reported to be functioning sufficiently to assist the consumer support processes despite complexity of needs.

Interviews revealed that the most common method of information sharing was through mental health assessments and local partnership meetings during discussions about referrals. Optimal information sharing occurred in those sites where ongoing management of individual consumers was through worker-to-worker meeting structures (see section *Partnerships between LHDs and CMOs*).

Some staff (mostly CMO) are unclear about consent processes for information sharing, despite the Program Guidelines explicitly allowing for sharing information under normal informed consent conditions. Staff who were unsure indicated that they were uncertain if initial consent provided by consumers at program entry was sufficient or if additional consent should be sought for each new event of information sharing.

Final-round interviews with CMO and LHD managers and CMO support workers also indicated that a primary concern was that CMOs were not routinely sharing information with partners, particularly sharing of ISPs (see section *Care planning*). At several sites, ISPs were only shared with CMH workers who were actively involved in the development or review of ISPs; access was not given to the ISPs of other consumers. It was also noted that ISPs were rarely shared with other clinical practitioners (e.g., STARTTS, private practitioners), despite the Program Guidelines stipulating that this should occur to support the delivery of services. As one LHD manager noted:

“... [it] proves an impasse to a proper functioning partnership.” (LHD manager #10)

Flexibility of model of care

The MH–CLSR model of care emphasises flexible, person centred, individualised supports. In general, CMO managers and workers, and consumers, expressed appreciation for this provision and attempted to apply it appropriately. At times though CMO managers and workers raised concerns that flexibility in offering support was at the risk of non-compliance with other model of care provisions.

Support for asylum seeker consumer was one area where the model of care was noted by CMO managers and support workers as needing a more flexible approach. This is because asylum seekers visa status limits their access to basic health, welfare and financial support compared to refugees.

As a result, many asylum seekers present to the MH–CLSR program with a broader range of support needs, including the need for access to legal services in relation to proceedings in their claim for asylum. Access to health care, including pharmaceuticals, also continues to be problematic for this group of consumers. In addition, asylum seekers did not have the benefit of settlement services support, including access to English language training. As one CMO manager noted:

“The main issue is that asylum seekers can't get income benefits and health care so there are higher levels of homelessness and less support in general available [to them]. There is more pressure on the MH-CLSR program to “be all things to all people” because limited services overall are available to this client group – not even settlement services.” (CMO manager #7)

In seeking to meet (or not meet) the basic support needs of asylum seekers, some CMO managers and support workers expressed a need for better understanding about whether the way they implemented the model of care was consistent with other sites, after allowing for ‘acceptable’ and ‘flexible’ interpretations of the model of care.

The issue of transporting consumers is another example of support where flexibility was required but where there was uncertainty and inconsistent application of the practice between CMOs. Some CMOs interpreted transport as an activity solely related to support worker travel time to and from consumer locations. Others included transport as a form of support activity (e.g., for accompanying a consumer to and from appointments). Several consumers reported the high value that they placed on support services that included transport – in one instance, to make visits to a close family member’s grave.

USE OF INTERPRETERS

Relevant evaluation question/s:

- *Are interpreters being used by staff with consumers when required?*
- *Are staff competent in using interpreters with consumers?*

Consumer satisfaction with language support

The baseline data collection findings revealed that interpreters were widely offered and used. However, the quality of interpreting support was reported by CMO respondents to be variable, particularly for those languages with few accredited interpreters available. Consumers reported being more satisfied with the quality of interpreting services offered by the NSW Health Care Interpreter Service than via the national Telephone Interpreter Service (TIS). However, CMO staff reported that the former is difficult to access for services that are not part of NSW Health in most LHDs. Overall, the levels of satisfaction with interpreting services were generally good.

All CMO managers indicated in the second-round survey that they were ‘satisfied’ with the general quality of interpreter services. The findings from the final data collection round showed that:

- On average, just over 2% of total CMO expenditure was in use of interpreters. The proportion spent on interpreters varied though between sites from 0.4% to 9% (see section *Operational expenditure, FY 2020/21*)
- Support workers routinely offered interpreting support. Based on MH-CLSR Service data reported in the March 2021 quarter by the CMOs 72% of consumers required an interpreter. Of those requirements only 8% experienced difficulties and these were almost all confined to a single rural site.

- The inclusion of easy access to interpreting was a component of the program that was highly valued by interviewed consumers.
- Consumers were confident that they can have access to an interpreter whenever they feel they need one.

Several consumers who were interviewed rated their English comprehension as 'good' or 'very good'. Despite this level of competence, most of these consumers utilised the option of an interpreter for situations where the vocabulary might not be familiar and/or it was very important to make sure they understood everything properly.

"I feel confident speaking English, but I always ask to have an interpreter if it is important, like with a lawyer or a doctor." (Consumer #6)

Several consumers also expressed a high level of appreciation when they were able to speak their own language (or even a shared third language) with service providers (and CMO support workers in particular). This ability to communicate directly with support workers without the inclusion of a third party appeared to assist greatly in supporting the development of a trusted relationship. In addition, several consumers nominated 'walking and talking' as one of their preferred service modes – an option that became significantly restricted in many areas during the pandemic lockdown measures.

A benefit of this type of engagement was the opportunity to work on improving their English. One support worker also described one consumer's stated preference to communicate with the support worker directly using Google Translate as a support in their communication process, rather than including an interpreter.

Where CMO support workers did not speak the language/s of local consumers, one CMO had incorporated the use of casual 'bicultural workers' to assist with service provision. Feedback from managers, support workers and consumers were uniformly positive about this option, with the added benefit of providing potential connections into local community networks.

Support worker competence using interpreters

First-round survey data showed that all support workers had received training in using interpreters. The second-round survey data showed that there was a clear policy or procedure in place for using interpreters in all MH–CLSR services, and that two thirds of managers were 'very confident', and the other third were 'confident' in their staff use of interpreters.

Comments made by support workers in first-round interviews indicated that they were well-aware of the issues of interpreter use, including how and when to use them and the variable quality between individual interpreters that can result from the range of interpreter services available. Some interpreter shortcomings they identified included:

- interpreters taking liberties with their own ideas about the issues discussed
- male interpreters putting their own judgement into the conversation
- short translations of very long sentences.

One support worker used to train interpreters, and another indicated they were so worried that a conversation was properly interpreted that they immediately booked another interpreter in a separate session to check. While these instances are likely a small minority of experiences across the large number of interpreter sessions completed, they served, along with the survey data mentioned above, to indicate that support staff were in most part quite competent in using interpreters.

CARE PLANNING

Development of Individual Support Plans

Relevant evaluation question/s:

- *Are care plans being developed holistically?*
- *Do consumers find their care plans reflect and help them to achieve their psychosocial aims?*

Development and review processes

Individual Support Plans (ISPs) are a compulsory component of the model of care. At the time of baseline data collection, developing ISPs took up almost 18% of all 'accounted for' support worker time invested in 'support'. In the most recent data analysis this had reduced by almost half to 9.6% of total support.

ISPs are to be completed soon after (within two weeks) the consumer is accepted into the program and a mental health assessment is completed. The level of compliance with this requirement had reduced since baseline collection. The April 2021 CMO survey indicated that almost half of the CMOs completed ISPs within two weeks only 'sometimes' or 'rarely' (Figure 5). Delays in developing ISPs were largely attributed to support workers improving how ISPs were completed with consumers, allowing consumers more time to build trust in the service and to understand the concept of 'goals'. Some support workers noted that consumers could find goal-setting a bit challenging to start with, with one support worker stating:

'... the whole goal-setting thing can be quite a Western concept and not immediately understood.'
(CMO support worker #8)

This issue of completing ISPs was addressed at a workshop in June 2021 with CMO, LHD and Mental Health Branch representatives following the second round data findings. An agreed action from the workshop was that the timeframe to develop an ISP with a new consumer would be extended in the model of care from two to four weeks. This change was prompted because all CMOs agreed that language barriers and time to develop trust with consumers were the key reasons for ISPs taking longer than the previously stipulated two-week timeframe.

Following this, the final-round data collection from CMO manager interviews indicated that compared to earlier in the program, there had been a greater focus on the importance of ISPs. Some CMOs have established a 'No ISP, no service' policy and most support workers saw the ISP as central to their work.

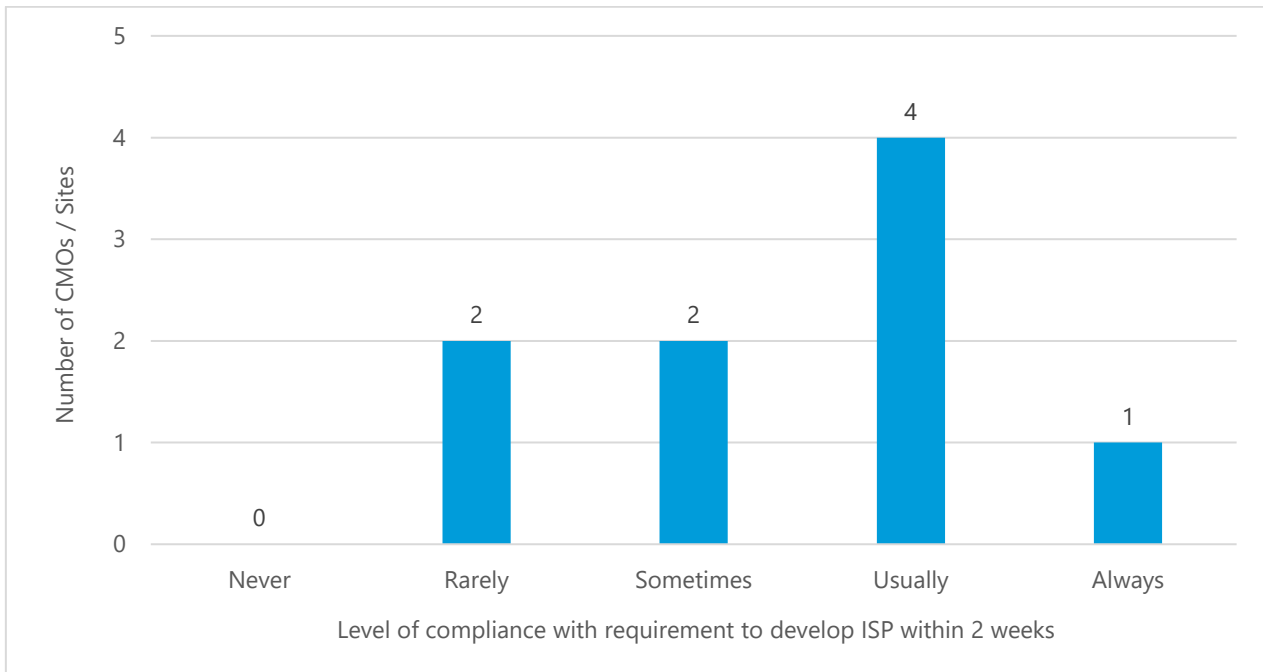


Figure 5: Distribution of CMOs/sites by level of compliance with ISP development timeliness (Source: Second Round CMO Manager Survey – April 2021)

The model of care indicates that ISPs should be reviewed and revised every 12 weeks. Baseline survey data indicated that only one CMO met this requirement with all ISPs. However, most support workers reported in the final data collection round interviews that ISPs were reviewed and revised every 12 weeks with the consumer, and that was largely confirmed by CMO manager survey data. Some support workers even suggested reviews be carried out more regularly:

“Personally, I like to review ‘on the run’ ... when goals need changing. In fact, I check on goals on each contact occasion although some goals are more time-dependent.” (CMO support worker #4)

Analysis of the MDS data from the collection period of April–July 2021 supported the findings above:

- 77.1% of consumers had an ISP newly drafted or reviewed during the latest data collection period.
- 30 consumers exited the program during this period (and therefore might not have had their ISP reviewed), therefore only 15 (8%; n=200) consumers did not have their ISP initially completed or reviewed during the period.

CMOs indicated in the April 2021 CMO manager survey that nearly all (90%) of ISPs are ‘developed in collaboration with the consumer’. Collaboration between CMOs and LHD CMH in the development of ISPs is variable across the sites. Based on second round data collection, at four of the nine sites there were few common consumers, so ISPs were developed in collaboration with the LHD mental health team only sometimes or rarely (see Figure 6). At the other five sites collaboration between the CMO and LHD to develop ISPs was more the norm. The level of collaboration barely changed between the baseline and second round data collections.

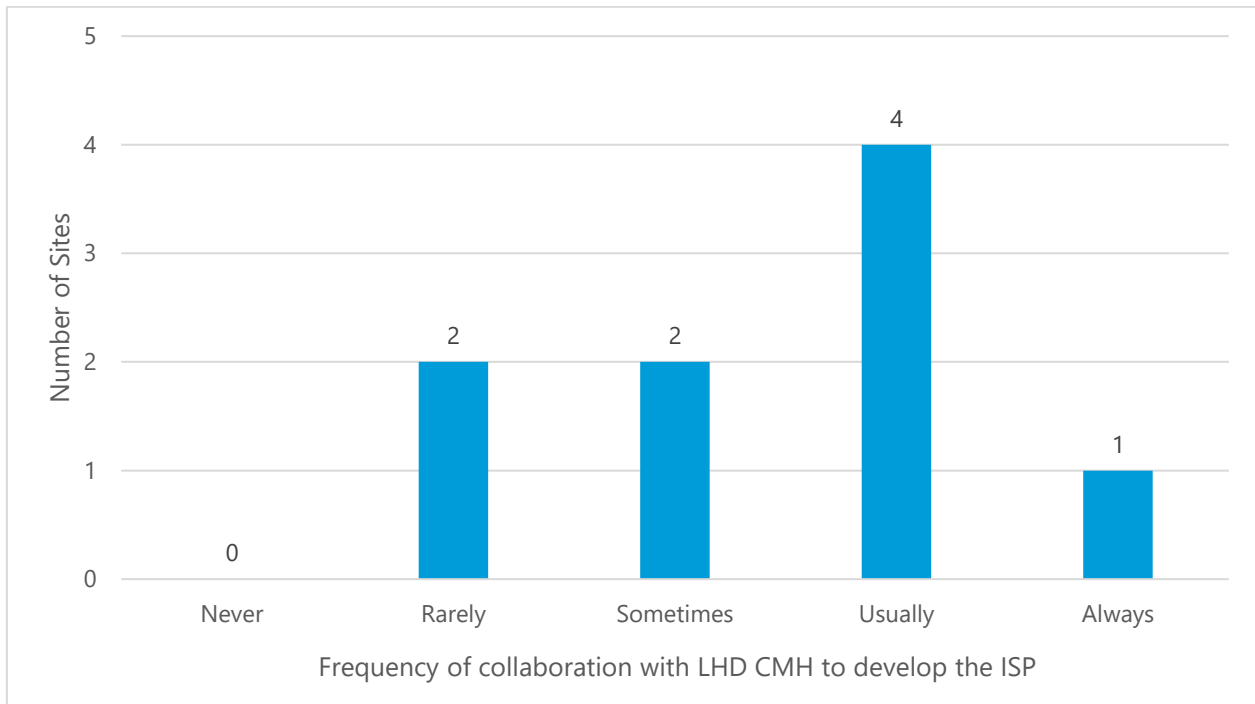


Figure 6: Distribution of CMOs/sites by level of collaboration with LHDs to develop the ISP (Source: Second Round CMO Manager Survey)

Monitoring of goal achievement

At an individual level, the final round interview data indicated that, compared to earlier in the program, support workers appeared to have an increased focus on goal achievement. They had increased their appreciation of the importance of ISPs in working with consumers and directing delivery of support.

At a manager level, the final-round interview data showed that some CMOs monitored goal achievement more consistently than others. Currently this was 'tracked on paper' but at least two CMOs were introducing new Customer Relationship Management (CRM) software¹⁵ where ISP data could be stored in whole or part. Once in electronic format, managers would be able to track progress in achieving goals. As one manager noted about the introduction of a CRM:

"... should help make the ISP again become central to the processes of support." (CMO manager #3)

¹⁵ For example, <<https://lumiere.solutions/newp/views/lumiere-crm.php>>

Types of psychosocial support services provided

Relevant evaluation question/s:

- Are the full range of psychosocial supports being delivered – including assistance with daily living, support attending appointments, support to manage medication requirements, and assistance in building parenting functioning skills and facilitating access to family therapy?
- Are services being provided in a whole-of-family manner where appropriate?
- Has there been an increase in participation in clinical and community-based health services and psychosocial supports?

Types of support provided

In keeping with the program’s intent, a broad range of service activities were reported as being delivered to meet the needs of consumers. Final-round interviews with support workers and consumers explored the types of services being provided and general satisfaction was expressed by both groups of respondents for these services. The MDS provides quantitative data for direct contact hours by location and 15 different types of support. For the period April to July 2021:

- the total number of hours allocated to support across all MH–CLSR sites was 17,363
- these total hours translate into an estimated 28.6 full-time equivalent (FTE) support workers (based on a 38-hour week).

The distribution of these hours across each of the 15 nominated support activities is shown below in Table 8 and in graph form at Appendix 5.

Table 8: Current support hours for the total MH–CLSR program provided to consumers by type of support, April-July 2021 (Source: InforMH Data Set, April-July 2021)

Type of support (MDS defined)	Support hours	Support hours as a percentage of total
Support in accessing other support systems	3,052	17.6
Support in psychosocial intervention	2,710	15.6
Support preparing support plans	1,671	9.6
Support in daily living skills	1,661	9.6
Support in medical/health activities	1,626	9.4
Support in travel	1,486	8.6
Support in social activities	1,341	7.7
Support in social activities in own refugee community	858	4.9
Support in family connections	646	3.7
Support for accommodation	549	3.2
Support in educational activity or work	541	3.1
Individualised support by >1 staff	492	2.8

Type of support (MDS defined)	Support hours	Support hours as a percentage of total
Support in medication support	338	1.9
Support of direct specialist clinical intervention	307	1.8
Support provided as group activities	84	0.5
Totals	17,363	100

The tabulated data indicates that the total hours consumed ranged from 3,052 hours for 'Support in accessing other support systems' (17.6% of total hours) down to only 84 hours (0.5%) for 'Group activities'. The other support type using a lot of support worker time was 'Support in psychosocial intervention' (15.6% of total support worker hours). Compared to the distribution of hours allocated to support tasks in the baseline data, there was an obvious shift in support hours from 'Support preparing support plans' to 'Support in medical/health activities' and 'Support in psychosocial intervention not accommodation'.

The Program Guidelines do not provide direction for how support hours should be distributed other than:

"... the emphasis is on the provision of a broad range of community based psychosocial supports."

While there is an emphasis on the delivery of a 'broad range' of supports, the top five types of support accounted for over 60% of total support hours and the other ten support types accounted for only 38% of total support time.

Conversely, the Program Guidelines recommend:

"Rather than trying to provide everything, MH-CLSR providers are expected to work collaboratively to facilitate partnerships with a broad range of specialist service providers and promote good service and care coordination."

The large proportion of support hours allocated to 'Support in accessing other support systems' seems consistent with this model of care direction. The method adopted for this study did not allow for an examination of the relationship between support hours allocation and the needs of the consumer population (as per the goals of the ISP).

Differences between sites in support hours distribution

Appendix 6 details the proportional distribution of support hours that were allocated across all fifteen types of support activity by service site. There were marked differences between sites in the types of support activities in which support worker hours are invested. The findings did not discern as to whether the different patterns of support distribution reflected differing consumer population needs, differing interpretations of the model of care, different service organisation contexts especially workforce capabilities or simply different interpretation of the meaning of each type of support (see section on method and data limitations in the *Discussion*).¹⁶

¹⁶ After the second feedback workshop, CMOs with varying support allocation patterns arranged discussions to consider their differences. The differences reportedly stemmed more from a different interpretation of what was allowable under the model of care rather than a different interpretation of the types of support.

Again, the method adopted did not allow for an examination of the relationship between types of support employed and site consumer population needs. Similarly, there was no capacity in the current evaluation to examine if seemingly different support approaches are producing different consumer outcomes. An impact evaluation could explore this more deeply.

Whole-of-family approach

One of the key features of MH–CLSR is a ‘whole-of-family’ approach. Providers and partners regularly raised this as an issue requiring more clarification. The Program Guidelines describe this aspect of the service model as follows:

“A whole-of-family approach should be adopted, where assistance with parenting functioning and family therapy is provided as needed, and children’s trauma histories and associated issues are also taken into account.”

In the period April–July 2021, InforMH data analysis indicated that 38.9% of consumers had family and carer involvement in the support intervention. This proportion was a reduction from 41.9% in March 2021 (second-round data), which was also a reduction from 43.5% in the baseline data.

The last round of data collection also indicated that while there was a high proportion of consumers who had family and carer involvement in the support intervention, this was at odds with the comparatively low level of support hours allocated to ‘Support in family connections’ (3.7% of total support hours). As noted above, family therapy and parenting function receive special mentions in the Program Guidelines as types of support that may be needed. However, the evaluation did not uncover any evidence that this was occurring.

There were several matters in family support that CMO managers in the final-round interviews described as ‘not well understood’. These might help explain the above findings. First, there was a common experience of more than one individual within a family needing support. This could be responded to with one or both of the following:

- Enrol the other family individuals in MH–CLSR as independent consumers.
- Initiate a family therapy intervention with all family members.

These choices had practical operational implications, as one LHD manager pointed out:

“When family members require individual support, should they be referred to intake and admitted formally to the program? If not, then how does the CMO provider treat the support they require in the context of the allocated number of clients and support hours?” (CMO manager #2)

One CMO manager interviewed in the final round noted that while worthwhile, there were resource implications to consider:

“... it is a good aspect [of the program, family support] but it can put a strain on the resources.” (CMO manager #5)

There were other practical implications in the above choices as family therapy intervention required considerable support worker skills. There was limited evidence from the CMO manager and support worker interviews that these skills were widespread or that family therapy training had been prioritised.

Types of support valued by consumers

Consumers described a wide range of supports that they had received within the program. This included support with:

- access to health care – including finding a GP, liaising with a pharmacy, supporting a child through a blood test, connecting with a women’s health centre, working out how to get a COVID-19 vaccination, as well as help with attending health appointments with GPs, psychologists, and psychiatrists
- home and family administration – including shopping, finding a home, finding a job, arranging licences and car registration, finding a tradesperson to fix an appliance, setting up devices and apps, linking them with charities for food, furniture and clothing, reading, explaining and responding to official letters, engaging with Centrelink, helping with access to lawyers
- family support – including ‘any queries’ in relation to kids’ needs, finding a childcare centre/ kindergarten or school, liaising with teachers/school administration, finding support for home schooling when needed, facilitating children’s play activities and social connections
- transport – including to appointments, ‘to visit my daughter’s grave’, ‘to nice places where we talk’; in several cases, one concrete goal of support was to be able to drive and to get a car and that was achieved
- English language improvement – including providing books, doing dictation exercises, finding classes, and general English practice while engaging with the support worker
- regular opportunities to talk with support workers.

The simple ‘opportunity to talk’ (often described as ‘chatting’) was reported by all consumer interviewees as being very beneficial. It provided regular and highly valued experiences of human connection and a welcome opportunity to process their experiences with someone they could trust. This experience was described by many consumers as a very important component of their mental health improvement journey. It was also seen as an adjunct to more formal counselling services, which most reported as being helpful.

For several respondents, the experience of ‘walking and chatting’ was a highlight of their contact with the program. The combination of being with a trusted conversation partner, the opportunity to be outdoors, getting exercise and becoming more familiar with their local area was reported to provide a sense of wellbeing and contribute strongly to improving their mental health. For some, the constraints of the pandemic meant losing access to this regular activity and this was reported as having a negative impact. For instance, one consumer offered:

*“[The lockdown] affected me a lot – I couldn’t go walking or learn to drive but I still felt their support.”
(Consumer #8)*

Several support workers commented on the positive impact of regular opportunities to talk informally.

“Many of them [consumers] are in really difficult personal situations here and have suffered a lot of trauma – the opportunity to talk is really important to them.” (CMO support worker #1)

Group activities were also highly valued by consumers and appeared to be most beneficial as a form of ‘lived experience’ support network, where trauma did not need to be re-described. This type of support was provided least, according to the InforMH Data Set (less than 1% of total support hours – see Table 9).

Several CMO managers and support workers commented that the program budget tended not to be able to support much group activity, which required funds for refreshments, entry fees (e.g., swimming pool) or facilitators (e.g., yoga or meditation instructor). The result was that the support provided ended up being more on a one-to-one basis. One consumer commented about a women’s group that she was part of:

“We have all had similar experiences in the past that are still very traumatic for us. We don’t even need to talk about them directly – we just know that everyone understands what we have all been through and we can support each other.” (Consumer #7)

One CMO manager also noted the very beneficial impact of creating opportunities for people to relax and have fun with others, especially in the context where consumers are often leading quite isolated lives. This respondent described a group initiative where the local swimming pool manager arranged some private swimming sessions as a way of building the confidence for a group of male consumers. Though impacted by COVID-19, this initiative was described as very successful. It not only contributed greatly to consumers’ wellbeing, but it also led to them building lasting connections with the pool staff and increasing their confidence to attend the pool outside of the initial group sessions.

Participation in clinical and community-based health services and psychosocial supports

Second-round CMO manager survey data indicated a good range of services became available to MH-CLSR consumers through program referrals. These ranged from clinical LHD services and private psychologists to employment, drug and alcohol, women’s health, and aged care support. Some managers also reported that CMOs had provided training to referral services to improve the quality of the support provided by the referral service and to strengthen inter-organisational relationships.

LIVING IN THE COMMUNITY QUESTIONNAIRE (LCQ)

Application of the LCQ

As stipulated in the Minimum Data Set specification, the 26-item LCQ should be completed with consumers at program entry and exit and twice a year. It provides a baseline and subsequent measures to be used to track improvement in functioning over time.

Baseline analysis of the InforMH data set indicated that the LCQ had been completed for just over one third (30%, n = 132) of consumers and 8% had declined to complete the questionnaire. In the second round of data collection 58% of consumers had completed a LCQ (n = 213) of which 37 (30%) had been administered the LCQ twice.

During baseline data collection one support worker described the challenges to obtaining a completed LCQ thus:

“We need to get them [LCQs] done by making a separate appointment, there are a lot of questions to be asking people. To complete we first need to ask for consent, provide a rationale for the assessment, and then book a time to complete it. I don’t think customers find the process useful; people don’t want to disclose that they haven’t got any friends or gone to dinner, they feel a bit of shame. Asking them if they have looked for a job ... there can be some perception that support workers are judging them if they haven’t looked for a job.” (CMO manager #6)

At the baseline data collection generally, it was found that support workers considered completing the LCQ to be arduous, demanding high literacy skills, and potentially being ‘threatening’ for consumers.

There had been some improvement in the level of LCQ administration. Even so, at the feedback workshop to discuss the second-round data findings, CMOs agreed that they could complete the LCQ in parts with consumers over a few sessions so as not to overwhelm them. In the latest round of data collection, some of the earlier support worker antipathy to LCQ administration was found to still exist. One support worker noted:

“The tool is quite long – it seems that it is looking for particular things and goes deep – it takes about 2 hours to complete it.” (CMO manager #7)

Another support worker commenting on the content of the questionnaire said:

“Questions about feelings can be confusing – they [consumers] often can’t really say how they feel. The question about whether they have support from family and friends is a bit too deficit-focussed.” (CMO support worker #3)

For the most current data collection period (April–July 2021):

- 53% of consumers had completed the LCQ at least once (n = 200), and 5% of those had completed the LCQ twice.
- Across the program, 26% of consumers had ‘declined to complete’ the LCQ.
- Some program sites had more success than others at obtaining a completed LCQ, with the decline rate ranging from 0% to 86%. One site did not record rejections, but, during the data collection period, did not seek to complete a single LCQ.

Compared to the findings from earlier data collection rounds the LCQ was being administered less frequently. Interviews with support workers revealed that some saw administration of the LCQ as just ‘ticking a box’. These support workers questioned the value of the measurement of outcomes through the LCQ, especially for asylum seeker consumers.

Use of the LCQ

In final-round interviews, most CMO managers saw the LCQ as a benefit to developing ISPs. This was in contrast with support workers, whose enthusiasm for the LCQ was more varied.

The Mental Health Branch contracted SBS Language Services to translate the LCQ into 18 relevant languages in June 2020, before commencement of baseline data collection. CMOs in MH-CLSR began administering these translated versions of the LCQ with consumers from July 2020. Several CMO managers and support workers interviewed during the final-round data collection were unaware of these translated LCQ versions.

In any case, at the second feedback workshop with CMOs to discuss the second-round data findings, CMOs noted that even with these translated LCQs, consumers needed an interpreter to assist them to complete the LCQ. This was due to poor literacy levels amongst consumers and the use of technical language in the document that did not translate well in text. They noted language can be a real barrier to expression about feelings – and using an interpreter for these types of communications can be problematic because they require an established emotional connection.

Issues included:

- some reluctance by support workers to administer a long and complicated screening tool
- challenges with the tool translations regarding consumer literacy limitations
- support workers not valuing the tool.

These issues contributed to poor use of LCQs despite manager acceptance of their value in assisting ISP development.

Some managers suggested alternative tools to the LCQ. These included:

- WHO Wellbeing Index – measures general wellbeing and asks respondents to rate their interest, engagement and mood. Already translated into over 30 languages and quick to administer, it is used by the NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS) in other programs they implement.
- Recovery Assessment Scale – Domains and Stages (RAS-DS) could be an alternative, although this tool also has many questions.

Several of these managers also suggested that, if the LCQ was retained as the principal or only means of collecting data on 'clinical' and outcome issues, it was critical that support workers have access to good training that would support them to use the LCQ as a broader tool – including in the preparation of ISPs.

COMMUNITY ENGAGEMENT AND PARTNERSHIPS

Relevant evaluation question/s:

- *How are community leaders engaged in promotion and support of the service?*

The Program Guidelines advise MH-CLSR providers that they:

“... should have comprehensive and culturally robust strategies for engagement ... with communities ... to promote community recognition of MH-CLSR, help integrate clients into community life and encourage referrals into the program.”

Interviews revealed that there was considerable variation in the way that community engagement strategies were implemented in each site. While the model of care only focusses on community **engagement**, many managers and staff also talked about community **development** and / or used the terms engagement and development interchangeably. Several CMO respondents called for better guidance on how to address this component of the program, including theory, method and relevant skills.

In the baseline data it was evident that early program implementation activities focussed on community engagement through special attention and resourcing. This included a careful process of identification of community leaders with a broad sphere of trust and influence. One CMO manager noted:

“We have found that it is very important for the program and for our organisation to work out who is respected in the community as this can really shift the conversation – it’s very important not to “back the wrong horse.” (CMO manager #7)

However, final-round interviews with stakeholders indicated that this early program activity appeared to have dissipated to a substantial degree in several sites. Only some of this downturn in activity was caused by constraints imposed by COVID-19 lockdowns.

As a concept, community engagement has been embraced as an important component of the service model in all sites. However, there was considerable variation between sites in both the strategies employed and the extent of engagement that is achieved. Sites in Sydney, Newcastle and Wollongong described their engagement with a wider range of service partners and community organisations than sites in regional centres. In these urban sites, respondents described strong working relationships with local partner organisations, including:

- multicultural and/or refugee support services
- specific cultural and religious organisations
- settlement services
- family and community services
- primary health care practices
- welfare support agencies.

In the rural sites however, there were fewer formal agencies and established community organisations. This meant that there was potentially a process of community development / capacity building to be undertaken in addition to community engagement, especially to satisfy the task of helping to “... integrate clients into community life”.

Several CMO managers and support workers described the important role played by bilingual and bicultural workers in assisting with building connections with local cultural communities. In many cases, these workers themselves were part of the refugee community and perceived as leaders, which facilitated better connections to community for the program.

In the final round of data collection, several stakeholders suggested that there needed to be more and continued capacity building in communities. There was also a strong desire from CMO staff for the focus on community engagement to return to the same level as the early stages of the program because it enabled consumers to be more independent and for clinical and other support services to be more capable of providing the required support to consumers.

Several CMO managers in interviews during final-round data collection noted that:

- it was challenging for support workers to commit adequate time to community engagement when balancing other priorities to provide more urgent forms of support to individuals (note from earlier findings that only 7% of total MH-CLSR workforce is dedicated to community engagement)
- the skillset required for effective community engagement was different to the one-to-one support worker skillset
- more guidance was needed on how to approach this component of the program, acknowledging the range of ways in which it could be done and the potential pitfalls.

STARTTS provided support to all sites to a greater or lesser extent, depending on their formal partnership arrangements in each site. STARTTS' counselling service also incorporated a component of community engagement as part of their service model, with a target of 30% for each counsellor in their work program.

SKILLS AND TRAINING OF WORKERS

Relevant evaluation question/s:

- *Do service providers have staff trained in cultural competence (including interpreter use) and/or mental health (including trauma informed care)?*
- *Have all relevant training packages been funded, facilitated and/or directly offered in a timely way?*

Workforce size

As of May 2021, the CMO manager survey data indicated that there were 94 individual CMO staff (managers, support workers, case managers and peer workers) employed across the program sites; at the baseline there were 48 individual staff. In total, 1849 working hours per week were reported for these 94

individual staff, which translates into 48.7 full-time equivalent (FTE) staff¹⁷ a FTE conversion rate of 0.52. This seems to be a very low FTE conversion factor but is comparable to the total CMO mental health workforce FTE conversion factor of 0.59 identified by Ridoutt (2021).

The proportion of the workforce ‘in the field’ working directly with consumers had reduced by almost 10% since the baseline. By FTE, the most common type of worker was ‘support worker’ (36.3%), ‘case manager’ (16.9%) and ‘peer worker’ (6.6%). Almost a third (29%) of the workforce (by FTE) was comprised of managers and team leaders.

There was some difference in estimated workforce size calculated from the CMO survey and the costing data collection (with the latter providing a lower estimate). The primary reason was that the survey data counted all workforce hours whereas the cost data indicated only FTE for permanently employed staff and did not indicate hours budgeted for casuals (for instance, casually employed ‘bi-cultural assistant client support workers’). In some sites these were an important FTE contribution to service delivery.

Support worker time distribution

Based on data collected from support workers during the final-round data collection interviews, the proportion of hours spent in direct care support varied between CMOs and between support workers within CMOs. The ‘average’ distribution of support worker time is estimated in Table 9.

Table 9: Estimate of ‘average’ distribution of support worker time (Source: Final round CMO manager and support worker interviews)

Type of work	Estimated average % of all support worker hours	Range of proportions
Direct support (includes face-to-face and remote contact, organising support, writing ‘clinical’ notes, ISPs, etc.)	65%	55–80%
Community engagement/community development	5%	0–25%
Training/clinical supervision	8%	5–15%
Meetings	8%	5–20%
Administration	14%	10–25%

The proportion of support worker time in direct care support ‘used to be higher pre-COVID-19’ according to most support workers and managers and was closer to 80%. One operations manager suggested that:

“... 85% of a support worker’s time in direct care was aspirational (that is the CMO’s desire) but that currently in the COVID-19 context this was almost impossible to achieve.”
(CMO manager #5)

Some support workers who were interviewed in the final data collection round assessed the current time spent on direct care as appropriate. Pre-COVID-19, a similar group of support workers had contended that

¹⁷ FTE assumes a full-time person works 38 hours per week.

the 80% direct care level current at that time left insufficient time for other types of activity that made direct care support more effective, such as planning. Similarly, so much time spent on direct care support ultimately posed a challenge for them to focus on professional development. As one support worker commented:

“... if we are not learning, we are not evolving.” (CMO Support worker #6).

Other support workers felt that more effort was required on community engagement. In three of the sites, some support workers were designated in their primary role specifically as community engagement/ community development officers. These support workers accounted for just over 7% of the workforce, possibly reflecting the relative emphasis placed on community development. In other CMOs where the community engagement function was incorporated into a dual role (that is, combined with an individual consumer support role), some support workers reported that the community development effort tended to take lower priority. In the baseline and final data collection rounds, CMO managers and support workers who were interviewed reported a general desire for a stronger staffing focus on community engagement and development.

Recruitment approaches

The distribution of the direct care workforce according to their highest qualifications is shown in Figure 7 for the baseline and final data collection periods. As the program matured and increased in workforce size after its inception, the emphasis shifted to the employment of more highly qualified support workers. The baseline data indicated that 40% of the workforce had a relevant higher education level qualification, whereas the most recent costing data (2020/21 financial year) indicated that this had increased to 52% (Figure 7).

Baseline data from the CMO survey, interviews and document review indicated that two key approaches to recruitment had been adopted by the CMOs. One approach prioritised mental health competencies to manage the level of complexity in consumer presentations and to be able to form credible relationships with other mental health clinicians (e.g., LHD services). This pathway favoured recruitment of persons with relevant tertiary-level qualifications, such as qualifications in social work. The other approach prioritised lived experience – meaning experience of mental illness, but more often meaning having lived or be able to understand the refugee experience.

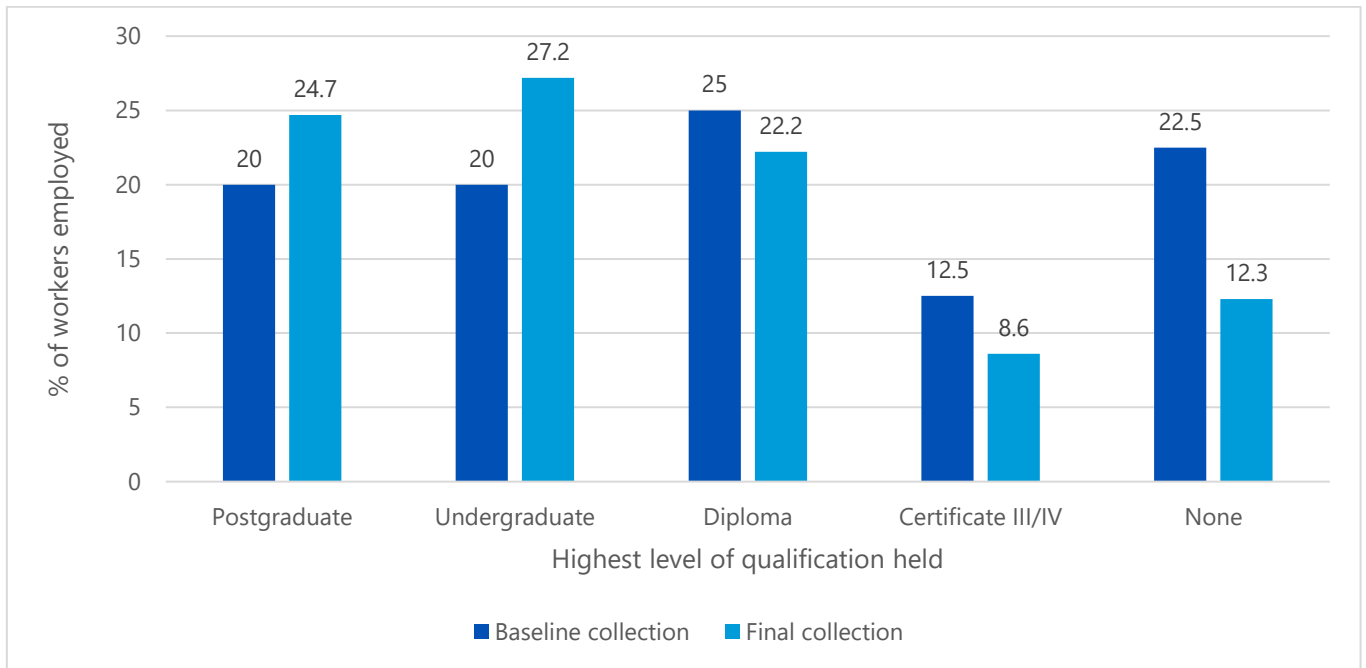


Figure 7: Distribution of the MH-CLSR workforce by highest level of mental health relevant qualification (comparison between baseline and final data collection, n = 48 and 94 respectively) (Source: CMO Manager Survey – Baseline and Second Round)

Figure 8 below suggests that the focus on mental health competencies had been prioritised. However, it is important to note that while a shift to higher qualifications in recruitment was evident, 44% of support workers employed had 'lived experience' as a refugee and/or asylum seeker and 57% of support workers were bilingual. Both these proportions were lower than the comparable composition of the workforce proportions at the baseline data collection (56% and 85% respectively).

Despite this trend, the second CMO manager survey results showed that all providers emphasised the value of support workers with lived experience. The following comments were provided about the lived experience of staff members:

"We actively recruited staff with lived experience or that are bilingual, and this has been a success of the service." (CMO manager #1)

"An absolute asset to the program and imperative to trauma-informed, culturally sensitive service delivery. Consideration needs to be made for re-traumatisation and vicarious trauma, as well as the complexity of working within own community (as is the case with our key worker and our casual bi-cultural workers). This means extra resources (e.g., time for de-briefing) is needed and clinical supervision is required for the wellbeing of staff and optimal delivery of services. Additionally, professional development for key workers in management of bi-cultural staff within a trauma-informed framework (including professional boundaries within your own community) [would also be desirable]." (CMO manager #9)

Training and continuing professional development (CPD)

Cultural competence and mental health training

CMO manager survey data collected from CMO managers indicated that, at least up until the long lockdown period of 2021, most support workers were supported to undertake directed training in cultural competence and mental health (see Figure 8).

However, according to data collected through support worker interviews, there was varied training investment across the CMOs. Support workers observed that, during the program’s start-up there had been an initial push and specific program funding allocated for training and scholarships (the focus of which tended to be manager-directed) but there had been less access to training in the past 12 months. According to data collected through CMO support worker interviews, training efforts became more worker-directed. This meant that support workers were required to identify and access training under their own initiative, which appeared to be typically accessing and participating in online courses. Managers explained this shift in terms of the greater level of autonomy given to support workers to self-identify competency needs that emerge as the program’s workforce becomes more mature and stable. They contended that the same applied when support workers came from other programs (e.g., HASI), bringing appropriate skills with them. In other words, a more mature level of workforce skill and competence meant that the need for additional training became more specific to particular support workers.

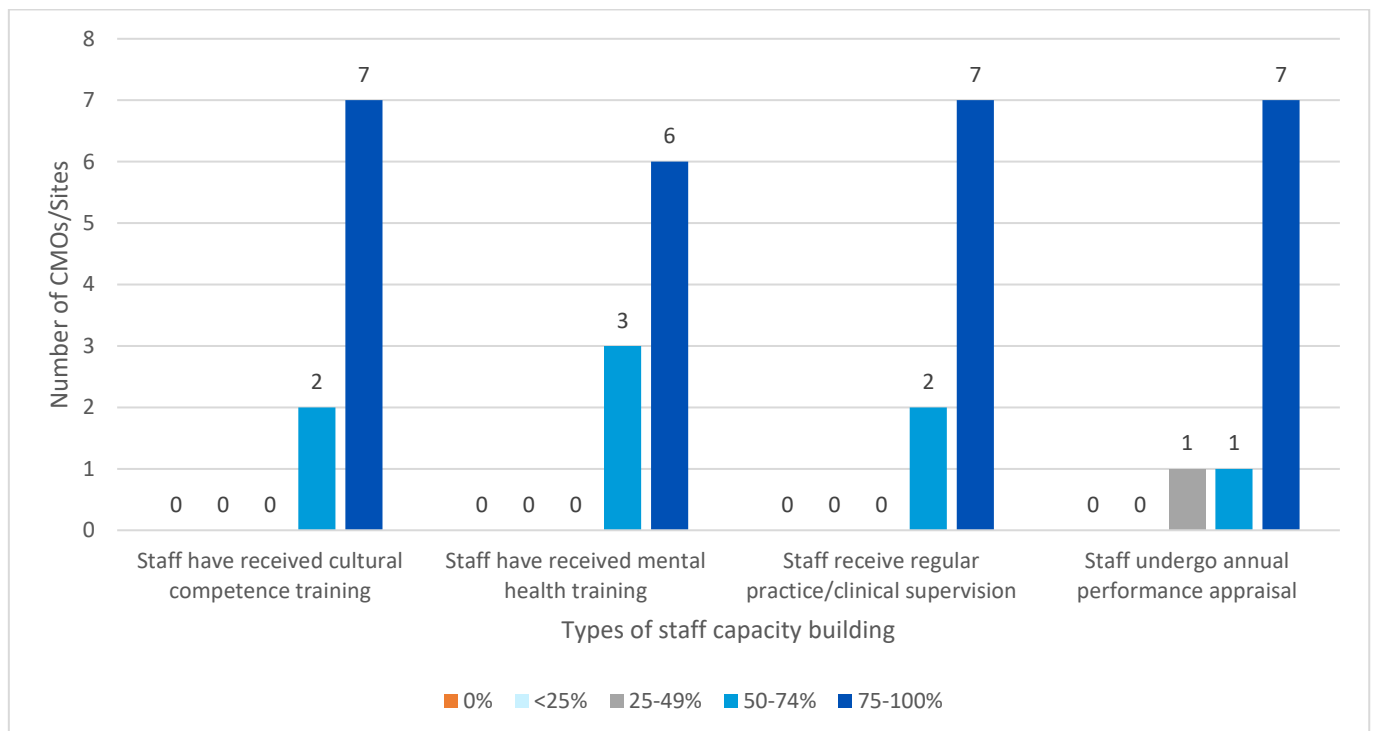


Figure 8: Distribution of CMOs by training and supervision actions taken by the proportion of their workforce covered by those actions (Source: Second Round CMO Manager Survey)

Some managers and support workers expressed concern that there were risks associated with worker-directed training if the selection of courses prioritised were not immediately pertinent to skill gaps and the service’s needs. There remained a role for managers to supervise training needs.

Support workers also identified a need for more cross-site training and workshops to support more interaction and cross-fertilisation of ideas between sites. For example, STARTTS had planned such a workshop (at least between STARTTS/New Horizons sites) but the workshop was not held.

The CMO support worker interviews revealed that the strongest interest was in incident reporting and risk management training. LHD managers also perceived this to be an area of training need for many MH-CLSR workers and believed that, on average, CMO support workers tended to pick up on perceived deterioration in the consumer too early. They argued that experience of risk, how to recognise it and when to be concerned, was an area that could be further developed in CMO support worker skillsets.

Some CMO support workers also reflected that they believed they [still] had an under-developed understanding of the mental health issues, despite in some cases having been supported to undertake relevant VET courses. Most support workers expressed a need to better understand trauma-informed care, suicide risk, and the recovery approach. Some would have liked more training on counselling and specific psychological therapies (in particular, cognitive behavioural therapy). Those support workers who had come to the program with no lived refugee experience stated that they would like to understand more about refugee issues. One support worker stated:

“I would like more training on issues specific to refugees and asylum seekers and it would be very helpful to have a bit more understanding of the immigration visa categories, their implications for customers and the overall application process.” (CMO support worker #3)

Some LHD managers also liked this for their staff:

“LHD workers need to improve understanding of CALD communities and issues of settlement.” (LHD manager #1)

Clinical supervision

According to data collected through the CMO manager survey, most support workers received regular clinical supervision and performance management (see Figure 8). From CMO manager final-round data collection interviews, it was determined that supervision could be provided at three levels:

1. the administrative/performance management (team leader level)
2. the clinical supervision (external level)
3. the peer supervision level.

Based on support worker interviews, only the first type of supervision was universally provided across CMOs. At two of the nine sites, CMOs had supervision implemented at all levels according to support worker reports. While CMOs managed multiple sites, separate site management arrangements had resulted in variations in approaches, such as for clinical supervision, despite broader overlying organisational processes and procedures. Comments from support workers about clinical supervision included the following:

“Administrative supervision and appraisal happens reasonably regularly ... we discuss customers and how to handle tricky issues. There is virtually no clinical supervision though – just online ‘catch-ups’ around performance management.” (CMO support worker #3)

OUTCOMES OF THE PROGRAM

Relevant evaluation question/s:

- *Are services meeting the diverse needs of the target groups?*
- *Are consumers, providers, program partners, families and carers satisfied with the way supports are designed and delivered?*
- *At baseline, what are consumers' levels of independence and functioning, health and wellbeing, family, community and economic participation?*
- *For those that complete the program within the timeframe of this evaluation – were there improvements?*
- *Has there been any increase in participant access to and participation in education, employment or community activities?*

Consumer trust and satisfaction with service

All consumers who were interviewed expressed a high level of satisfaction with the program and the services that they have received. All consumers also reported that the pathway of access to the program was very easy for them, despite describing a wide variety of referral avenues. A prominent theme in the consumer feedback was a sense of personalised support from trusted support workers. The opportunity to communicate in their own language was beneficial to help them to understand what the service was about and to engage with support workers. Although few reported that they had a copy of their care plan, all were aware of being part of developing a plan with support workers and described feeling good about that process.

Many consumers described the support workers as 'friends' who could be relied upon to be in regular contact with them and that this contact gave them a great sense of stability, which had been missing for many. They also highly valued and trusted the promise of confidentiality that support workers offered them, which gave them confidence that they could discuss anything that was concerning them. This was particularly important for some in the initial part of their engagement with the program for those who felt shame or isolation due to their experience of mental illness.

Support workers also reported that consumers seemed very satisfied with the support they get. They perceived that the flexibility of the program was highly beneficial for consumers and CMO support workers reported the benefits of that flexibility. One CMO support worker noted:

"Clients feel very enabled to make contact and to decide what type of support would work best in each situation – such as direct support, going along with them or referring them to other services." (CMO support worker #8)

Outcomes for consumers

All consumers interviewed in this round described the positive impact that the program had on themselves and their families. For the small number of consumers who were interviewed in all three rounds of this evaluation, it was clear that they had experienced a journey from a sense of isolation and dependence on the program to a sense of wellbeing, confidence and independence, including having a licence and a car and a more stable and comfortable place to live. Meeting these needs and supporting a sense of optimism appeared to provide a sense of forward movement in their lives and perhaps gave them the strength to process the more deep-seated trauma, grief and loss.

One consumer commented on this:

*"I want the service to be able to focus on people with very sad loss in their lives."
(Consumer #5)*

For most, the experience of feeling safe and confident in the service was reported as a very significant empowering element of the program, providing a highly beneficial scaffolding effect for them to take steps towards improvement in a wide range of ways. One consumer observed:

*"I trust them like a friend – I feel safe. It improved my life and made the biggest difference to my mental health."
(Consumer #3)*

In reflecting on outcomes, support workers felt confident that the program was having a very positive impact on most if not all consumers. One CMO support worker reported, however, that the journey was not always fast or direct:

*"We share responsibility to reach their goal ... it's not the quickest way to proceed but really helps to build recovery. The program's way of working gives people a voice – for instance, it helps consumers obtain and properly use an interpreter."
(CMO support worker #4)*

A CMO manager interviewed in the final-round data collection commented:

*"The program really fills a gap in the service network for this target group – it is able to help people on a very personalised basis. Clients really see the support workers as a significant part of their overall support network. The program means that clients have a reliable point of support, sometimes the only one – it has a big impact."
(CMO manager #6)*

LCQ changes in consumer outcomes

As noted previously, the administration of the LCQ was not comprehensive. This was especially true of the second administration of the tool, to be able to assess change in consumer status. Of a possible 545 consumer that could have potentially been administered the LCQ over the period of the program (up to July 2021), only 53 (10%) had been administered the LCQ twice.

An analysis of those 53 was undertaken, looking at changes in consumer outcomes on the last six LCQ wellness indices (all scored between 1 = poor and 5 = excellent).

The categories were:

LCQ Q28 – Your hopefulness for the future

LCQ Q29 – Your happiness with your life

LCQ Q30 – Your ability to achieve the things that are important

LCQ Q31 – Your sense of being part of a group or community

LCQ Q32 – Your ability to get support from family or friends when you need it

LCQ Q33 – Your overall well-being.

Total negative (a change in score from higher to lower) and positive (a change in score from lower to higher score) outcome scores were tallied. Overall, there were 70 negative outcomes and 60 positive outcomes.

In truth, the low number of consumers being administered the LCQ twice and the lack of training of workers in the administration of the LCQ and limited reflection on its use, meant the findings at this stage were indicative only. Qualitatively there was strong belief expressed during the final round of interview data collection across all stakeholder types that good consumer outcomes were being achieved. The following comment from a LHD manager was indicative:

"[The program is] ... phenomenally useful when you see the difference between entry and exit. The program has a very good reputation within the LHD." (LHD manager #8)

DESCRIPTION OF IMPLEMENTATION COSTS

Relevant evaluation question/s:

- *What are the costs associated with MH–CLSR program implementation?*
- *Based on the program reach, what are the expected benefits of the program to government in monetary terms?*

Total expenditure, FY 2020/21

Across the 2020/21 financial year the program incurred expenditure of \$5.3 million, with operational expenditures accounting for 96–97%, on average, across the sites (Table 10). There were minor variations between sites with the operational share of total expenditure ranging from 91.2% to 99.6%. As the program duration evolved, spending on establishment and capacity building reduced as expected. In the second half of the 2020/2021 financial year, only three of the sites had establishment and capacity building activity expenditures, in contrast to the first half of the financial year when all sites had such expenditure.

Table 10: Establishment, capacity and operational expenditures, FY 2021 (Source: Costings Survey)

Site	Establishment / capacity	% Share	Operational	% Share	Total
Western Sydney	73,022	8.8%	755,093	91.2%	828,115
Wollongong	36,636	5.3%	656,928	94.7%	693,564
Newcastle	15,057	3.0%	467,632	97%	482,688
Armidale	11,359	4.0%	287,466	96%	298,824
Coffs Harbour	17,431	2.6%	643,078	97.4%	660,509
Fairfield/Liverpool	5,438	0.4%	1,273,424	99.6%	1,278,862
Ashfield	42,070	7.7%	504,661	92.3%	546,731
Wagga Wagga	–	–	232,925	100.0%	232,925
Griffith	–	–	270,743	100.0%	270,743
Average	21,666	4.3%	556,163	96.5%	577,829

Note: For Wagga Wagga and Griffith there was no expenditure on Establishment or Capacity activities

Operational expenditure, FY 2020/21

Employees accounted for approximately 80% of total operational expenditure on average across the program (Table 11). There was significant variation between LHDs with, for example, lower expenditure on employees as a proportion of total spend in Western Sydney (–14%) and Illawarra-Shoalhaven (–9%). In contrast, Murrumbidgee LHD sites spent proportionally more on employees than the average (+9%).

Other notable variations in expenditure included use of interpreter services, where Western Sydney incurred a much higher spend on relevant services as a proportion of total operational expenditure (9%) compared to the average (2%). In comparing the first and second halves of the financial year, there was relatively limited change in the proportion split regarding other operational items.

Table 11: Main expenditure categories, FY 2020/21 (Source: Costing Survey)

Sites	Types of expenditure (\$'s)						Total
	Employees	Interpreters	Occupancy	Travel	IT	Other	
Western Sydney	602,422	66,474	66,848	15,892	3,457	–	755,093
Wollongong	434,596	9,911	59,624	23,061	54,136	75,600	656,928
Newcastle	372,466	9,283	22,423	8,676	36,731	18,052	467,632
Armidale	248,311	6,188	14,948	5,784	199	12,035	287,466
Coffs Harbour	497,888	9,141	9,269	22,619	35,913	68,248	643,078
Fairfield/Liverpool	990,405	4,975	22,530	52,068	52,985	150,461	1,273,424
Ashfield	374,883	6,101	24,518	10,304	26,801	62,054	504,661
Wagga Wagga	195,735	1,200	12,750	2,700	2,390	18,150	232,925

Sites	Types of expenditure (\$'s)						
	Employees	Interpreters	Occupancy	Travel	IT	Other	Total
Griffith	239,273	2,325	9,490	1,751	1,235	16,669	270,743
Average	455,615	12,236	27,456	14,706	23,128	44,198	577,338

Consumer support

The average cost per consumer was \$1,408 at the program level, with Figure 9 illustrating the associated variations between sites, with a high of \$2,522 and a low of \$583.

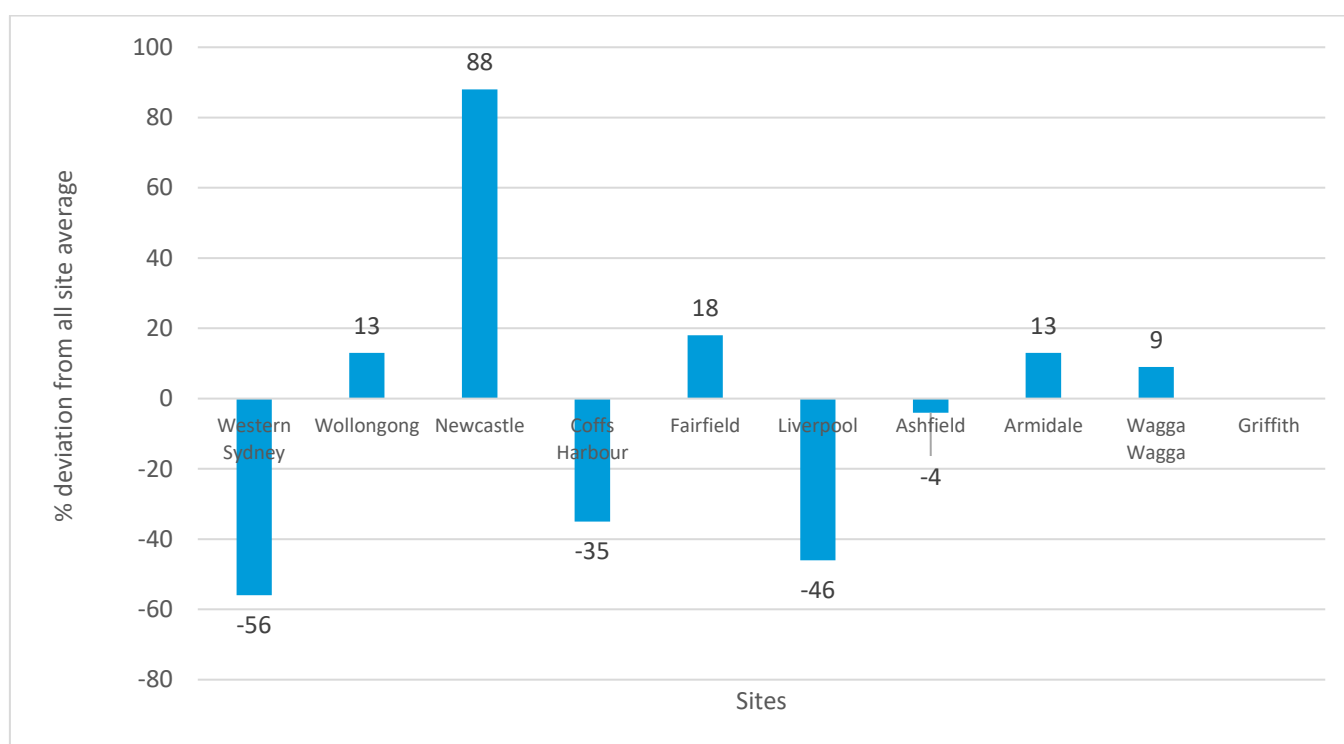


Figure 9: Variation in cost per consumer between sites, monthly average, Jan-June 2021 (Source: Costings Survey and InforMH Data Set)

Most sites deviated from the program average expenditure per consumer by between 1 and 10%, but some of the sites varied from the average by as much as 88% (above average, Newcastle site) and 56% (below average, Western Sydney). In other areas where findings had identified variation between sites the possibility of site variation on location (urban/rural), population composition (refugee/asylum seeker), externally available resources and service delivery approach was offered as a possible means of explanation. The magnitude of the differences in this variable are more difficult to explain. Relevant CMO actions to examine the issue post the second-round data collection feedback workshop failed to satisfactorily explain the differences.

In comparing consumer support between the time periods January–June 2021 with July–December 2020, the total program number of support hours increased by (almost) 150 hours (6%) with an increase in total consumer related costs of \$6,238 (5%). The average per site monthly number of consumers being

managed is unchanged (approx. 17), and there is an increase of 5 hours of consumer support, with an associated increase in the average cost per consumer of \$218 (15%).

CMO governance expenditure, FY 2020–21

The expenditures on attending governance meetings, accounting for staff time costs, was on average \$18,088 per site (Table 12), with 42% accounted for by wider engagement activities. There was significant variation between LHDs, ranging from \$73,030 (8.8% of total expenditure) in one to \$4,322 (less than 1% of total expenditure) in another.

Figure 10 illustrates the proportional split of total expenditure by the type of governance activity. There was reasonable similarity across LHDs, with certain exceptions – such as one site concentrating 85% of governance on wider engagement activities.

Table 12: Expenditure on governance, by meeting type, FY 2020/21 (Source: Costings Survey)

Sites	Expenditure on governance type areas (\$'s)				% of total budget
	Program governance	Wider engagement	Capacity building	Total	
Western Sydney	15,800	31,607	25,623	73,030	8.8
Wollongong	6,843	7,505	20,352	34,700	5.0
Newcastle	3,758	4,322	626	8,707	1.8
Armidale	3,758	7,517	1,315	12,591	4.2
Coffs Harbour	1,128	2,255	1,002	4,385	0.7
Fairfield/Liverpool	752	5,262	188	6,201	0.5
Ashfield	2,255	1,879	188	4,322	0.8
Wagga Wagga	3,980	2,669	6,073	12,722	5.5
Griffith	2,804	4,613	3,088	10,506	3.9
Average	4,673	7,644	5,771	18,088	3.1

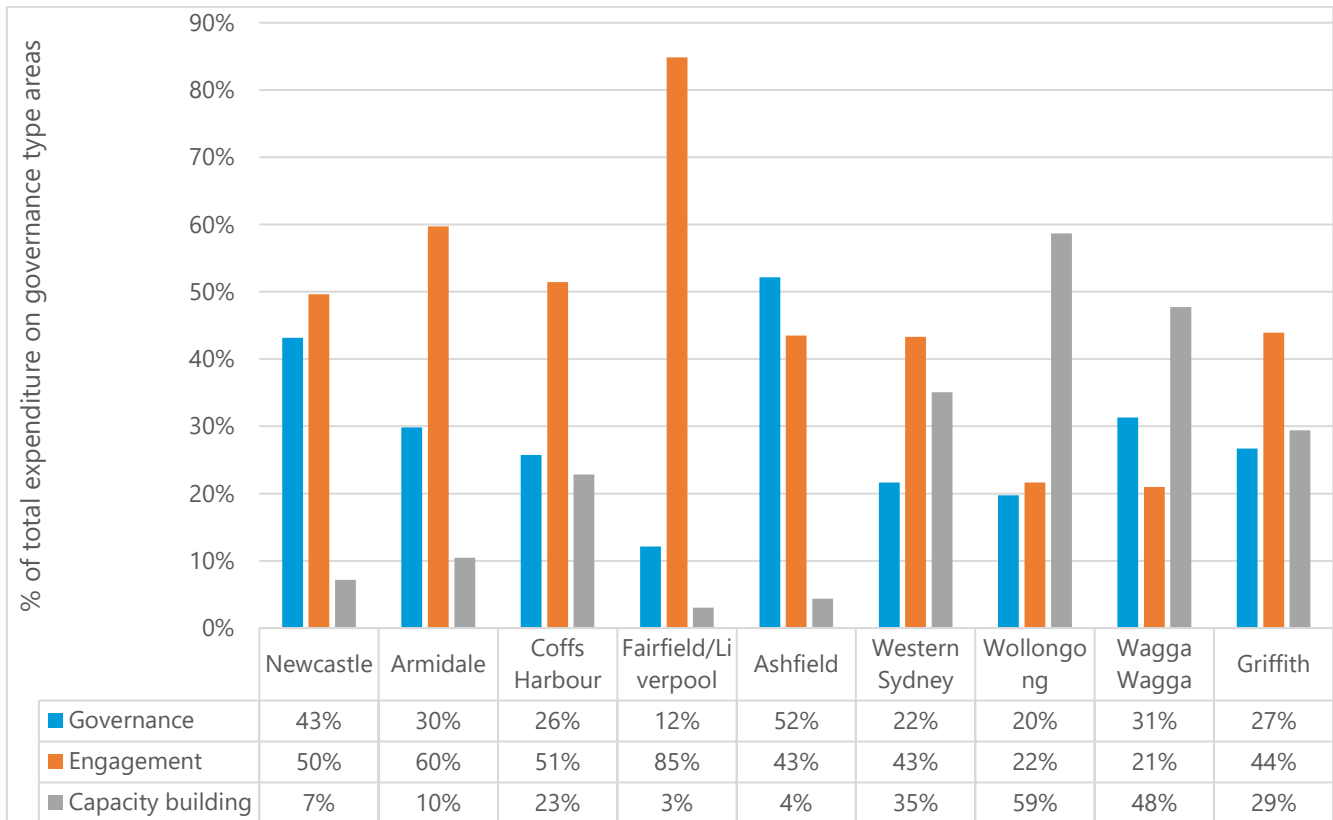


Figure 10: Proportion of governance expenditure, by meeting type, FY 2020/21 (Source: Costings Survey)

3. SUMMARY ASSESSMENT OF PROGRAM IMPLEMENTATION

FIELD IMPLEMENTATION RATING SCALE SCORES

Of the 11 criteria assessed at the baseline and final-round data collections (two criteria were only assessed at baseline), eight showed improvements in either variation or fidelity or both. No criterion showed a regression in assessed implementation performance, although for three criteria there was no improvement noted between baseline and final-round data collections. In the case of these three criteria, the initial baseline implementation was assessed as moderate or good so the scope for improvement was less.

Two criterion areas received considerable attention during the evaluation and were the focus of the two feedback workshops. These were:

- effectiveness of the local partnership meetings
- working relationships between CMO and LHD.

In the case of both these criteria, significant improvement in implementation was observed.

A summary assessment for each criterion is provided in Table 13 below.

Table 13: FIRS rating of implementation on selected criterion across all of the nine sites (Sources: InforMH Data Set, Second Round CMO Manager Survey, and Final Data Collection Round)

FIRS criteria	Final-round assessment	Variation between CMOs/ sites (low, moderate, or high)		Fidelity across the sites (poor, moderate, good)	
		Baseline	Final round	Baseline	Final round
Readiness for implementation	Across the sites, CMOs were well placed and experienced to deliver the program. They generally possess expertise (or have acquired through partners) to support refugees and asylum seekers and people with a mental health issue.	Low	Not assessed	Good	Not assessed
Leadership and commitment to the program	The values of CMOs across the sites were reported to align with the values of the program. Across the sites CMOs have strong internal commitment to the CSLR Program and leadership from managers and senior managers.	Low	Not assessed	Good	Not assessed
Access and intake to the program	Across the sites, these processes were initially variable regarding mental health assessments being conducted by LHD CMH teams and this finding continues. Overall, processes are consistent with the Program Guidelines.	Moderate	Low	Moderate	Moderate
Individual Support Plans (ISPs)	Timely completion of ISPs steadied by the final round (aided by increasing the time to complete from 2-4 weeks) and review rates of ISPs every 12 weeks improved.	High	Low	Poor	Moderate
Living in the Community Questionnaire (LCQ)	Completion of LCQ continues to be variable within and between the sites and deviates from the Program Guidelines.	High	High	Poor	Poor
Workforce composition of the program and professional development	Increases in workforce size and more qualified staff were evident in the final-round data, reducing variation between sites and increasing fidelity to the Program Guidelines. Attention to relevant professional development has deteriorated in some cases.	High	Moderate	Poor	Good
Use of interpreters	Interpreter use across the sites has not changed substantially since inception. There is moderately good use, acceptance, and appreciation of interpreter services, but the quality of interpreter services varies depending on the service or model used.	Moderate	Moderate	Moderate	Moderate

FIRS criteria	Final-round assessment	Variation between CMOs/ sites (low, moderate, or high)		Fidelity across the sites (poor, moderate, good)	
		Baseline	Final round	Baseline	Final round
CMO relationship with the local community (e.g., refugee, religious leaders, etc.)	Effective relationships with local community groups were established early across all sites, but in the final-round data there is evidence of reduction of focus on this important strategy. Time allocated to community development by support workers was variable across the sites. COVID-19 has limited community development activities.	Moderate	Moderate	Moderate	Moderate
CMO relationship with other local partners and services	Across the sites CMOs work with a range of partner services; however, effectiveness of relationships with different services is variable, including between urban and rural sites.	Moderate	Low / moderate	Moderate	Good
Appropriateness of the SLA	SLAs across the sites are consistent with the requirements of the Program Guidelines. All SLAs were in place by the second-round data collection.	Moderate	Low	Moderate	Good
Effectiveness of the local partnership meetings	Convening and effectiveness of partnership meetings between CMOs and LHDs was improved by the final-round collection. Bi-lateral meetings are now in place in all sites, though structure and attendance varies in some sites.	Moderate	Low	Poor	Moderate / Good
Working relationships between CMO and LHD	Variations across the sites continue, but there have been improvements in relationships in some sites.	High	Moderate	Poor	Moderate
Clarity of purpose and direction of the program	The Program Guidelines and site level policies provide clear purpose and direction of the program across the sites. A lack of clarity has emerged over time among some support workers concerning fidelity to the model of care of their practice and that of other sites.	Low	Low	Good	Good
Referral mechanisms to other services	Referrals by CMOs to other services is in line with the Program Guidelines across the sites, but there is variability in availability and capacity of other services, especially between urban and rural sites.	Low	Low	Moderate	Good

IMPACT OF COVID-19 ON IMPLEMENTATION

During the first wave of lockdowns in 2020:

- Partnership meetings were less frequent.
- Face-to-face support of consumers decreased.
- The use of phone and video technology increased.
- Access to other services and quality interpreters decreased.
- Social isolation increased because of reductions in community events and language classes.

The reduction in face-to-face contact was thought to be particularly critical. As one support worker noted in an interview:

“Before the recent lockdowns, we had established good relationships with our clients and face to face contact was a big help in this. The quality of the relationship tends to drift when that momentum of contact is lost – clients express the need for more personal contact. When the momentum is lost, they tend to feel more isolated and become more and more desolate.” (CMO manager #7)

While these issues continued in the second wave in 2021, in the months leading up to the final data collection round, the higher vaccination rates facilitated an increase in face-to-face support. Sites that continued to provide face-to-face contact and/or reinstated such support, made the case that the MH-CLSR support was an ‘essential service’. Providing these services needed significant additional organisational arrangements. These included:

- preparing safety plans
- providing additional information (such as Frequently Asked Questions)
- ensuring vaccination access for support workers.

Some CMO manager and support workers reported that COVID-19-related information, including vaccine information, was increasingly available in community languages. On the other hand, consumers’ difficulty in understanding the general community information channels (e.g., television news) meant that they were often confused about why they needed to stay at home. This was particularly acute in relation to children not being able to go to school, leaving them to be ‘home-schooled’ by a parent or parents with limited English proficiency and often also with mental health problems. CMOs reported that there was little personalised support available from schoolteachers, even when requested. Some CMOs were able to pivot their support strategies to provide some schooling support, as reported by one CMO manager:

“We are using our networks to scramble to try to help them however we can – for example, we are working with STARTTS to deliver homework groups 3 times per week, including parents if that’s desired.” (CMO manager #4)

LHD managers and workers in the final-round data collection reported a major impact on their capacity to provide regular services and to participate in meetings with CMOs and other service providers due to widespread diversion of LHD staff to COVID-19 testing and vaccination activities.

4. DISCUSSION

The final-round data collection confirmed that the program was largely being delivered in compliance with the Program Guidelines (model of care) and to the satisfaction of stakeholders, including consumers. There was widespread support for the program and agreement that it was targeting a genuine need that has previously been unmet.

In this section, the evaluation findings are discussed according to the following themes to summarise how the program was being implemented and to highlight the opportunities and considerations to improve the design and delivery of the program:

- Understanding the model of care
- Service delivery and fidelity to the model
- Relationship with community groups and leaders
- Relationship between CMOs and LHDs
- Consumer experience
- Workforce and training
- Cost of implementation

UNDERSTANDING OF THE MODEL OF CARE

The findings from the final round of the evaluation confirmed that the program was largely perceived as having a strong purpose and direction. This reinforces the high level of satisfaction expressed by CMO and LHD managers with the Program Guidelines and in the MoH's direction of the program that was identified first during the baseline data collection. The findings also confirmed that the program was largely being delivered in compliance with the Program Guidelines (model of care) and to the satisfaction of stakeholders, including consumers.

Despite this overall level of satisfaction, final-round interview data revealed that providers sometimes often novel situations where guidance was either missing or ambiguous in the Program Guidelines at the site or CMO level. This underscored the need for the Program Guidelines to continue to evolve based on feedback from CMOs.

One key area identified where clarification was needed related to service provision to families. The 'whole-of-family' approach outlined in the model of care was widely supported but could result in administrative and practice issues. Administratively, it could create pressures on the service capacity and budget if more than one member of the family needed intensive support, but service capacity had already been reached. To reduce this pressure, CMOs require clarification on an agreed way for delivering this element of the model. From a practice perspective, the model of care advocated the inclusion of family therapy-type support. Yet, service data suggested that family therapy had not been widely offered. This may be in part due to the relatively high level of skill required to implement family therapy and it is not clear that there was a requisite skill base in the workforce to support it.

Another key issue where clarification was required, was the need for better guidance around consumer exit from the program. At some sites, a waiting list to access the program had been created and there could be a lack of clarity about how and when consumers should exit the program. This could occur if other local support services were not available to provide suitable longer-term support if needed. Adding to the complexity was that many consumers were content to stay in the program, even if only because the

CMO was one of only a few trusted services available to them. To address this, the MoH could provide CMOs with a description of a typical consumer journey of a consumer/family accessing the program, including the types of supports that might be needed to support a successful exit from the program.

Opportunity #1: *The Program Guidelines could include evidence based 'best practice' approaches and criteria to guide CMOs to better develop consumer goals and interventions; plan their supported recovery and to assess the readiness to exit consumers.*

In the longer term the proposed Impact Evaluation, especially the audit of ISP goal achievement, should provide program-specific 'best practice' guidance.

More generally, most CMOs reported having to make informal adjustments of approach in response to specific local issues. CMOs were uncertain if these adjustments were within the Program Guideline's acceptability of flexibility, or 'non-compliant' with [the core principles] of the model of care. Therefore, improved guidance is required to confirm what adjustments may be 'reasonable and acceptable' to reduce uncertainty for CMO managers and support workers. This could be through discussions and clarification with other services and program managers.

Opportunity #2:

Regular workshops (quarterly) could be conducted with CMOs to provide guidance on the approach to specific situations such as the whole of family supports, transport of consumers and supporting asylum seekers who have much broader settlement-related needs because of their ineligibility for services.

Where appropriate, Program Guidelines could be updated on the agreed approaches.

Consistent practice and understanding about transporting consumers and consent requirements for information sharing between services are two such issues that could be improved through regular workshops and discussions between CMOs.

SERVICE DELIVERY – FIDELITY TO THE MODEL OF CARE

Service volume

Since the program began, the number of consumers receiving a service climbed steadily and plateaued in 2021 at, or above, contracted levels; at the final data collection round (July 2021) CMOs, collectively, were supporting 109% more consumers than contracted and providing 24% more hours overall than contracted. Yet, CMOs were spending less time on average per consumer, 41% less time than contracted (1.3 hours per day per consumer versus the 2.2 contracted hours).

Despite the significantly lower average hours of support per consumer being provided, CMO managers largely reported that the funded support hours were, in their opinion, sufficient and not compromising the quality of care. No consumer who was interviewed reported receiving insufficient support and the lower 'per consumer hours of support' is consistent with the model of care.

Lower average hours of support per consumer than that contracted could be the result of many factors:

- the shift during COVID-19 lockdown periods to remote communication (which can be more efficient) and greater challenges to delivering some types of support
- the availability at some sites of greater alternative support resources than were expected, which allowed referral actions to be initiated sooner and earlier consumer exit and/or less intensive support requirement in the program
- the possibility that that the original support requirement budgeted for average support hours was too high.

While the qualitative evidence suggests no untoward effects of reduced per-consumer support hours, quantitative evidence of the relationship between hours of support and mental health outcomes was not available at the time of reporting. An outcome analysis of available LCQ data was attempted in the final data round, but the numbers of consumers with at least two completed LCQs was very low and insufficient to explore the relationship with support hours received.

Service pattern

There are fifteen possible types of support identified in the model of care, yet the evaluation revealed that in practice one third of all support hours for allocated to 'support in accessing other support systems' and 'support in psychosocial intervention'; the remaining two thirds of total support time was expended on 'Support preparing support plans', 'Support in daily living skills' and 'Support in medical/health activities' (see Table 8 for detail). While this support appears to be concentrated on only these five types, this was consistent with the program's emphasis on flexibility of approach. The Program Guidelines also do not provide specific guidance on the 'correct' balance of support activities to be provided.

As noted earlier, consumers appreciated group activities, yet the data on support hours to date revealed that, overall, there was little group work being carried out (less than 1% of total support hours). CMO and community organisation representatives reported consistently in both the baseline and final data collection rounds that the constraints of the pandemic had made it difficult to arrange and conduct group activities. In addition to these constraints, it is difficult to conclude what other issues may have contributed to such a low level of activity. However, it is likely that group facilitation skills were not necessarily held by all support workers and might need further development. Some CMO respondents suggested that access to brokerage funds, such as for use in providing morning tea or gaining entrance to a local destination, would help to facilitate their support for group activities.

There are many differences between the sites in the way available support hours were allocated. To some extent, this no doubt reflects natural differences that could be anticipated between sites based on consumer population needs (e.g., refugees versus asylum seekers), service context (e.g., urban versus rural) and service environment (the availability or not of partner services). Differences between site approaches are also anticipated by the model of care, given that support activities are meant to be determined by the consumer's ISP and therefore the consumer's recovery goals.

Evidence of the impact of service delivery decisions on consumer outcomes is yet to be assembled – this is an intended focus of the proposed future Impact Evaluation. In the interim, and before strong evidence on the value of specific service delivery pathways is available, more reflection on the patterns of support activity, both within and between sites, would be appropriate.

Opportunity #3: Hold regular workshops with CMO managers to consider whether certain types of support activity are being under-utilised by the program workforce, so that where needed CMOs can modify the distribution of support hours and support worker approaches in the development of ISPs.

Development of ISPs

The development of ISPs was widely agreed to be a critical component of the program’s model of care and there was good evidence to suggest that all sites approached this task accordingly. Compared to baseline data, more recent data (from survey and interviews) revealed that the quality of ISPs had improved, and their review had become more regular and consistent. Support worker understanding of the ISP as the key tool to direct support activities appeared to have improved as well, although interviews revealed that a few support workers still lacked this understanding. While there was much more certainty among support workers (compared with the baseline data) about how to construct goals, some uncertainty remained about what types of goals were the most appropriate and best to foster recovery.

There was a push within some CMOs to make more of the current documentation of ISPs electronic so that it could be shared and analysed more easily, including for internal quality improvement.

Opportunity #4: CMOs could be encouraged and supported to introduce efficient client record management software platforms to better capture, store and access consumer information including ISPs. This would greatly assist a future Impact Evaluation of the program to access and analyse consumer outcome data more easily.

Completion of the LCQ

In the baseline data collection, the LCQ was shown to be administered infrequently and often incompletely. Despite some improvements in performance and some CMO managers and support workers recognising more fully the value to the development of a more relevant ISP, LCQ completion rates and quality of returns continued to remain a challenge. And despite the tool having been translated into 18 community languages, support workers continued to report that consumers experienced difficulties in completing the LCQ – both from the perspective of language difficulty (even if in their own language) and the types of questions and concepts contained in the tool itself.

Opportunity #5: A short interactive training course could be developed for all MH–CLSR support workers to use the LCQ more in their work, and to better use the LCQ outcome measures to obtain feedback about the effectiveness of consumer supports provided.

Opportunity #6: In consultation with CMOs and LHDs, explore the use of alternative outcome measure tools to the LCQ that can be used with consumers (such as Recovery Assessment Scale – Domains and Stages [RAS-DS], Camberwell Assessment of Need [CAN] and the WHO Wellbeing Index). These alternative tools capture similar data on living skills, recovery needs, and independent living outcomes as the LCQ, but are not as arduous to complete and are also available in translated form.

RELATIONSHIP WITH COMMUNITY GROUPS AND LEADERS

All sites appeared to be finding a range of ways to build connections with local community organisations and other potential referral agencies. The focus of these initiatives, according to the Program Guidelines, should include 'refugees and asylum seekers and community and religious leaders' to promote the program and integration in community life.

Compared to the initial phases of the program, progress in advancing community engagement slowed down, according to CMO managers. COVID-19 related lockdowns were reported by CMO staff as having a significant impact on their capacity to reach out to community groups and the community groups' capacity to conduct regular activities. However, final-round interview data suggested that slow progress was also attributable to service-related constraints. These included:

- the inherent challenges of community engagement work (and determining what strategies can be effective)
- the different skills that may be required by support workers to perform community engagement activities
- difficulty for support workers to commit adequate time to community engagement while balancing other urgent support priorities.

Many sites called for more guidance on how to define, undertake and manage community engagement activities, especially where some capacity building work may be required in addition to community engagement efforts. Some resources and valuable experience already existed within the MH-CLSR stakeholder community and these could be built upon to create better guidance resources for all sites. The evaluation team reviewed a STARTTS guidance document that outlines a structured and evidence-based approach to community engagement / development (STARTTS, 2015) which could be more broadly promoted to assist in this area of practice.

RELATIONSHIP BETWEEN THE CMOs AND LHDs

In each site, structured and functional partnerships between CMOs and the seven LHDs were established and formalised in line with the Program Guidelines. This was an improvement on the situation found during baseline data collection. The existing partnership arrangements all reportedly (from CMO and LHD manager interviews) functioned sufficiently well to meet their needs.

Arrangements varied between sites regarding the regularity of meetings, membership composition, and the meeting content. As noted above, all arrangements addressed and managed structural partnership issues well, but not all arrangements fully supported operational effectiveness – in particular, support for smooth relationships between CMO and LHD workers at the level of individual consumers. The implications of this were felt in varied ways across the sites. Some common issues tended to be:

- CMO support workers and/or consumers having to go through the general LHD Mental Health Access Line intake process to refer individual consumers for assessment and/or support.
- Imperfect capacity to share care planning and other clinical information to support well-aligned care. This was often the result of a misplaced emphasis on privacy (that can be on the part of the CMO or the LHD clinician).

- Inconsistency in conducting mental health assessments. In several sites, the LHD would not carry out assessments unless they were directly involved with the consumer, thereby requiring the CMO to assess the case themselves or find an alternative.

Those CMOs/LHDs that had a better operational relationship tended to be characterised by:

- high levels of trust, inevitably built on previous lengthy experience of working together in other programs (especially HASI)
- dual partnership arrangements where governance arrangements below the SLA level allowed team leader and even support worker level communication that discussed operational issues at the individual case level
- an effective LHD resource person whose role was to promote and facilitate liaison between LHD clinical assets and other services (including MH–CLSR program services).

Most CMO and LHD managers agreed that a shared-care approach to consumers being supported in common was the ideal. However, in most cases a form of ‘parallel’ care (at best) was practised.

Opportunity #7: Capture and distribute across the MH–CLSR program examples of excellent shared care practices that are in place between some CMO and LHD workers to support consumers. These examples can show case ways that all CMOs and LHDs can overcome cultural and practice barriers to practice genuine shared and achieve better outcomes for consumers.

Opportunity #8: LHDs could assign an operational level contact person or unit for CMOs to liaise with to discuss consumer support issues and to clarify LHD processes and engagement as needed.

CONSUMER EXPERIENCE

Consumers unanimously found the program easy to engage with, as shown by data collected through individual interviews. Consumers also very much appreciated the flexible and personalised approach that could be taken by program staff to meeting their short and longer-term support needs.

Consumers valued the practical support provided through the program but, perhaps most of all, they appreciated the level of trust they could develop with support workers. In a refugee environment, trust is a valuable and potentially rare commodity. The existence of trust has benefits not just for the MH–CLSR program, but also for those services to which the trusted support worker might make referrals.

Trust provides a good platform for goal setting and future independence. However, it can also promote dependence. There is clearly a need to focus more on how to ‘exit’ people constructively from the program as they improve – many consumers will not initiate this and may even resist it. It might be appropriate to consider some form of ‘step-down’ approach where a lower level of support could be provided over the course of a transition period. This would provide both the CMO and the consumer with the opportunity to monitor the effectiveness of referrals and the availability of other support networks.

Opportunity #9: CMOs could formally including in the ISP how a consumer may ‘step-down’ or transition out of the program as part of their recovery journey. This will assist the consumer to transition out of the program in a planned way when appropriate to do so.

Group activities were also highly valued by consumers and appeared to be most beneficial as a form of ‘lived experience’ support network where trauma did not need to be re-described. They could also constitute part of a more structured step-down approach.

CMO respondents reported that asylum-seeker consumers often needed more intensive scaffolding for basic needs of living – at least in their initial phase of engagement with the program. They reported that this could have time and budget implications for sites where there was a large asylum-seeker cohort in their consumer group. In addition, visa issues could be all-consuming and often services for members of this consumer group were directed to putting them in touch with immigration-related supports. This singular focus was often reported to be the highest current stressor in asylum seekers’ lives. It could also impede CMO efforts to resolve other psychosocial issues.

Some CMO and LHD respondents (particularly from those organisations with less experience in providing settlement services), reported that they would benefit from access to better information about the constraints imposed by different immigration status requirements. It would seem beneficial for all parties involved in delivering the program to have access to clear guidance about what restrictions are faced by consumer groups with diverse immigration constraints.

Opportunity #10: *Some CMOs and LHDs would benefit from information and training about the implications of specific visa categories in terms of access to income support and health care in particular.*

WORKFORCE AND TRAINING ISSUES

Since the initial baseline data collection, the MH–CLSR program workforce had doubled in size and was reaching maturity, in accordance with the funded service delivery parameters. In reaching this state, there seems to have been a broad recruitment shift across the CMOs to higher reliance on relevant formal qualifications and a secondary focus on lived experience. Nevertheless, there was still a considerable proportion of the workforce with lived refugee or mental health experience, in keeping with the Program Guidelines. Lived experience was still widely acknowledged in interviews with CMO managers and support workers as a useful contribution to the process of overall support planning and service provision.

The one area of recruitment which seemed to be of concern was in relation to community engagement. Based on cost data, only 7.2% of the workforce was dedicated to community engagement. Data captured during the interviews of support workers confirmed that possibly even a lower proportion of total support worker time was spent in this area. Typically, with dual roles, where support workers have both individual consumer care and community engagement responsibilities, the latter role appeared to be negatively impacted. The support worker competencies required to plan, develop and conduct community engagement activities are relatively complex and therefore cannot be assumed as a core capability of all support workers. Access to better training and support to undertake these activities has the potential to improve exit outcomes for consumers.

Opportunity #11: *The Program Guidelines could clarify what is meant by community engagement and the types of community engagement activities that CMOs should undertake that would satisfy the purposes of the model of care. It should also outline the proportional effort CMOs are expected to make in community engagement, and the types of outcomes expected from this activity. This in turn would inform the types of skill required by the workforce to implement those activities effectively.*

Training of the workforce in the early program stages was found to be comprehensive and appropriately targeted, largely due to the early investment of specific program funds for this purpose. In the final round, data collection manager and support worker interviews seemed to identify a broad shift in training strategy from manager-directed to worker-directed, where support workers took responsibility for setting up and pursuing their own professional development goals. The risks of this approach were:

- support workers might not be sufficiently motivated
- support workers pursued development that was not critical to current organisational and program needs.

Therefore, it may now be timely to treat the MH–CLSR workforce more generically and look to establish learning interventions that could apply to most of the workforce.

Opportunity #12: Consider undertaking a broad training-needs analysis of the MH–CLSR workforce and identify areas of common learning needs. The Ministry of Health and CMOs could collaboratively initiate a range of strategies to meet these identified training needs including cross CMO shared learning workshops; practical on the job learning activities and online and face to face training courses.

One possible example of a potentially common learning need lies with risk assessment and management activities, as identified in the Program Guidelines:

“Training must ... be undertaken by staff to ensure a shared understanding of risk assessment, risk management plans, critical incident reporting ... ”

This area of learning need for program support workers was widely reported by LHD managers and could be the focus of a joint LHD and CMO-designed training initiative. The provision of training support for support workers in skills to deal with grief and loss and other trauma-related experiences was another area of focus that was commonly mentioned as a priority. For some, this support was already being provided by the local STARTTS team, but this could be made more consistent across the program.

Clinical supervision was reported to be quite variable in frequency and quality across, and sometimes even within, CMOs. The only widely implemented regular form of supervision recently was administrative, and while this was supportive of on-the-job learning it tended not to foster active reflection. Support workers need to be well supported and a range of supervision models should be available to address performance, debriefing, and stress from working with people who have experienced trauma. This is a key area of required improvement.

Opportunity #13: Consider undertaking an audit of current clinical supervision through a survey of MH–CLSR support workers, seeking their views on the consistency and quality of clinical supervision they receive. Following this, the Program Guidelines could include guidance for CMOs on best practice clinical supervision including frequency, amount of time and quality.

COST OF IMPLEMENTATION

There were only minor differences between CMOs in the distribution of total expenditure to operational and establishment components. As the program evolved over time, spending on establishment and capacity building had reduced, as expected. On average, expenditure on workforce (including management) accounted for approximately 80% of total operational expenditure across the program.

There was, however, significant variation between sites, with the site spending the least proportion on the workforce being 14% lower than the average spend.

There was also a notable variation in expenditure on interpreter services, ranging from 9% to 0.6% (the average being 2%) of total operational expenditure. These differences could be explained, as noted previously, by varying Health Care Interpreter Service access and pricing policies.

However, the most significant differences between sites were in the cost per consumer. These cost differences are correlated with differences in consumer numbers, but this provides only a partial explanation. Differences occurred between CMOs, but also large differences occurred between sites managed by the same CMO. Table 14 compares the two 'outlier' sites in terms of average expenditure per consumer against a range of selected site characteristics, which could possibly be influencing expenditure.

Table 14: Comparison of highest and lowest average spending sites per consumer on a range of selected site variables (based on final-round data collection – multiple data sources)

Site characteristics	Western Sydney	Newcastle
Deviation in site average cost per consumer from program average	-56%	+88%
Service location	Urban	Urban / regional
Consumer population	Majority asylum seeker	Refugee
External resource availability	Plentiful availability	Moderate availability
Direct care support workforce	Mostly permanent	Mostly casual
Operational expenditure as % of total expenditure	91%	97%
Workforce expenditure as a % of total operational expenditure	80%	80%
Source of referral	Mixed, no dominant source	Primarily settlement services and CMH
Average monthly consumer numbers compared to contracted numbers	313%	233%
Average daily hours used to provide support compared to contracted hours	82%	209%

There are marked differences in characteristics between the two sites. However, these differences do not account for the significant differences in average costs per consumer except in one case – the proportion of actual daily hours of support provided compared to hours contracted. How the Newcastle site was able to provide such levels of support above budgeted support hours could not be determined. It could be an anomaly from the data reporting period (previous data collection rounds found almost half as many average support hours per consumer), or it could be the result of an operational management approach that delivered significant efficiency in use of resources. If the latter, then the Newcastle site's approach should be considered for use on other sites.

Opportunity #14: The Ministry of Health could continue to capture CMO expenditure data (perhaps on a half-yearly basis) using the 'costings survey' used in this evaluation. Analyse and share any positive site expenditure findings with all CMOs that may promote more efficient operational spending.

The approach to economic analysis for this evaluation period has focused on implementation and process evaluation. The available data did not allow an assessment of reach nor provide an estimate of the expected benefits of the program to government in monetary terms. Insufficient time has passed to observe substantive changes in consumer outcomes (such as reductions in acute service use) that could be attributed to the program. There should be opportunities to do this in the future once further time has elapsed and adequate data has been collected. This has been proposed in the deliverable that outlines an Impact Evaluation method.

CONCLUSION

The program appeared to be a valuable and widely welcomed addition to services for refugees and asylum seekers living in NSW who are experiencing psychological distress, mental ill-health and impaired functioning.

CMOs were progressing well in implementing the program, largely according to the model of care. However, there were notable aspects of the model that had been less well implemented and where improvement was still required. These aspects include:

- development and use of ISPs
- completing LCQs and therefore creating a better record of impact
- engaging at a clinical level between LHD assets and CMO workers
- re-focusing and maintaining focus on community engagement
- re-focusing and maintaining focus on training and development of CMO staff
- clarifying aspects of the model care.

Despite these identified areas for further improvement, CMOs, LHDs, other service stakeholders, and community members had all observed individual case successes and perceived the potential for the program to achieve considerable benefits.

This process evaluation has been subjective in determining the positive or negative impact of the program on the target consumer population. It concludes that the program is certainly headed in the right direction. A separate deliverable has been prepared to guide a possible future performance monitoring, impact and outcome evaluation (as per Objective 4).

The proposed Impact Evaluation would determine objectively whether implementation of the program translated into improved mental and physical health and well-being outcomes for refugees and asylum seekers experiencing psychological distress.

STRENGTHS AND LIMITATIONS

A significant strength of this evaluation was the inclusion of CMO providers, LHD services, staff and consumers who were refugees or asylum seekers experiencing psychological distress. The inclusion of all sites involved in the delivery of the MH-CLSR program ensured participation of staff and consumers from different geographic locations and varying lived experience and support needs. This sample of interviews

provided rich and detailed information giving confidence that the findings of this evaluation may reflect the support needs of refugees and asylum seekers and their families living in NSW and Australia more broadly. However, the results of the evaluation should be interpreted with consideration for several study limitations.

The original evaluation method for the baseline data collection round was for data to be collected as part of site visits. These visits were scheduled to occur during the first wave of COVID-19 cases. After consultation with MoH program managers, the method was modified to accommodate government restrictions in response to the COVID-19 pandemic across all data collection periods. All data were therefore collected remotely via email, phone and video conferencing. In addition, the final data collection round coincided with severe and extended lockdown periods to control the impact of the pandemic in the Western Sydney region, which greatly impacted sites in the South Western Sydney, Western Sydney and Sydney LHDs. Conducting interviews remotely could have impacted the capacity of the evaluation team to establish a rapport and therefore obtain optimal data quality.

Therefore, the findings from the interviews may not be transferable to all refugee and asylum seekers or other mental health services (e.g., other LHDs or private services). There may have different perspectives about the program between consumers chose or were available to participate and those that did not. While generalisability is not the aim of qualitative data collection, it is possible that the interview findings cannot be applied to other populations other than those who participated in this evaluation.

Another limitation relates to the InforMH Data Set. The data dictionary for this data set¹⁸ is comprehensive but provides potentially ambiguous definitions for several key variables. Key amongst those were the variables seeking data from CMO providers on hours spent on different types of support. For instance, the 'Number of hours of support in daily living skills' is defined as, "The number of hours spent directly with the client assisting with daily living activities such as cleaning, shopping, cooking, personal hygiene, using transport, etc.". This all-encompassing definition could be used to include most support activities. Another similar variable, 'Number of hours of support in family connections' is defined as "The number of hours spent directly supporting the client to maintain or rebuild family connections". This definition can be narrowly interpreted by CMOs to focus only on activities undertaken one to one with the client. In this case, work that was more holistic, for example, support adopting a family therapy approach, might be captured elsewhere as another item but not as a 'family' support item. How CMO providers interpreted these definitions and then allocated their support hours is not known. It is also not known what impact this might have had on analysis. It was clear, however, that there were differences in interpretation.

ETHICS STATEMENT

This evaluation was conducted in accordance with the recommendations of the National Statement on Ethical Conduct in Human Research.

This evaluation was reviewed and approved by the Population Health Research Evaluation Committee. Site Specific Approvals were also obtained from each of the participating LHDs.

¹⁸ Community Living Supports (CLS), Housing and Accommodation Support Initiative (HASI), HASI Plus and Mental Health Community Living Supports for Refugees (MH-CLSR) – Minimum Data Set Final specification V3

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APPENDIX 1: MH-CLSR PROGRAM LOGIC

Inputs	NSW Health Activities	MH-CLSR Service Providers Activities	Outputs	Short term impacts	Medium term impacts	Long term impacts	Outcomes
<p>Funding</p> <p>Staff (LHDs, MH teams, MoH, Multicultural teams)</p> <p>Stakeholders (CMOs, NGOs, clinical partners, working groups)</p> <p>NSW Health infrastructure</p>	<p>LHDs develop service level agreements with MH-CLSR services</p> <p>Establish formal partnerships between LHD multicultural health and mental health staff implementing program</p> <p>MoH develop and implement program guidelines to assist coordination of services</p> <p>MoH subsidise and facilitate access to cultural competency training,</p>	<p>Employ multidisciplinary staff with cultural competence and mental health expertise</p> <p>Provide training to staff on cultural competency, interpreter use and mental health</p> <p>Develop service level agreements with LHDs</p> <p>Identify and establish partnerships with clinical partners</p> <p>Support consumers to identify and understand their psychosocial support needs and develop a care plan with their clinical partner, service providers and family</p> <p>Support consumers to access health services</p> <p>Develop and implement a model of care that supports flexible, whole of family psychosocial support</p> <p>Develop and monitor assessment and referral systems</p> <p>Identify and establish formal partnerships with relevant service providers (these may include physical and mental health services/ practitioners; child/family therapists; immigration settlement services / community services; education providers, employment services and community and religious leaders)</p> <p>Work together with community and religious leaders to develop strategies to promote the program</p>	<p>LHD and MH-CLSR services work in partnership</p> <p>Care plans that address identified needs developed and implemented</p> <p>Consumers connected with clinical and community health and other service providers and supported to utilise these services</p> <p>MH-CLSR services and service providers are well coordinated with sound governance practices</p> <p>Culturally and linguistically responsive services provided by skilled and qualified workforce</p> <p>Assessments conducted and referrals prioritised and made</p> <p>MH-CLSR program is promoted by religious /community leaders and settlement / community services</p> <p>Flexible, whole of family, psychosocial support services provided (which may include: trauma informed recovery oriented therapy /counselling, support with family functioning and daily living skills; community and social engagement activities and education and employment services /opportunities)</p> <p>Consumers appropriately transitioned in and out of the program</p>	<p>Increased participation in relevant clinical and community-based health services</p> <p>Services accessed more quickly</p> <p>Increased participation in family and community engagement activities</p> <p>Increased participation in educational, vocational</p>	<p>Improved compliance with medication and clinical care</p> <p>Care plan goals achieved</p> <p>Reduced acute mental health crises, avoidable admissions to hospitals, presentations to ED, mental health facilities</p> <p>Consumers are connected with family, carers and community</p> <p>Increased education</p> <p>Increased employment</p>	<p>Improved daily living skills and greater independence and functioning</p> <p>Improved mental and physical health, wellbeing and continued recovery</p> <p>Increased personal, family and community participation</p>	<p>Sustained improvements in mental and physical health and wellbeing</p> <p>Reduced costs to Government</p>

<p>(IT, systems, policies and processes)</p> <p>Training providers</p>	<p>interpreter use and mental health training</p> <p>LHDs prioritise referrals to MH-CLSR service providers</p>	<p>Develop and implement a plan to transition consumers both into and out of the program</p>		<p>and employment programs</p>	<p>Improved responses to acute episodes</p>	<p>Increased economic participation</p>	
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APPENDIX 2: EVALUATION QUESTIONS AND DATA SOURCES

Evaluation questions	Evaluation focus	Management audit	Consumer interviews	Manager survey	InforMH MH-CLSR MDS	Cost data
Have LHDs and MH-CLSR contractors/service providers developed service level agreements, and what are the key elements?	Service coordination & governance	✓		✓		
Are the MoH Guidelines useful in assisting with the coordination of services and are changes required? Is the level of detail appropriate to ensure good governance locally?		✓				
Are referrals being prioritised by LHDs?		✓		✓		
How have the referral and / or transition systems been working?		✓		✓		
Has a flexible model of care been developed and implemented?	Model of care	✓	✓	✓		
Have all relevant training packages been funded, facilitated and/or directly offered in a timely way?	Skills and training of support workers	✓		✓		✓
Do service providers have staff trained in cultural competence (including interpreter use) and/or mental health (including trauma informed care)?		✓	✓	✓		
Are interpreters being used by staff with consumers when required? Are staff competent in using interpreters with consumers?		✓	✓		✓	
Are care plans being developed holistically (i.e., cover a range of psychosocial supports and appropriately involve family and community), with a trauma informed lens? Do consumers find their care plans reflect and help them to achieve their psychosocial aims?	Care planning	✓	✓	✓	✓	
Are the full range of psychosocial supports being delivered including assistance with daily living, support attending appointments, support to manage medication requirements, and		✓	✓	✓	✓	✓

Evaluation questions	Evaluation focus	Management audit	Consumer interviews	Manager survey	InforMH MH-CLSR MDS	Cost data	
assistance in building parenting functioning skills and facilitating access to family therapy?							
Are services being provided in a whole of family manner where appropriate?		✓	✓	✓	✓		
Have clinical partnerships and pathways been established and used and how are they functioning?	Community engagement and partnerships	✓		✓			
How are community leaders engaged in promotion and support of the service?		✓					
How are all formal and informal partnerships with MH-CLSR service providers working? Are strategies being designed to fill gaps or improve functioning?		✓		✓			
Are services meeting the diverse needs of the target groups?	Outcomes of the program	✓	✓		✓		
Are consumers, providers, program partners, families and carers satisfied with the way supports are designed and delivered?		✓	✓				
Has there been an increase in participation in clinical and community-based health services and psychosocial supports?		✓	✓	✓	✓		
At baseline, what are consumers’ levels of independence and functioning, health and wellbeing, family, community and economic participation?		✓	✓		✓		
For those that complete the program within the timeframe of this evaluation – were there improvements?							
Has there been any increase in participant access to and participation in education, employment or community activities?		✓	✓		✓		
What are the costs associated with MH-CLSR program implementation, and based on the program reach, what are the expected benefits of the program to government in monetary terms?							✓

APPENDIX 3: FIRS METHOD

The Field Implementation Rating Scale (FIRS) seeks to distil and measure the characteristics of a program ‘... whose presence is entirely essential to the existence of the program’ (Rubin et al., 1982). FIRS facilitates an appropriate assessment of the Program implementation by:

- finding a means of focusing on ‘core’ implementation elements of ‘program mechanisms’
- quantifying levels of Program implementation to allow for objective analysis.

Implementation is not assessed in terms of achieving an [implementation] objective or not, but rather by the *extent* to which an objective was achieved or the *extent* to which it fell short of attainment.

Thirteen criteria were developed for this evaluation as follows:

1. Readiness for implementation
2. Leadership and commitment to the program
3. Access and intake to the program
4. Individual Support Plans (ISPs)
5. Workforce composition of the program and professional development
6. Use of interpreters
7. CMO relationship with the local community (e.g., refugee, religious leaders, etc.)
8. CMO relationship with other local partners and services
9. Appropriateness of the service agreement
10. Effectiveness of the local partnership meetings
11. Working relationships between CMO and LHD
12. Clarity of purpose and direction of the program
13. Referral mechanisms to other services.

Each of these criteria were assessed as being critical to the program’s implementation success at some point in time (commencement, early implementation, maturation stage).

Each of these criteria was assessed by several questions rated on Likert scales of various domains, but all on a scale of 1–5. The evaluators undertook the quantitative assessments utilising the data collected in field interviews, the CMO manager surveys and where appropriate the data from the InforMH data set. The assessments for each FIRS criteria presented in Table 13 (see section *Summary assessment of program implementation*) are an interpretation of the total scores from the Likert responses to all questions for each FIRS criterion.

Program implementation was assessed on two levels:

1. The degree to which implementation varies between sites. A low level of variation between sites is assumed to be an indication of quality program implementation. A high level of variability is assumed to be a sign of poor implementation
2. The degree to which sites have implemented the program, for each relevant criterion, with fidelity to the specifications of the Program Guidelines. Good fidelity indicates all sites have implemented the program according to the Program Guidelines. Poor fidelity indicates only some sites have faithfully implemented the program.

APPENDIX 4: PROPOSED IMPACT EVALUATION APPROACH FOR MH–CLSR PROGRAM

MH–CLSR AIMS

The Mental Health Community Living Supports for Refugees (MH–CLSR) program commenced in 2019. \$4.8 million in recurrent operational funding was announced in November 2017 and forms part of the NSW Government’s mental health reform strategy that has been underway since 2014. The program was designed to provide trauma-informed, recovery-oriented, and culturally safe and responsive psychosocial supports to refugees and asylum seekers who are experiencing psychological distress, mental ill-health, and impaired functioning.

The aims of the MH–CLSR are to:

- a. improve the mental health, wellbeing and functioning of program clients
- b. increase social participation and community integration of program clients
- c. prevent acute mental health crises and avoidable admissions to hospital or presentations to emergency departments

EVALUATION AUDIENCE AND PURPOSE

A process evaluation of the program has been undertaken and covered the first two to three years of program implementation. This evaluation provided regular reports and feedback workshop opportunities to the program proponents and other stakeholders to facilitate continuous quality improvement. An on-going commitment to process evaluation remains important to monitor variation between CMOs and sites in program implementation. Any such variation could become the focus of further investigation to test whether variation in implementation delivers variation in outcomes).

It is proposed to extend the process evaluation to undertake an Impact Evaluation to cover the years 2022 to 2025 and which will:

- Assess the extent to which the program is reaching consumers in need of the program
- Assess the achievement by consumers of their goals and capacity to live independently
- Measure the impact of the program on consumer connection with their family and meaningful participation in the community
- Assess the capacity of the program to support sustained improvement in consumers’ mental and physical health
- Assess the degree to which the program has resulted in wider impacts, including reduced presentations to mental health, emergency department, other services and increased employment thus resulting in reduced costs to Government

The audience of the Impact Evaluation can be identified as one or more of Cronbach, et al.’s¹⁹ ‘Policy-Shaping Communities’ for evaluation information. These are outlined in Table 15 below.

Table 15: Likely audiences for the proposed Impact Evaluation

Audience Category	Description	Program relevant Examples
Policy Makers	Refers to those in positions capable of influencing policy direction and implementation. Includes government and quasi-government bodies.	Ministers for Health and Mental Health. Ministry of Health executives
Program Administrators	Those who plan programs (in line with policy) and keep them going.	Ministry of Health program managers LHD senior mental health managers
Operating Personnel	These are the persons who accept responsibility for implementing programs. Operating personnel are mostly concerned with identifying appropriate <i>tactics</i> for treating specific instances of program operation.	Funded CMO providers LHD line and operational managers Program workers
Illuminators	Individuals or groups who reflect on public affairs and offer interpretations.	Consumer representatives Refugee Community advocates Academics
Constituents	Members of the ‘public’, who generally express themselves and exert influence through various constituencies.	Consumers of the program Refugee and asylum seeker communities

The Impact Evaluation will be guided, as was the process evaluation, by the program logic. The MH–CLSR Program Logic, provided in Appendix 1 of the Final Report, outlines the outputs, impacts and outcomes that are envisaged being achieved through implementation of the program. The areas shaded blue in the Program Logic are the subject of the proposed Impact Evaluation.

¹⁹ Cronbach, L.J. and others (1980). *Toward Reform of Program Evaluation*, San Francisco, Jossey-Bass.

EVALUATION QUESTIONS

The following evaluation questions, developed from the Program Logic, are proposed:

Short-term impacts

- Has the program been able to meet community demand for services by reaching all relevant persons in need?
- Did families of program participants perceive they had been supported? Has there been increased program consumer participation in family and community engagement activities?
- Have the goals of individual consumers (set through individual support plans) been achieved?
- Has there been increased program consumer participation in social activities?

Medium term impacts

- Have admissions to hospitals and presentations to ED and mental health facilities been reduced as well as acute mental health crises?
- Has there been an increase in participation in education²⁰ and/or employment of consumers of the program?

Long term impacts and outcomes²¹

- Have consumers shown evidence of recovery through improved daily living skills and greater independence and functioning?
- Has the mental and physical health and wellbeing of consumers of the program been improved and sustained over time?
- Have consumers continued to recover after exit from the program?
- Has the program impacts also resulted in reducing overall costs to Government?

MIXED METHOD APPROACH

As would be expected for an evaluation of such significance, several both qualitative and quantitative methods are proposed within a mixed methods approach. The methods proposed include:

- a. Audit of Goal achievement
- b. Analysis of InforMH / LCQ data - before and after comparisons within a client's experience
- c. Qualitative data collected from consumers and other stakeholders

²⁰ Note that this question differs somewhat from the relevant program logic element because of the questioning of CEE

²¹ Some of these outcomes may not be attained or at least be able to be measured within the proposed timeframe.

- d. Before and After population cohort study
- e. Retrospective Cohort study - Treatment and Control group comparison
- f. Economic costing analysis

Each of these methods are briefly described below.

Audit of goal achievement

Each CMO in the program is required to develop an Individual Support Plan (ISP) with consumers within four weeks of acceptance into the program. The ISP identifies individualised goals toward the consumer's mental health recovery and is reviewed every 12 weeks. While compliance with this requirement is not complete, it is quite high. Most workers see the genuine worth of ISPs and setting and re-setting goals.

ISPs are currently mostly paper based but are stored (much like clinical records) and routinely internally audited if only for performance management and/or clinical supervision purposes. Two of the four CMOs (New Horizons and Grand Pacific) are moving to create electronic means of tracking transactions with clients through CRM (customer relationship management) software. This will include ISP development and goal achievement.

This should make analysis of the types of goals set, over the consumer journey, and success in achieving goals (possibly by type of goal) comparatively simple.

Even if CRM software is not introduced, the more expensive process of paper auditing of a sufficient sized random sample of ISPs from each CMO to track goal achievement would still be an appropriate evaluation investment.

Analysis of InforMH / LCQ data

Pre- and post-consumer level analysis (that is within an episode of care from the commencement of service to exit / discharge) to:

- determine changes in engagement in social activities, participation in study and employment, social connectedness and support, perceived physical health and overall wellbeing
- Utilisation of health and social services reported in InforMH (Triangulate with linked pre and post admission data)

Participants in the MH–CLSR program will be the basis of exploration of the two aims (1) improve the mental health, wellbeing and functioning of program clients, and (2) increase social participation and community integration of program clients. This analysis will use the InforMH minimum dataset (MDS) and the LCQ results (also part of the MDS).

Every participant should have data collected at baseline (entry to the program) and at regular intervals whilst in the program – at a minimum at the point of exit from the program. The MDS contains information on demographic characteristics, diagnosis, number of hours of support that is provided, health service utilization (general practitioner visits, specialist visits, ED visits, hospitalisations) and Living in the Community Questionnaire (LCQ) outcomes including on:

- physical health
- ability to get support from family or friends when you need it
- confidence to have your say about issues that are important to you
- sense of being part of a group or community
- hopefulness for the future
- Participation in social activities
- Participation in study
- employment status and participation
- overall wellbeing.

The LCQ has been developed as part of a national project to standardise outcome measurement in the community mental health sector. The LCQ is completed approximately every six months²² and scores recorded in the MDS. Changes in the LCQ at regular intervals and/or at exit from the program will be compared to baseline scores for each consumer. Other outcome measures that can be potentially extracted from the MDS include:

- Housing status
- Smoking status
- Concerns about possible harmful or dependent alcohol or other drug use
- Concerns about possible domestic or family violence
- Visited the GP during the reporting period
- Visited a private psychiatrist during the reporting period
- Visited / accessed other services in the reporting period
- Accessed a healthy lifestyle activity, program or group
- Number of hospital admissions in the reporting period (Mental health related)
- Number of hospital admissions in the reporting period (Medical related)
- Number of Emergency Department presentations in the reporting period.

Unfortunately, there will not be a control group, i.e., refugees who are not enrolled in the MH–CLSR program, as non-participants will not have data on the LCQ. However, it is possible to compare changes in LCQ in refugees and asylum seekers in the MH–CLSR program over time, for instance for consumers exiting the program between 2019 and 2021, between 2022 and 2023, and between 2024 and 2025. A true benefit of the InforMH data set is that it is historical and can be analysed over any time period.

As well, MH–CLSR consumer outcomes could be compared with those who are non-refugees/asylum seekers in the CLS program. This would not form a true ‘control’ group but would provide an interesting

²² CMOs are required to offer the LCQ to consumers at entry and exit from the program and in April and Oct of each year.

point of comparison. CLS LCQ data, just like MH-CLSR data, is captured in the InforMH data set and can be accessed historically for equivalent time periods

Qualitative data collection

Post program consumer interview/survey

During the process evaluation interviews were undertaken with consumers primarily to assess the type and quality of the experience they had with their CMO and worker. Data was analysed to understand how overall they perceived the interaction and what parts of the process they found most helpful.

An impact evaluation could cover some of these process issues but would focus more on consumer outcomes. A sample of consumers discharged from the program could be followed up after 6 months and interviewed.

The interview schedule could be based on an existing assessment tool to provide structure and an outcomes focus. For instance, the *Recovery Assessment Scale – Domains and Stages* (RAS-DS) seeks perspectives on consumer 'meaningful contribution', future optimism, capacity for self-management of the mental health issue, and the context of connecting and belonging.

Interviews with program stakeholders

If it is not possible to provide obtain a suitable comparison group (see 'Retrospective cohort study' below), the evaluation will need to provide a plausible explanation of the counterfactual (what would have happened in the absence of the MH-CLSR).

This could be at least partially achieved through interviews with community organisations (referrers to the program and other non-referring organisations but with strong links to refugee / asylum seeker communities), with community leaders and 'Illuminator' stakeholders. They could be asked about awareness of the program, perceptions about whether it is meeting needs, barriers and enablers to access, perceptions of consumer outcomes and ongoing support needs after discharge, fit and integration with other support services.

This could provide some context for the changes caused by the MH-CLSR and identifying external factors influencing change.

Before and after service utilisation study

The MH-CLSR program is eligible to refugees and asylum seekers within the first 10 years of arriving in Australia. The study population would be limited to refugees and asylum seekers who have participated in the MH-CLSR program. ED visit and hospitalisation rates of refugees and asylum seekers will be compared for the 6 months before entering the MH-CLSR program and the 6 months after exiting the program (whether that be a planned or unplanned exit). The feasibility of this approach will depend on the sample size of the MH-CLSR cohort as well as the length of follow-up before and after entering the MH-CLSR program.

Each participant will need to be linked to the ED dataset (NSW Emergency Department Data Collection; EDDC), the hospitalisation dataset (NSW Admitted Patients Data Collection; APDC) and the ambulatory

care for mental health (NSW Mental Health Ambulatory Data Collection; MH-AMB) to determine and compare health service utilisation between pre-program and post-program individuals using the service.

Retrospective cohort study²³

The third aim of the MH-CLSR program is to prevent acute mental health crises and avoidable admissions to hospital or presentations to emergency department.

Refugee and asylum seeker identifying information from the NSW Refugee Health Service will need to be obtained. This information will be provided to the Centre for Health Record Linkage (CHeReL), Ministry of Health, for data linkage with EDDC, APDC and MH-AMB.

All refugees and asylum seekers who settled in NSW in the last 10 years will be recruited. There will be two groups of subjects – a group of refugees and asylum seekers who are participating or have participated in the MH-CLSR program and a much larger group who would not have participated in the MH-CLSR program but could be identified through one or more of the above data sets to have used a NSW Health service for mental health care.

Each participant will be linked to EDDC, APDC and MH-AMB to determine and compare health service utilisation between groups.

Data linking can offer more rigorous analysis if the budget is not a constraint.

Economic costing analysis

Overview: The premise of the economic analysis would be aligned with the underlying rationale for the program of improving equity: to identify and address unmet needs for vulnerable individuals and communities. The specific aims are to inform the cost-efficient delivery of the program and to support the value proposition regarding benefits generated.

Part 1 - Investment cost to address unmet needs: The first part of the analysis would collate the implementation evaluation regarding cost of delivery with the impact evaluation data linkage and consumer interviews on the (non-monetary) outcomes achieved. A descriptive 'cost consequence analysis' would report the program delivery costs incurred.

Part 2 - Potential cost savings and monetary benefits generated: Conditional upon sufficient data regarding changes in key health outcomes (e.g., ED presentations, hospitalizations), and social outcomes (employment and education) the associated cost savings and monetary benefits can be estimated. State-level health costs will be estimated using the relevant National Weighted Activity Unit (NWAU) adjusting for patient length of stay. Employment outcomes (captured through the MDS and LCQ) will be converted to monetary benefits by using average, sector specific, wage rates from the Australian Bureau of Statistics (ABS). Education and training outcomes will be converted into increased probability of future employment, using the latest academic literature, with average expected wage rates applied using ABS sources. Like the

²³ This will need full ethics as we are linking data and will also cost \$ for data linkage. These two processes could take up to 18 months. The MoH is the data custodian of all the datasets, including I assume the refugee/asylum seeker database. So, maybe the MoH could do it for free/as a priority. If not, the costs get built in, and I am sure the funders would be fine with that. Can also look at length of stay.

evaluation in general, the feasibility of this approach will depend on the sample size of the MH–CLSR cohort.

To draw together part 1 and part 2, the economic analysis would make clear that cost savings is not the aim of the program but rather to address unmet needs where possible, avoid acute problems and improve social and economic participation. The intent of the economic analysis is to further add to this value proposition by demonstrating that, in addition to improved equity, the program may also lead to costs savings and pay for itself, over the longer term.

ETHICS CONSIDERATIONS

This Impact Evaluation will need full ethics approval as it is proposing to interview vulnerable individuals (consumers of the program) and to link data sets with sensitive information.

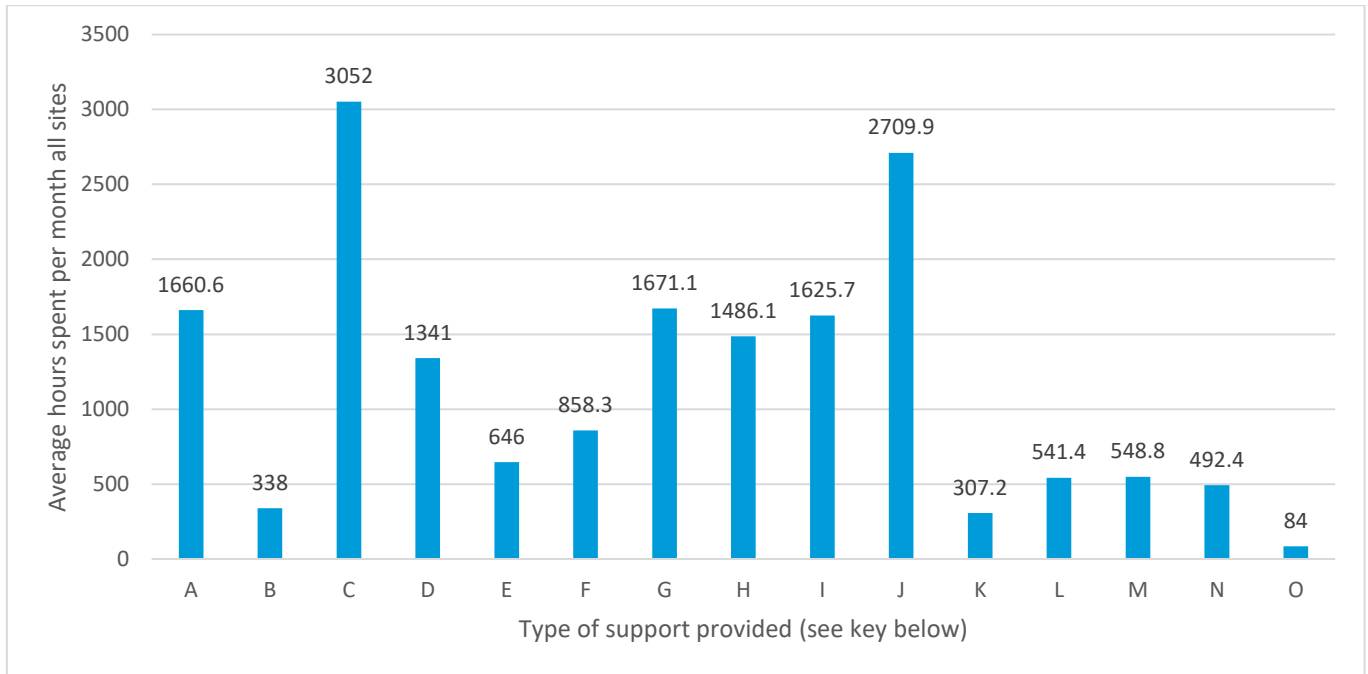
METHOD CAPACITY TO SATISFY DATA NEEDS

In Table 16 below the capacity of the proposed methods to meet the data demands of measuring various types of impact is assessed and noted.

Table 16: Demonstrated relationship between method / data collection process and ability to respond to evaluation questions

Evaluation questions	Method elements					
	Audit of goal achievement	Analysis of InforMH / LCQ data	Consumer interviews	Before and after study	Retrospective cohort study	Cost analysis
Has the program been able to meet community demand for services by reaching all relevant persons in need?					X	
Did families of program participants perceive they had been supported?	X		X			
Has there been increased program consumer participation in family and community engagement activities?	X		X			
Has there been increased program consumer participation in social activities?		X	X			
Have the goals of individual consumers (set through individual support plans) been achieved?	X		X			
Has there been increased participation in educational, vocational and employment programs by consumers of the program?	X	X	X			
Have admissions to hospitals and presentations to ED and mental health facilities been reduced as well as acute mental health crises?		X	X	X	X	
Have consumers shown evidence of recovery through improved daily living skills and greater independence and functioning?	X	X	X			
Has the mental and physical health and wellbeing of consumers of the program been improved and sustained over time?		X	X	X		
Have consumers continued to recover after exit from the program?			X			
Has the program overall reduced costs to Government?		X		X	X	X

APPENDIX 5: HOURS OF SERVICE BY CATEGORY



Key to Support Activity codes

A = Support in Daily living skills

B = Support in Medication support

C = Support in Accessing other support systems

D = Support in Social activities

E = Support in Family connections

F = Support in Social activities in own refugee community

G = Support preparing Support plans

H = Support in Travel

I = Support in Medical/Health activities

J = Support in Psychosocial intervention not accommodation

K = Support of Direct specialist clinical intervention

L = Support in Educational activity or work

M = Support for accommodation

N = Individualised support by >1 staff

O = Support provided as group activities

APPENDIX 6: COMPARISON BETWEEN SITES IN PROPORTION OF HOURS ALLOCATED TO DIFFERENT TYPES OF SUPPORT ACTIVITY

Team code	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	TOTAL
Anglicare Western Sydney	248	12	370.8	118	10	45	59.8	311.5	95.5	496	173	38	5	335.4	38	2355.9
Grand Pacific Health Wollongong	35.9	13.7	305.7	69.8	31.8	3.0	657.1	147.6	115.9	26.1	2.7	112.1	83.6	0	0	1605
New Horizons Newcastle	256.4	14.2	127.1	142.9	76.1	130.9	14.4	18.0	94.3	1211.1	116.0	126.6	12.6	0	0	2340.7
New Horizons Coffs Harbour	401.6	31.9	201.6	444.3	39.9	140.5	92.9	48.6	358.1	3.4	0	56.8	98.9	0	0	1918.4
New Horizons Fairfield	23.0	40.1	311.2	10.1	0	0.1	77.1	150.5	90.4	59.2	0	0	0	0	0	761.6
New Horizons Ashfield	48.7	41.2	429.9	13.7	44.0	8.6	10.3	140.2	47.6	256.9	0	45.0	0	0	0	1085.9
New Horizons Liverpool	331.9	112.2	987.0	148.8	49.9	35.4	431.1	416.0	713.4	526.1	5.9	23.8	130.9	0	0	3912.5
New Horizons Armidale	88.3	13.8	81.8	195.2	105.2	306.8	126.6	36.1	109.5	131.3	0.5	57.0	43.7	0	0	1295.8
Red Cross Wagga Wagga	93	15	107	75	153	88	72	50.5	1	0	9	32	64	65	16	840.5
Red Cross Griffith	134	44	130	124	136	100	130	167	0	0	0	50	110	92	30	1247

Data collected between April and July 2021

Key to Support Activity codes

A = Support in Daily living skills

B = Support in Medication support

C = Support in Accessing other support systems

D = Support in Social activities

E = Support in Family connections

F = Support in Social activities in own refugee community

G = Support preparing Support plans

H = Support in Travel

I = Support in Medical/Health activities

J = Support in Psychosocial intervention not accommodation

K = Support of Direct specialist clinical intervention

L = Support in Educational activity or work

M = Support for accommodation

N = Individualised support by >1 staff

O = Support provided as group activities



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