UNSW SYDNEY

Evaluation of the Integrated Rehabilitation and Recovery Care Program (IRRCP), Work Plan

Author:
Abello, David; Fisher, Karen

Publication details:
Report No. SPRC Report 5/08
9780733426278 (ISBN)
1446-4179 (ISSN)

Publication Date:
2008

DOI:
https://doi.org/10.26190/unsworks/284

License:
https://creativecommons.org/licenses/by-nc-nd/3.0/au/
Link to license to see what you are allowed to do with this resource.

Downloaded from http://hdl.handle.net/1959.4/34359 in https://unsworks.unsw.edu.au on 2024-04-25

EVALUATION OF THE INTEGRATED REHABILITATION AND RECOVERY CARE PROGRAM (IRRCP)

WORK PLAN

DAVID ABELLO AND KAREN FISHER

SPRC Report 5/08

Social Policy Research Centre
April 2008

Social Policy Research Centre, UNSW

Karen Fisher, David Abelló and Kristy Muir

School of Psychology, Victoria University

Heather Gridley and Jennifer Sharples

Authors

David Abelló and Karen Fisher

Contact for follow up

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

For a full list of SPRC Publications see, www.sprc.unsw.edu.au or contact:
Publications, SPRC, University of New South Wales, Sydney, NSW, 2052, Australia.
Telephone: +61 (2) 9385 7800 Fax: +61 (2) 9385 7838 Email: sprc@unsw.edu.au

ISSN 1446 4179

ISBN 978 0 7334 2627 8

September 2007

© Social Policy Research Centre, UNSW 2008.

Suggested Citation:

Abelló, D. and K.R. Fisher (2008), Evaluation of the Integrated Rehabilitation and Recovery Care Program (IRRCP), Work Plan, report prepared for the Department of Human Services, Victoria, September 2007.

Contents

1 Introduction 1
2 Background, Development and Key Features of the IRRCP 2
2.1 Background 2
2.2 Objectives 2
2.3 Framework for Service Delivery 2
2.4 Roles and Responsibilities of IRRCP Partners 4
Southern IRRCS 4
Western IRRCS 4
North Eastern IRRCS 4
Specialist Mental Health Services 4
Psychiatric Disability Rehabilitation and Support Services (PDRSS) 4
Secure Extended Care Units and Community Care Units 4
3 Framework for the Evaluation of the IRRCP 6
3.1 Key Evaluation Questions 7
4 Methodology and Instruments 8
4.1 Data Framework 8
4.2 Data Collection 10
Literature review 10
Primary data collection 10
Interviews with consumers 11
Consumers' family members and carers 12
IRRCP and other service providers 12
Area and peak consumer and provider organisations 13
Observation, process data and document review 13
4.3 Secondary Data 13
Admitted and non-admitted data 13
Clinical staff data 14
IRRCP provider data 15
4.4 Analysis 15
5 Management 17
5.1 Reports 17
First progress report (December 2007) 17
Second progress report (May 2008) 17
Third progress report (December 2008) 17
Draft final report (May 2009) 18
Final Report (June 2009) 18
5.2 Research Timetable 19
5.3 Communication with Consumers and Key Stakeholders 19
5.4 Ethical and Equity Considerations 20
Appendix A: Key Performance Indicators collected by IRRCP Provider 22
References 23

List of tables and figures

Figure 2.1: Long Term Housing and Support Continuum for People with Serious Mental Illness 3
Table 2.2:Three Metropolitan SECU Clusters for the Implementation of IRRCP 5
Figure 3.1: Evaluation Conceptual Approach 6
Table 4.1: Data Framework 8
Table 4.2: IRRCP Evaluation Questions and Data Sources 9
Table 4.3: Samples and Timing 10
Table 5.1: Evaluation Timeframe 19
Table A.1: IRCCP providers' KPIs relating to consumer processes 22
Table A.2: IRCCS providers' KPIs relating to consumer outcomes 22

Abbreviations

ARAFEMI	Association of Relatives and Friends of the Emotionally and Mentally Ill
CCU	Community Care Unit
DHS	Department of Human Services, Victoria
EACH	Eastern Access Community Health
ERMHA	Eastern Regions Mental Health Association
IRRCP	Integrated Rehabilitation and Recovery Care Project
IRRCS	Integrated Rehabilitation and Recovery Care Services
LOS	Length of stay
MHB	Mental Health Branch, DHS
MSTS	Mobile support and treatment services
NGO	Nongovernment organisation
PDRSS	Psychiatric Disability and Rehabilitation Support Services
SECU	Secure Extended Care Units
SPRC	Social Policy Research Centre
UNSW	University of New South Wales
WRHC	Western Region Health Centre

1 Introduction

This plan outlines the methodology for the evaluation of the Integrated Rehabilitation and Recovery Care Project (IRRCP). The evaluation will research the implementation, process and outcomes of the program. The objectives of the evaluation are to:

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

The evaluation will also make recommendations to inform the Victorian Department of Human Services (DHS) of possible directions for future development of IRRCP. This evaluation plan consists of the following sections:

- Background, development and key features of IRRCP;
- Evaluation framework;
- Consultation and information framework;
- Methodology and instruments; and
- Management.

2 Background, Development and Key Features of the IRRCP

2.1 Background

Over the last fifteen years, mental health services within Australia have undergone a significant shift in focus from inpatient care to community based care (ADD 1999; DHS 1996). This change in service delivery has highlighted the importance of providing independence for people with mental illness and identified supported accommodation as a key priority for enabling community participation, independence and an improved quality of life (DHS 1996; Freeman et al. 2003; O'Brien et al.). National Mental Health Plans have identified mental health service partnerships with primary health providers and nongovernment organisations as the key to creating and encouraging the development of a seamless integrated continuum of care from clinical intervention, to psychosocial rehabilitation and disability support (Department of Health and Ageing 2005).

2.2 Objectives

The IRRCP is targeted at consumers in Secure Extended Care Units and Continuing Care Units, who need a higher level of combined clinical and community treatment and support than is usually available, if they are to be reintegrated into the community. IRRCP aims to improve consumer outcomes through:

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

IRRCP also aims to embed system improvements through:

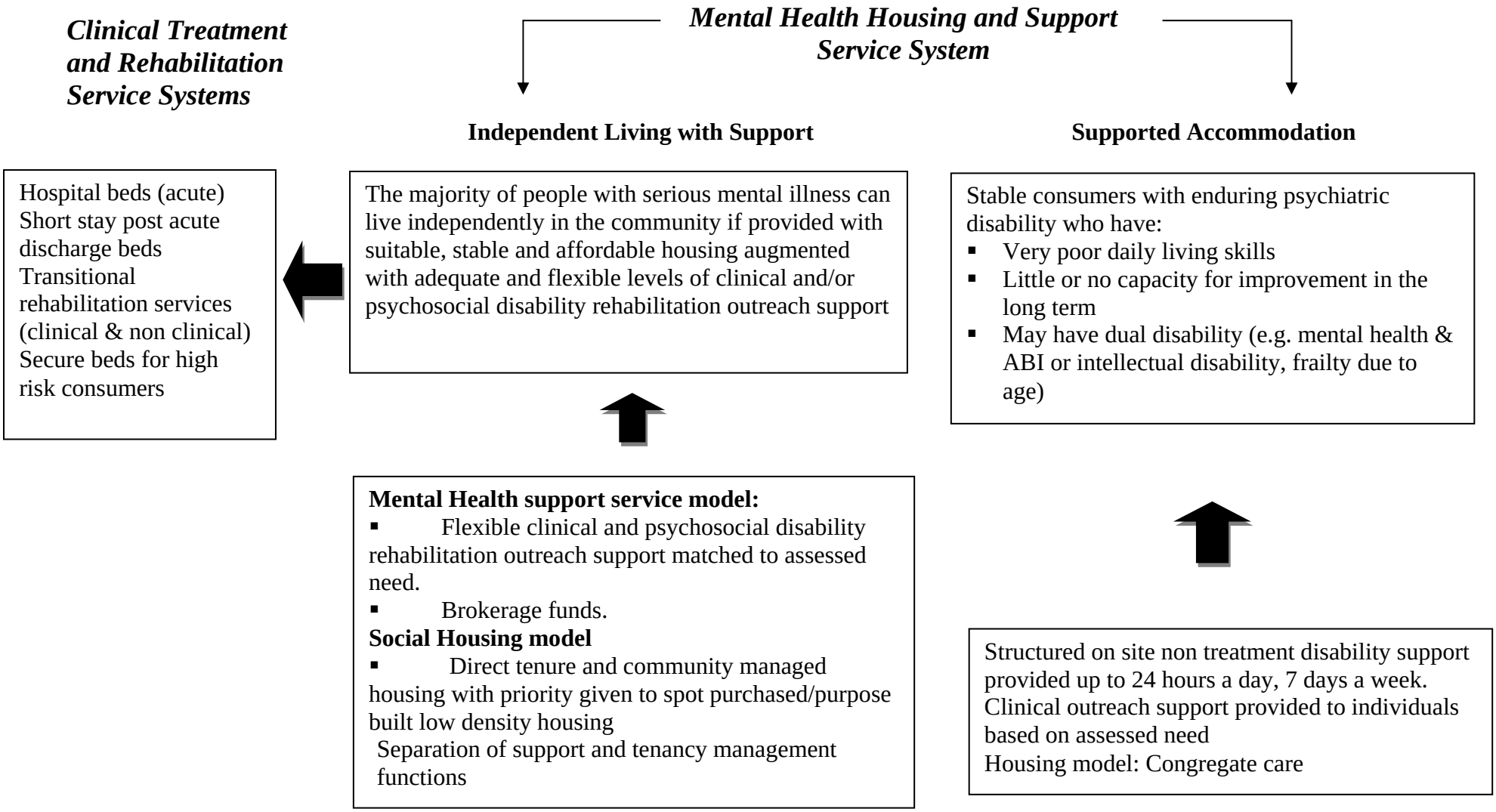
- strengthening collaborative practice between the PDRS services, extended care clinical services (SECU and CCU) and local MSTS;
- improving continuity of care for consumers across these service components, particularly at critical transition points;
- increasing capacity for PDRSS sector to support high needs consumers; and
- increasing response capacity of clinical bed-based services.

2.3 Framework for Service Delivery

Features of and flows within the mental health, housing and support continuum model are presented in the following table. In short they are:

- Mental health services provide clinical treatment and transitional rehabilitation services (clinical and non-clinical);
- Mental health support services provide, through outreach, flexible clinical and psychosocial disability rehabilitation based on individual need; and
- Social housing services provide accommodation tenure and tenancy management.

Figure 2.1: Long Term Housing and Support Continuum for People with Serious Mental Illness



Source: DHS, 2007

2.4 Roles and Responsibilities of IRRCP Partners

The consortia selected to implement the IRRCP in three health regions comprise the following organisations.

Southern IRRCS

The Eastern Regions Mental Health Association (ERMHA) (lead agency), Prahran Mission; Peninsula Support Services; Reachout; and Richmond Fellowship Victoria.

Western IRRCS

The Western Region Health Centre (WRHC) (lead agency); North Western Mental Health; Norwood Association; Doutta Galla Community Health Service; Werribee Mercy Mental Health Program; Richmond Fellowship Victoria; Dianella Community Health; and Moreland Community Health Service.

North Eastern IRRCS

Richmond Fellowship Victoria (lead agency); Eastern Access Community Health (EACH); and the Association of Relatives and Friends of the Emotionally and Mentally Ill (ARAFEMI Victoria).

Specialist Mental Health Services

Clinical mental health services are auspiced and managed by public hospitals and provide assessment, diagnosis, treatment, rehabilitation and clinical case management services to people with a serious mental illness and include both residential and non-residential components.

Psychiatric Disability Rehabilitation and Support Services (PDRSS)

Psychiatric disability rehabilitation and support services (PDRSS) provide psychosocial assessment, rehabilitation and support to people with an enduring mental illness living in the community. These supports are aimed at reducing a consumer's social isolation, assisting the consumer to learn or relearn activities of daily living, to develop social skills and to access to community services.

Secure Extended Care Units and Community Care Units

Consumers chosen for participation in the IRRCP will be drawn from the SECUs and CCUs administered by the mental health services in the three trial areas (Table 2.2).

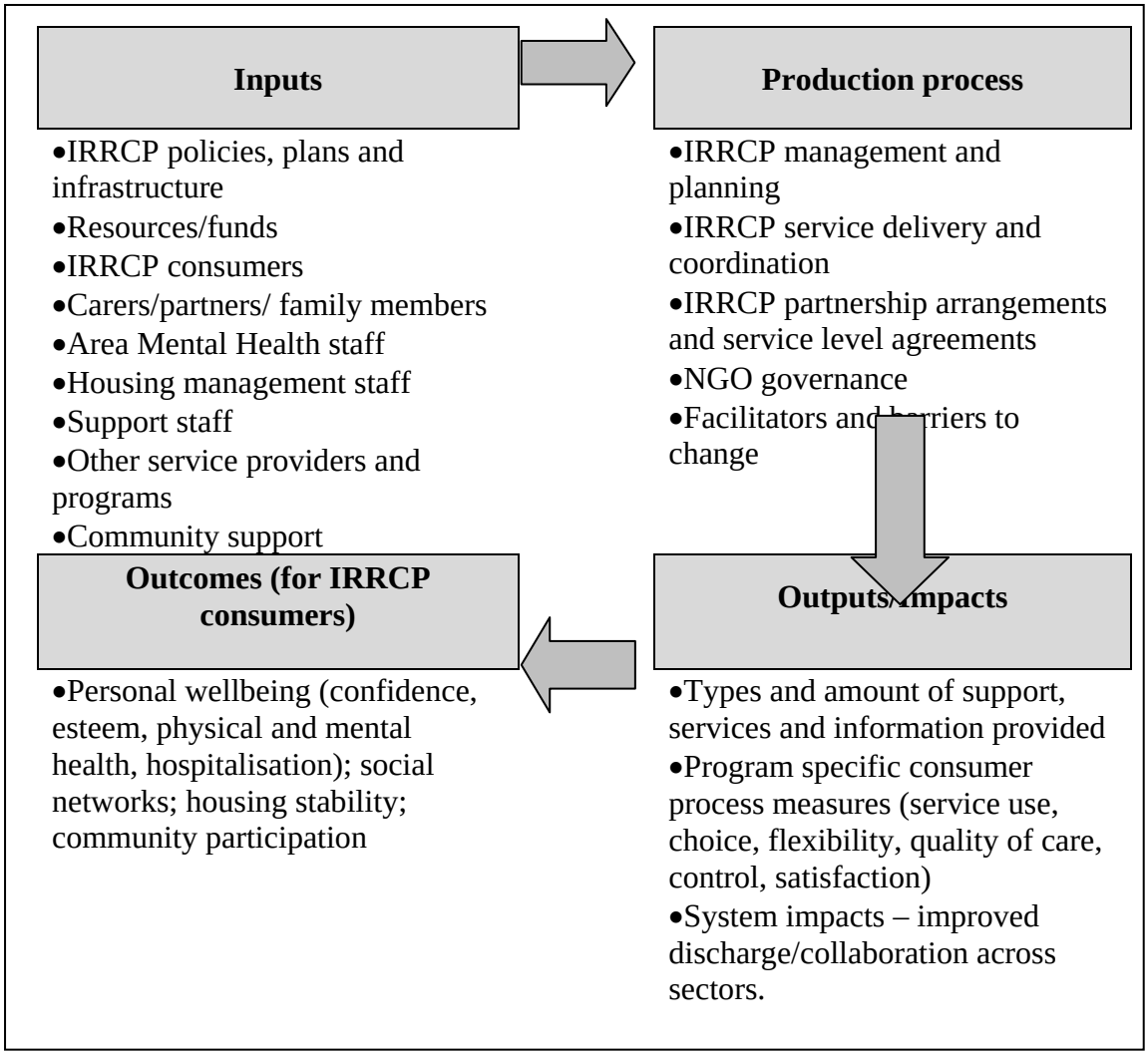
Table 2.2: Three Metropolitan SECU Clusters for the Implementation of IRRCP

Region	Service clusters
Southern metropolitan areas	Secure Extended Care Unit (20 beds) Wirringa Unit (Dandenong Campus Southern Health) Community Care Units (80 beds) Doveton CCU (Dandenong Campus, Southern Health – 20 beds) Middle South CCU (Monash Medical Centre, Southern Health – 20 beds) Spray Street CCU (Frankston Hospital, Peninsula Health– 20 beds) The Alfred CCU (The Alfred Hospital, Bayside Health - 20 beds)
Western metropolitan areas	Secure Extended Care Unit (26 beds) Adult Mental Health Rehabilitation Unit (North Western Mental Health) Community Care Units (80 beds) Mid West CCU (North Western Mental Health – 20 beds) North West Broadmeadows CCU (North Western Mental Health– 20 beds) Inner West Norfolk Terrace CCU (North Western Mental Health– 20 beds) South West CCU (Werribee Mercy Hospital - 20 beds)
Northern & Eastern metropolitan areas	Secure Extended Care Unit (25 beds) Bunjil House (Austin & Repatriation Medical Centre) Community Care Units (70 beds) Central East Canterbury Road CCU (Box Hill Hospital, Eastern Health – 10 beds, with a further 10 being constructed) Outer East Bona Street CCU (Maroondah Hospital, Eastern Health– 20 beds) Footbridge CCU (St Vincent's Health - 20 beds) Northern CCU (North Western Mental Health– 20 beds)

3 Framework for the Evaluation of the IRRCP

The evaluation conceptual approach is derived from program theory (Figure 3.1) (Bickman 1996).

Figure 3.1: Evaluation Conceptual Approach



This approach distinguishes four linked stages in the process of human service delivery: inputs, process, outputs and outcomes. It is particularly valuable in attempting to understand the complex interaction of individuals, communities, IRRCP providers and government agencies over time. It helps draw attention to the ways in which the program is operationalised and implemented, how this impacts on the delivery of services, and how the consequences of these are eventually expressed in terms of outcomes.

Applying the approach to the evaluation of IRRCP draws attention not only to the outcomes of the strategy, but also to resourcing, participation, planning and implementation. It provides an approach for measuring and analysing the extent to which IRRCP consumers are able to maintain appropriate housing and participate in the community.

Within this framework a participatory methodology will be adopted. This will involve stakeholders being consulted and engaged at each stage of the evaluation including design, collection and analysis. This method will, depending on DHS requirements, give some ownership of the evaluation to stakeholders, and provide early evaluation data 'feedback' to the ongoing implementation and improvement of the program.

We will use longitudinal and comparison measures for people in the program, combining both quantitative and qualitative data analysis techniques (Section 4).

3.1 Key Evaluation Questions

A number of evaluation questions, which focus on the aims of the IRRCP, have been formulated by DHS. These relate to appropriateness, efficiency and effectiveness of the program. The evaluation questions will guide the research methods, instruments and analysis.

Appropriateness

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

Efficiency

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

Effectiveness

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

4 Methodology and Instruments

This section outlines the evaluation methodology. The primary stakeholders are the consumers, IRRCP service providers and DHS. Other stakeholders include other mental health consumers, families, carers and other human service providers and funders.

4.1 Data Framework

The data sources include:

- Literature review of assessment tools;
- Output and key performance indicators (KPI) dataset collected by IRRCP providers and transferred to DHS;
- Financial and administrative data, including mental health outcomes and service use, cost of individual packages ect; and
- Evaluation data collected by the SPRC through interviews and observation.

The data framework applies these data sources to the evaluation objectives (Table 4.1) listed in Section 1.

Table 4.1: Data Framework

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

More specifically, the evaluation questions (Section 3) are linked to the data sources in Table 4.2.

Consumer outcome fields include personal wellbeing (confidence, esteem, physical and mental health); social networks; housing stability; community participation; program specific process measures (service use, choice, flexibility, quality of care, control, satisfaction). Other instruments will measure outcomes, process and economic measures for government, service providers and carers to cover the fields for analysis.

Table 4.2: IRRCP Evaluation Questions and Data Sources

	IRRCP consumers	Carers/ family	Mental health providers	PDRRS	Tenancy managers	Advisory group
Appropriateness						
Have appropriate consumers been targeted by the IRRCP service providers?	✓	✓	✓	✓	✓	
Have the targeted consumers received appropriate mix and level of services and support?	✓	✓	✓	✓	✓	✓
How well does the implementation of the IRRCP align with the current policy directions of associated sectors (e.g. housing, community health etc)?			✓	✓	✓	✓
What is the support for the program among key stakeholders?	✓	✓	✓	✓	✓	✓
Efficiency						
What key processes were involved in establishing/implementing, operating and maintaining IRRCP at organisational and system level?			✓	✓	✓	
What opportunities exist to simplify or improve implementation over time?	✓	✓	✓	✓	✓	✓
Effectiveness						
To what extent have the implemented procedures and consumer-related documentation complied with the guidelines for service provision established during the program implementation?			✓	✓	✓	✓
What consumer and carer outcomes and systemic improvements have been achieved through implementation of IRRCP?	✓	✓	✓	✓	✓	
What are the different models of care implemented by the IRRC services and which key components have had the greatest impact upon consumers and carers and the service system?	✓	✓	✓	✓	✓	
What unanticipated positive and negative outcomes have arisen from implementation of IRRCP?	✓	✓	✓	✓	✓	✓
What barriers and facilitators exist to influence wider implementation of IRRCP in Victoria?	✓	✓	✓	✓	✓	✓

4.2 Data Collection

Literature review

A brief literature review will be conducted in relation to assessment tools and processes for the final report. It will compare assessment tools used in similar programs to the processes proposed for IRRCP to inform the program development.

Primary data collection

Primary data will be collected and analysed at the beginning and end of the evaluation. The two evaluation periods will include quantitative and qualitative data collection in the three IRRCP sites. We will establish a liaison person at the three IRRCP sites to facilitate the evaluation activities. Site visits will include the following activities:

- Interviews with the following stakeholders: IRRCP consumers, family and/or carers, IRRCP providers, Area Mental Health case managers and/or staff, relevant housing and housing managers and/or staff, and, where relevant, advocates. In-depth interviews will also be conducted with AMHS planners, central policy managers and regional administrators;
- Observation of IRRCP processes, activities, planning and follow up; and
- Ongoing liaison about management of quantitative data as collected by IRRCP stakeholders according to the KPI requirements of IRRCP service providers.

Ethics approval has been gained from UNSW. DHS will organise a centralised process of government ethics approval following the UNSW ethics approach. All aspects of the work plan will be approved by the Advisory Committee before commencing evaluation activities. Regular discussions with the IRRCP Advisory Committee and the Evaluation Reference Group will inform and modify the evaluation process.

Primary data collection methods will be applied to collect data from consumers, service providers, carers and other stakeholders, particularly from DHS and other service providers. Research instruments will measure the range of outcomes and process experiences to address the research questions. Primary data collection will be after consumers enter the program at the beginning and end of the evaluation (February and September 2008). This will supplement the secondary data analysis of the outputs and KPI data from service providers and other financial and administrative data from DHS (Table 4.3). This timing is flexible depending on the reporting needs of the Department and when consumers enter the program.

Table 4.3: Samples and Timing

Task	Measurement	Approximate number
Consumers – interviews	March 08,09	12
Other stakeholders – interviews	November 07, 08	24
Consumers – KPI data	October 07, 08; April 08,09	all

The samples will be selected as follows:

- All consumers at the baseline in the program who consent to participation (approximately 12);
- A sample of other stakeholders including government officials responsible for the pilot implementation, policy, service delivery; attendant carers; service providers; disability support groups; and informal carers and family if applicable; and
- KPI data of all consumers.

If more than 12 consumers are recruited to the program by the baseline fieldwork and agree to participate in the qualitative interviews, we will randomly select 12 for interviews. Alternatively, more consumers could be interviewed face to face and interviews with other stakeholders can be conducted by telephone.

Interviews with consumers

We will conduct a longitudinal study of all consenting IRRCP consumers in the three sites. In-depth interviews will be used, and themes relating to program objectives (sustained tenancies, reduced inpatient admissions, continuity of mental health care, primary health care, community participation, independence, consumers' well-being, met and unmet needs, satisfaction with lifestyle, satisfaction with program elements and providers, etc) will be explored.

The qualitative consumer data will be triangulated with the data provided by PDRSS (see below) and limited quantitative data collected from consumers by the PDRSS (Personal Well-being Index, self-identified health (ABS National Health Survey). These are discussed below.

The same fieldworker will conduct consumer and carer interviews, so as to encourage a trusting relationship. The field-worker will liaise with the support provider to obtain a sense of each consumer's specific needs prior to the interview. Consumers will be given a $30 voucher per interview for their participation in the evaluation.

The initial approach to the consumer will be by a trusted person through an agreed process. If the consumer gives initial consent to the trusted person, the contact details will be passed to the researchers to arrange the fieldwork and full consent. A similar recruitment process was successfully applied for the participation of people with disabilities in the Resident Support Program (QLD) project conducted by the SPRC.

Interviews will be offered individually, with or without trusted support persons or interpreters as needed and at a location comfortable to the consumer. The methods will be adapted to be effective and inclusive of diverse experiences such as people in Indigenous communities, women, a range of mental health conditions, people living in culturally and linguistically diverse communities and people with print or communication impairments. The SPRC has an Indigenous Research Protocol for this purpose. We will provide advice and support to ensure all processes are accessible and responsive to the requirements and preferences of people with a mental health condition. People participating in the research will be selected through an ethical consent process. Considerations will include clear, accessible information about participating in the research, voluntary consent to participate (with continuous opportunities to withdraw from the research), respect for individuals' rights and dignity, reimbursement for participation and confidentiality.

Data variables

The interviews will emphasise qualitative reporting of experiences in IRRCP including:

- Outcomes of being in IRRCP relating to the objectives – rehabilitation, housing, community participation, mental and physical health and wellbeing, functioning, social networks, service use, confidence;
- Experience of the process of being in IRRCP – entry, support (housing, support for daily living, clinical and community mental health, community participation, social connections, budgeting), exit, satisfaction, quality; and
- The in-depth interviews with consumers will include some limited quantitative data collection relating to satisfaction with lifestyle (Heal and Chadsey-Rusch 1986 and Schwartz 2003) and self-identified personal well-being

Consumers' family members and carers

Where consumers give permission and have the support of family members, significant others or carers, they will be invited to participate in the evaluation. Interviews will canvass their perceptions of the impact of IRRCP and their sense of the appropriateness and effectiveness of IRRCP service provision.

IRRCP and other service providers

Interviews will be conducted with management representatives and staff of the members of the IRRCP provider consortia (Section 2.4) and other service providers including clinical staff.

Interviews with IRRCP providers will focus on consumer selection, aspects of care coordination with other parties, consumer support needs and service provision, housing management issues, impacts of IRRCP on related providers and facilities (e.g. employment support providers, mental health support, mainstream community and leisure activities), service funding and viability, partnership effectiveness and governance.

Other mental health service interviews will focus on consumer selection, aspects of care coordination with other agencies; consumer support needs and service provision, integration of IRRCP within the MHS and partnership effectiveness. Another aspect for discussion will be the interactions between IRRCP and other AMHS/NGO services.

If relevant, interviews with housing providers/tenancy managers will focus on consumer selection, implementation and tenancy issues, management of individual tenancies, the immediate neighbourhood effects of IRRCP and partnerships.

Organisations will also be asked to provide the information which is required within their contracts by DHS, namely the key performance indicators (KPI), which address the objectives of the program directly (process and outcomes) (Appendix A).

Area and peak consumer and provider organisations

Interviews with area and peak consumer and mental health provider organisations will inform the backdrop to the implementation of the IRCCP and canvass issues relating to implementation issues and specific consumer, carer and provider issues**.**

Observation, process data and document review

Process data collection will be ongoing through a range of mechanisms to facilitate open and active communication. Documents held by the Department, the sites and other stakeholders relating to the IRRCP will be collected or analysed on site as agreed (policies, finances, planning and implementation).

4.3 Secondary Data

The IRRCP evaluation work plan needs data about the consumers, including mental health outcomes and service use. Three potential sources of these measures are available:

- Admitted and non-admitted data;
- Clinical staff data;
- IRRCP provider data; and
- SPRC evaluator collected data described above.

If no electronic data are available, transfer of hard copy data might be possible, given the small number of IRRCP consumers.

Admitted and non-admitted data

One indirect measure of health outcomes is hospital admissions. We assume that the people who will become IRRCP consumers currently have data in the Victorian Admitted Episodes Dataset. The dataset includes the following items, which are important for measuring change in hospitalisation. None of the measures are direct mental health outcomes:

- accommodation type during admission
- accommodation type on separation
- hospital admission and hospital separation dates
- hospital admission sources
- hospital admission types
- diagnoses codes (ICD-10-AM)
- leave with permission days total
- leave without permission days total
- mental health legal status (involuntary status)
- onset date (prior to or at admission)
- patient days total

- separation mode (status at separation and where released to, where applicable)
- hospital separation referral (how separated and to where referred).

In addition, people who will become IRRCP consumers might have data in the Victorian Integrated Non-Admitted Health Minimum Dataset. The dataset includes the following items, which will be used for measuring changes in service use. None of the measures include direct mental health outcomes:

- event start and finish dates
- delivery mode
- event settings
- event main purpose
- professional group providing services
- service event provider
- event session type (individual or group)
- date care plan is documented
- health condition(s)
- main carer's relationship to the patient
- organisation identifier
- other factors affecting health
- person identifier
- post-event referral destination and outcome
- referral source
- type of usual accommodation
- carer availability
- contact/client service event client present status
- hospital care type.

Ideally, we would prefer data for the five years prior to entry to IRRCP and during IRRCP by date. We also recommend DHS monitor data for the two years after a consumer leaves IRRCP.

Clinical staff data

Clinical staff involved in IRRCP care are required to complete the Mental Health National Outcomes and Casemix Collection (NOCC) (DHS 2003), including the following:

- HoNOS – symptoms
- LSP-16 – functioning
- BASIS-32 – consumer self rating

- Focus of care
- Principal and diagnoses
- Mental health legal status.

We understand from DHS that NOCC measures are completed by clinical mental health and a consumer self-assessment in Victoria. The NOCC requirement was implemented in 2003 but not all organisations and staff are complying with the NOCC protocols. The effect is that not all consumers will necessarily have all NOCC measures. Some measures may have been collected but not entered onto the database.

According to DHS, the 91-day review requirement for NOCC was introduced in Victoria in July 2006. NOCC also requires data on admission and discharge from inpatient and residential admissions so this data should be available for IRCCP consumers who have had an admission. Outcome measures are required on each change of setting and every 91-days when a person remains continuously in an area mental health service. The use of a suite of measures were designed to be viewed together longitudinally. We recommend that all providers are encouraged to collect data for the IRRCP consumers at least during the life of the evaluation.

IRRCP provider data

In addition, IRRCP providers are required to collect and transfer KPI data to DHS. One purpose will be analysis in the evaluation. The summary of KPI requirements in the IRRCP evaluation brief includes the following relevant measures:

- Collate the data from clinical staff and hospital data above (NOCC measures – HoNOS, LSP-16, BASIS-32, focus of care, principal and additional diagnoses, and mental health legal status, LOS in acute care units, SECU, CCU);
- DHS defined KPIs (Appendix A) – length of stay in acute care units, SECU, CCU; consumer characteristics (eg. demographics, diagnosis); assessments of independence in skills of daily living, domestic, community and economic participation; risk assessment; transitional care plan; and maintenance of tenancy.
- Two short self-rating measures on health and wellbeing: (International Wellbeing Group 2005) and self-identified health (ABS National Health Survey). These tools are good for longitudinal and normative comparisons.

If NOCC can be completed, we do not recommend introducing new measures such as Kessler-10 or GAF.

4.4 Analysis

The analysis will include five parts: outcomes, process and economic analysis; discussion of the research questions on appropriateness, efficiency and effectiveness; and implications for improving the model and applying the lessons to other consumers, service types and service integration.

Outcomes for consumers and the service system will be analysed by comparing the longitudinal KPI and interview data; and normative data from similar programs and the validated instruments used in the data collection (mental health; housing stability; satisfaction; confidence; community participation; social networks; wellbeing; service use).

The process data will be analysed in terms of the impact of features of the program through the experience of consumers, government officials, service providers, carers and other stakeholders. It will describe the experience of these stakeholders in the implementation of the program compared to the guidelines, quality of care, accountability, effective use of resources, efficiencies in costs, service integration, facilitators and barriers to outcomes.

Economic data on financial and other resources will be analysed in terms of cost to consumers, government and service providers for the purpose of economic evaluation of efficiency and effectiveness.

The discussion and implications analysis will address the three groups of research questions about appropriateness (consumer characteristics and needs, service types and level, policy directions, stakeholder acceptance); efficiency (processes, resource use, quality); and effectiveness (fidelity, outcomes, most effective elements, unintended effects, relative cost, sustainability, generalisability). From this analysis implications and options will be drawn for improvements to the IRRCP (cost, quality, accountability and participation); developing a model for assessment of most suitable consumers; applicability to other consumers of mental health services; and general lessons for applicability to other mental health services.

5 Management

5.1 Reports

Four evaluation reports will be produced to inform the formative evaluation aspects of the projects. The dates for the progress reports are flexible and will depend on when the program is implemented.

First progress report (December 2007)

The content of the first progress report will change due to the delays in implementation. Therefore the first progress report will include the following.

- Method
- Facilitators and barriers to the implementation of IRRCP experienced to date

The DHS RFQ includes profiles of consumers who have been selected to participate in IRRCP within the content of the first progress report. At this stage it seems unlikely that selection of consumers will be finalised, so consumer profiles will be reported on in the second progress report.

Second progress report (May 2008)

The second report will report on the following.

- Method
- Process and outcomes findings from fieldwork, KPI and administrative data
  - Descriptive profiles of the consumers selected for the program from service provider data
  - A summary of the content in first discussions with consumers, carers, service providers and other stakeholders
  - Provisional analysis of the baseline KPI data provided by IRRCP services
  - KPI progress report by consumer
- Discussion of evaluation questions
- Implications and options for improvement in process and outcomes

Third progress report (December 2008)

The third report will address the following.

- Method
- Summary of process and outcomes findings to date from fieldwork
  - Descriptive profiles of the consumers selected for the program since second progress report was finalised
  - A summary of the content in second discussions with consumers, carers, service providers and other stakeholders
  - Provisional analysis of the longitudinal KPI data provided by IRRCP services.
- Discussion of evaluation questions
- Implications and options for improvement in process and outcomes

Draft final report (May 2009)

The draft final report will present a synthesis of the progress reports relating to:

- Summary of findings and implications
- Background and method: aims, evaluation questions
- Findings
  - Outcomes for consumers and system: mental health; housing stability; satisfaction; confidence; community participation; social networks; wellbeing; service use
  - Process impact on outcomes: implementation, quality of care, accountability, effective use of resources, efficiencies in costs, service integration, facilitators and barriers to outcomes
  - Economic: financial and other resource cost to consumers, government, service providers
- Discussion
  - Appropriateness: consumer characteristics and needs, service types and level, policy directions, stakeholder acceptance
  - Efficiency: processes, resource use, quality
  - Effectiveness: fidelity, outcomes, most effective elements, unintended effects, relative cost, sustainability, generalisability
- Implications and options
  - IRRCP improvements: cost, quality, accountability, participation
  - Model for assessment of most suitable consumers
  - Applicability to other consumers of mental health services
  - Applicability to other mental health services

Final Report (June 2009)

The final report will incorporate the above (draft final report) content, taking account of the input of DHS management, the project advisory group and other relevant stakeholders.

5.2 Research Timetable

The timeframe is flexible according to when consumers enter the program.

Table 5.1: Evaluation Timeframe

Task	Output	Month
Meet with Project Manager		7/07
Finalise evaluation design		9/07
Present work plan	**Work plan**	**9/07**
Ethics approval – UNSW	Approval	8/07
Ethics approval – Victoria government	Approval	ASAP
Literature review		9/07
Telephone interviews with stakeholders		10/07
Preliminary process analysis		11/07
Progress report	**Progress report 1**	**12/07**
Baseline fieldwork: consumers, service providers, family interviews and observation		3/08
DHS transfer KPI, hospital and NOCC data to evaluators (baseline and retrospective)		3/08
Baseline analysis outcomes and process analysis		4/08
Progress report	**Progress report 2**	**5/08**
DHS transfer KPI, hospital and NOCC data to evaluators (6 month follow up)		10/08
Interim analysis		11/08
Progress report	**Progress report 3**	**12/08**
Final fieldwork: consumers, service providers, family interviews and observation		3/09
DHS transfer financial and administrative data evaluators		3/09
Final outcomes, process and economic analysis		4/09
	Draft report outline	4/09
Draft final report to DHS	Draft final report	5/09
Final report and presentation	**Final report**	**6/09**

5.3 Communication with Consumers and Key Stakeholders

Formative evaluation offers opportunities to engage early with and provide feedback to stakeholders in the program and evaluation. The purposes of this engagement are to: improve the evaluators' understanding of the program and their evaluation needs; discuss evaluation design considerations; communicate progress in the evaluation

design; and establish working relationships with the stakeholders to effectively implement the work plan. To communicate effectively, a single member of the evaluation team will be the primary point of contact for program stakeholders.

We will maximise communication with program stakeholders through the following methods (within the constraints of the design period and budget): visit the sites; attend collective meetings; contact by telephone and email; distribute components of the draft evaluation design for feedback as authorised by the Department; and advise on integrating evaluation processes into project management. Techniques developed to promote participation include: becoming visible to the agencies; fostering trust and an understanding of the purpose of the evaluation; designing effective data collection instruments; and providing feedback to stakeholders to inform future planning and monitoring after the completion of the research.

We must communicate with people using the program in order to recognise their contribution to the evaluation and to maintain good relations with people who have contributed insights from their experience. Thus, whenever research involves direct interaction with consumers, the evaluators ensure that their input is acknowledged, both in the research itself and in feedback provided to them.

The third aspect of the communication plan relates to researchers, policy makers and the public. The purposes of communication with these groups are: to encourage engagement with the consumers in the program; and to broaden engagement with researchers and policy makers in similar programs. In cooperation and agreement with the Department, we will disseminate information to researchers, policy makers and the public. We suggest using media such as: the SPRC newsletters (printed and electronic); SPRC, the Department and other websites; 1800 telephone number through the SPRC; and the distribution networks of the program stakeholders. With the prior agreement of the Department, we will also pursue any opportunities for presenting the evaluation at seminars and conferences.

5.4 Ethical and Equity Considerations

From the perspective of research ethics, it will be essential that privacy and confidentiality provisions are sufficient to ensure that any information disclosed by consumers to the evaluators during the course of the evaluation is not misused (used for purposes other than those expressly stated to the consumers by the evaluators).

The UNSW has a Code of Research Practice by which the researchers abide. We are also concerned in all our research studies to maintain high standards of ethical practice and to respect confidentiality and privacy of research participants. All the research instruments and forms will be checked by the University Research Ethics Committee to ensure that the research complies with the highest standards of practice.

Potential participants will also be supplied with clear information statements about the use to which information collected from them will be put and about the measures taken by the evaluators to ensure that their privacy and confidentiality are maintained. They will also be required to sign consent forms before they can become involved.

The researchers will ensure that all evaluation participants give informed consent to participating in the evaluation. All consent forms and other information about the evaluation are written in easy English and are culturally appropriate. The team

includes researchers who have extensive experience in developing and conducting effective consultation processes with people who have cognitive impairments.

The literacy and linguistic needs of consumers from a Non-English speaking or Aboriginal and Torres Strait Islander background will be accommodated through the provision of translators and interpreters as required. Where literacy is an issue, all forms can be delivered through sound recordings in English or in the appropriate community language. Field workers from support organisations will be engaged when necessary. Alternatively, trusted persons or peers may be of assistance in some circumstances.

In addition, the researchers will be sensitive to consumers' needs and requirements relating to gender, cultural issues, disability and sexuality. We anticipate that family members and support and housing service staff will also flag any issues of concern.

At each step of the research process confidentiality will be assured. All data collected will be de-identified and stored in a secure locality.

In the event that researchers are made aware of any unethical or illegal treatment of consumers or carers (e.g. abuse or neglect), they have a duty to assist the person to take the matter up with the relevant authority, using the relevant complaint, grievance, advocacy or law enforcement process.

Appendix A: Key Performance Indicators collected by IRRCP Provider

Table A.1: IRCCP providers' KPIs relating to consumer processes

Activities	Output Indicators
Select consumers	Guidelines developed to identify and select consumers; Criteria established to identify consumer's suitability for the program; Develop risk profile for each consumer; and Consumers selected to receive new service meet all predetermined assessment criteria.
Establish links with relevant community services for each identified consumer	Number and range of community resources, services, and infrastructure identified to support identified consumers and their carers; and Number and nature of agreements, referral pathways, guidelines and/or protocols between clinical, rehabilitation, and community services (e.g., housing, recreation, employment etc) established to support identified consumers.
Commence transitional care	Transition care plans comply with minimum documentation requirements for consumer/carer needs, and engagement strategy with negotiated community/support services; Crisis management & relapse prevention plan; and Out of area care plan (where applicable).
Discharge from SECU/CCU	Number of consumers who transitioned into community accommodation.
Provide high-level support of independent living	Compliance with treatment; Number type and duration of service visits per consumer; Number of referrals/consumer visits to support services; Percentage breakdown of direct/indirect care; Range of information provided to carer; Frequency & range of participation in community, leisure and recreation activities; and Vocational/education status.
Monitor consumer status	Documentation of new/changed needs and plans to address them.

Table A.2: IRCCS providers' KPIs relating to consumer outcomes

Outcomes	Outcome measures
Maximised individual symptom management and functional capacity	Number of nights spent in the community; Maintenance or progressive reduction of score on Health of the Nation Outcome Scales (HoNOS); and Improvement in self (carer)-rated mental health status.
Maximised engagement in the community	Progressive improvement in Life Skills Profile (LSP-12); Improvement in self(carer)-rated community functioning; Accommodation retention; Engagement with employment support services/community-funded agencies; Continuous engagement in community activities; and Progressive reduction in level of support.
Reduced intensity and frequency of demand for bed-based clinical services	Length of Stay (LOS) in acute care units, SECU, CCU for eligible consumers (incl., LOS for readmissions); Number of unplanned and planned re-admission episodes to acute units, SECU, CCU, and PARC

References

Ageing and Disability Department (ADD) (1999). *NSW Government Carers Statement*. NSW Government: Sydney.

Australian Bureau of Statistics (2007) National Health Survey, 4364.0, ABS Canberra.

Bickman, L. (1996). The Application of Program Theory to the Evaluation of a Managed Mental Health Care System', *Evaluation and Program Planning*, 19 (2): 111-119.

Bullen, P. and Onyx, J. (1998) Measuring Social Capital in Five Communities in New South Wales. Management Alternatives: Sydney.

Deakin, E. (2004). IRRCP Resource Manual: Working Draft. EJD Consulting and Associates: Marrickville.

Department of Health and Ageing (2005) National Mental Health Report 2005: Summary of Ten Years of Reform in Australia's Mental Health Services under the National Mental Health Strategy 1993-2003. Commonwealth of Australia, Canberra.

Department of Human Services (DHS) (1996). *Victoria's Mental Health Service Resources for Case Managers: Meeting Consumer Needs for Housing and Accommodation – A guide for Case Managers.* Aged, Community and Mental Health Division: Victoria.

Department of Human Services (2003) *Measuring consumer outcomes in clinical mental health services. A training manual for services in Victoria*, Second edition, DHS Victoria.

Freeman, A., Hunt, G., Evenhuis, E., Smith, D. and Malone, J. (2003). *High Support Accommodation for People with Psychiatric Disabilities – a survey of high support, very high support and residential rehabilitation services in NSW and assessment of the needs and satisfaction of consumers residing there*. Aftercare: Sydney.

Heal, L.W. and Chadsey-Rusch, J. (1986) 'The lifestyle satisfaction scale (LSS): assessing individual's satisfaction with residence, community setting and associated services', in *Applied Research in Mental Retardation*, Vol 6: 475-490.

International Wellbeing Group (2005). Personal Wellbeing Index. Melbourne: Australian Centre on Quality of Life, Deakin University http://www.deakin.edu.au/research/acqol/instruments/wellbeing_index.htm.

New South Wales Health (NSW Health) (2002) *Framework for Rehabilitation for Mental Health*: *NSW Government Action Plan*. NSW Health: Sydney.

O'Brien, A., Inglis, S., Herbert, T. and Reynolds, A. (2002). *Linkages Between Housing and Support – What is Important from the Perspective of People Living with a Mental Illness.* Australian Housing and Urban Research Institute (AHURI): Victoria.

Schwartz, C. (2003) "Self-appraised lifestyle satisfaction of persons with intellectual disability: the impact of personal characteristics and community residential facilities", in *Journal of Intellectual and Developmental Disability*, Vol.28, No. 3 pp 227-240, September 2003.