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community development – from design to evaluation

Hume Partners In Recovery (PIR) Evaluation

Interim Report, April 2015.

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Informants to the evaluation & questions asked of them:

Evaluation informants	***Males***	***Females***	***Details***	***Questions***
PIR participants	8	6		1. What do you understand by the term 'recovery' in relation to the Partners In Recovery Program? 2. Is your action plan the result of you alone putting it together or was there someone else involved (Ten Seed Technique – TST) 3. If someone else was involved, who was that person/persons? 4. Of the services you use, do you find they relate to you differently since you joined the PIR Program? If yes – how are they different? 5. Of any issues with services, are they related to quality or access/availability? 6. What difference has PIR made to your life?
Carers	1	3	One sister/one brother/two mothers	1. What is your understanding of 'recovery' in terms of PIR? 2. What do you think the person you care for understands by the term 'recovery' in relation to PIR? 3. Was the action plan of the person for whom you care developed by themselves or with other/s? (TST) 4. How do you see the person for whom you care responding to the action plan/PIR? 5. How do the services used by the person you care for operate in terms of 'recovery'?

				6. What is your expectation of service provision post PIR?
Support Facilitators	0	6	Gateway Health, Centacare, Mental Illness Fellowship Mind, St Lukes Anglicare.	1. What has been the highlight of your work to date? 2. Of all the PIR registered participants (not just those registered with your organisation) how many will achieve the goals of their action plans? (TST). 3. of those who will not, why is it lack of access to services or related to service quality? (TST) 4. In relation to quality, why is this a barrier – provider organisational culture, lack of awareness or individual officers? 5. Of the participants who have exited PIR, how many had achieved their goals? 6. Of those who had not achieved their goals, why did they exit? 7. In your own organisation, what is the support for 'the recovery process?"
Line Managers	2	2	Gateway Health St Lukes Anglicare Centacare	1. What are three positive things you are aware of in relation to PIR? 2. What are the challenges you see for PIR?
Other service providers	4	8	Intereach Deniliquin; Natramed, Shepparton; Finley Community Health; Gateway Health; St. Lukes; Nolan House; MIND PRR Program; PHaMs Gateway Health; Tallangatta Health; Wangaratta Community Mental Health; ACSO; Albury Wodonga Health; Alpine Health	1. What are three positive things you are aware of in relation to PIR? 2. What are the challenges you see for PIR?
Consortium members	4	2	AWAHS; Centacare; Gateway Health; N.E.	1. What is the Consortium's role in PIR? 2. What has Hume PIR done to bring about

			Multicultural Centre, Wangaratta; Hume Medicare Local. AWH	'system change'? 3. Of all those persons in your catchment with persistent and severe mental health problems, how many are impacted negatively/positively by their interaction with services/the system? 4. Of those impacted positively, how many are as a result of system change? 5. Of those who have been/continue to be impacted negatively how many are as a result the services/system quality or availability?
HML PIR staff		4		1. Of All services, how many are acting in line with a recovery model in relation to persons with mental health problems (participants and others)? 2. What changes have been made in response to the first interim report recommendations? 3. What have been the highlights since PIR began?

Limitations

1. Not all Consortium members could participate in this phase of the evaluation The number of service providers who indicated a willingness to participate, but didn't return calls/accept session invitations limited the number of service provider representatives informing this iteration of the evaluation, though there were more than the previous stage (12 compared to two previously).

Findings

Notable strategies and outputs of Hume PIR

- Employment and co-location of Support Facilitators
  All informants to the evaluation with an awareness of the Support Facilitator (SF) role and status felt that the co-location of SFs in the offices of the Service Provider organisations is enhanced by the relevant Service also being the employer of the SF. The fact that the SF is a staff member ensures a greater participation in and acceptance in the organisation by the SF. This latter point is seen as a very influential factor in relation to the organisation and 'recovery model' practice. (see finding #1, The influence of Hume PIR on these outcomes, below)
- The consumer-carer group which meets regularly is seen by members who contributed to the evaluation, as a valuable strategy providing the opportunity for participants and carers to contribute to the changes occurring in the mental health sector.
- The workshop/'world café' event organised and facilitated by the consumer-carer group is described by evaluation informants as a valuable opportunity to gain input from consumers and carers who are not members of the group but want an opportunity to contribute to the change process occurring which will impact upon them.

The findings listed below are grouped under the relevant focus area (as outlined in the RFP) to which they apply. The findings are the themes/issues arising from the discussions/interviews with the various informants listed above. The findings included in this interim report are findings which are either new (in that they were not identified in the first interim report) or they demonstrate change which has occurred relevant to the focus area. Where it is deemed relevant, the finding is attributed to the informant group/s from which it came most strongly.

Areas of focus

Client Outcomes reflecting the 'Recovery Model': as perceived by the participant, their carer and service providers.

1. PIR has provided opportunities for participants to contribute beyond their own situation

> *"Now that he has it (alarm watch) he can confidently go to bowls and I can let him because I feel he is in less danger. It has helped me personally and made him less dependent on me." (Mother/carer).*
>
> *"Her mobility as a result of the scooter has made a huge difference to her self confidence and life purpose." (Service provider representative)*

which in their own words contributes towards their recovery.

> *I enjoy being at the participants and consumers group meetings. These give me an opportunity to make a contribution to what is happening to all persons in the area with mental problems.""(Participant).*
>
> *"I wanted to have a say in the evaluation because I want to make a contribution. I'm always receiving. I want to give something." (Participant).*

2. PIR's flexible funding policy has enabled the removal of 'barriers' to recovery by enhancing mobility, independence and security among other issues. It has done this often without large expenditures but expenditures which have been strategic for the individual. Examples of such expenditures are, gymnasium membership, 'mobility scooter', a watch alarm (epilepsy).

3. The flexibility of the Support Facilitators is critical in ensuring that the participant receives services reflecting the priorities of the participant's action plan.

> *"The fact that the PIR coordinators (Support Facilitators) have the flexibility to spend the time and their persistence to access services for him makes his (participant) life and mine much more enjoyable". (Carer/mother)*

Service systems outcomes reflecting the 'Recovery Model".

1. There has been greater collaboration between services in terms of seeing their services as being one of and/or complimentary to other services which enhance the recovery for participants.

> *"There is a lot more cohesion among (service) providers, and more cooperation between clinical and non-clinical services. PIR's 'whole role' coordination has been great. It's the only thing that brings the sector together'. (Service provider representative)*

2. Some services have effected changes in policy and practice as a direct result of PIR.

> *"At (name of organization) we had an incident in the waiting area which normally would have resulted in the person responsible being removed and denied our service. As a result of PIR and our membership of the consortium, we determined to renew our practice and policy in relation to such incidents and we now have greater security and better action plans to deal with such incidents which do not result in a person in need of assistance being denied it through actions resulting from their condition". (Service provider staff member and Support Facilitator line manager).*

3. PIR helps to highlight the value of individual services due to the flexibility of the Support Facilitators to be able to 'persist' and to travel to support participants to access services which they may not have accessed previously.

> *"Because the PIR staff have the time and are able to travel to see clients (participants) those clients can reap the benefit of the service that they may not have had access to before." (Service provider representative)*

4. There is a more positive perception among service providers, Support Facilitators and participants in relation to service quality in that service quality (quality appears to equate to treating people with mental health issues respectfully though not necessarily a recovery approach) is less of an issue affecting participant outcomes than was previously thought. Previously (October 2014) service quality was perceived by respondents to be up to 80% responsible for participants not achieving the goals of their action plans. Service quality is now consistently seen as 50% responsible – the same as service access and the same as reasons pertaining to the participant themselves.

> *The working groups that have formed (as a result of PIR) bring services together. Before these groups rarely spoke to one another… Having consumer representatives on these groups is a real bonus" (Consortium member).*

The influence of Hume PIR on these outcomes.

1. The employment of Support Facilitators by service providers as distinct to just a co-location arrangement has had a positive effect of the staff within service provider organisations.

> *"Because they (Support Facilitators) are staff members they come to staff meetings and other staff functions. The influence they have had on the attitudes of other staff and the organization itself would not have happened if they were not an actual part of the organization."(Service provider representative).*
>
> *"PIR challenges how things are done. For example, having Support Facilitators within service provider organisations has been a strategic success in influencing organizational culture." (Consortium member).*

2. The coordination role of PIR amongst the service sector has led to greater collaboration among service providers.

> *"The flexibility, time availability, commitment of PIR staff is just wonderful. They are also an advocate for clients (participants) and in many ways keep services accountable"* (Service Provider representative).

3. Whereas in the first stage discussion Hume PIR was seen (by some service providers) as being a distraction (even a negative presence) due to the availability of money and their limited term ("3 years and then they'll be gone"), it is now seen as an overwhelming success by all service provider representatives consulted.

> *"PIR has provided a mechanism for change to a better service system." (Consortium member).*
>
> *"The working groups as a result of PIR have brought together organisations which previously didn't speak to each other." (Service Provider representative).*

4. There was some frustration expressed by one clinical service provider,that Support Facilitators can act beyond their mandate in therapeutic areas For example, issues relating to and/or involving medication administration. Some providers have also expressed concerns in relation to Support Facilitators disregarding the advice given in relation to a participant's capability.

5. There have been a number of expressions of frustration in relation to what is said to be inconsistency in the intake process and the time taken for this process to be completed. There is no question that the eligibility criteria for PIR has not altered. Understanding that criteria however may still be an issue for some services/individual service providers. Staff provided audit information which indicates that the time taken for the intake process is well within the benchmark of 5 working days. While the comments of most service providers interviewed does not support the view that the intake process takes too long, the perception is nevertheless real for some.

> *"Sometimes I don't know if I'm dealing with the client (participant) or the Support Facilitator." (Clinical service provider)*
>
> *"I referred a person to PIR and both I and the Support Facilitator believed that they fulfilled the requirements but they were rejected. After the person had another bad experience I re-referred them and another intake officer accepted them. What are the consistent guidelines?" (Clinical Service Provider).*

6. Among some service providers there is still a perception that the Support Facilitator (SF) role is not well defined or at best inconsistently understood/provided by all Support Facilitators. Some Service Providers point out what they see as inconsistencies in the way some SFs relate to their clients (participants) and to other service providers. This 'concern' has been expressed as an inconsistency in how participants are treated.

> *"Care coordination by (Support Facilitators) is a bit inconsistent. Meetings of services are arranged for some clients (participants) but not for others. How does the Support Facilitator interpret their role?" (Clinical Service Provider).*

7. PIR project staff, while acknowledging what appears to be an increased understanding of recovery as an approach, and its acceptance by the majority of service providers, query whether some organisational structures and organisational cultures still present a barrier to recovery oriented practice.

Conclusions

The conclusions drawn here are based on the findings outlined above and highlight the contradictions found when analyzing these findings.

- There is some evidence from both participants and their carers as well as from service providers that positive changes are occurring at the policy level as well as the practice level (See finding #2, Service systems outcomes reflecting the 'Recovery Model", and #1, the influence of Hume PIR on these outcomes above).
- Participants and carers and service providers generally see PIR as being overwhelmingly positive.
- Whilst most service providers see the Support Facilitator role as enabling participants to have hope and work towards recovery with Support Facilitators acting as empowering agents to Participants, a small number are perceived to take more of a carer/caseworker role 'doing for' the Participant. There is still inconsistency in the way the role is performed.
- There has been a significant shift in the manner in which PIR is viewed by all respondent categories. Overall PIR has moved from being seen as another service with a big budget, to being seen as a change agent with the mental health sector in the Hume PIR catchment.
- There is consistency among the consortium members as to what their role as a consortium is. Previously a number of members felt they were there to represent their own individual agency whereas now they see the role as that of 'change agent'.
- The role of the Support Facilitator while primarily focusing on the participant, is still sometimes seen by others outside of PIR as intruding into areas which they are not authorised and/or qualified for.
- A small number of clinical service providers have expressed concerns that 'clients' are not always treated in the same manner by Support Facilitators. Whilst this may indicate inconsistency in the understanding of the SF role by SFs it may also be a result of a lack of understanding that the action plan (and thus PIR activity) is not a response to a diagnosis but to the aspirations of an individual.
- Some service providers continue to suggest that The PIR intake process is not clear.

Recommendations

The following recommendations are drawn from the conclusions above.

1. The role of the Support Facilitator needs to be seen as being consistent across the region. Support Facilitators and their host organisations should reflect on and review the SF role to ensure SF work is undertaken within the role guidelines including not overstepping their role, and or doing 'for' participants. Support Facilitator roles must be consistent and not dependent upon an individual's response to the role.
2. PIR should continue to build awareness and understanding of recovery oriented practice amongst all service providers to ensure a consistent understanding of the recovery process and thus the role of Hume PIR, including the purpose and function of the individual's action plan.
3. The PIR program must ensure that the intake process – eligibility and the actual process and its timing - are clearly and consistently presented to and understood by all stakeholders.
4. The positive image of PIR must be reinforced through ensuring that its processes and practices are clearly and consistently displayed by all those directly representing the program.

Appendix 1 TST Results

Repondent	Question	TST Result (%) Nov. 2014		TST Result (%) April. 2015	
		Mine	Other	Mine	Other
Participant #1	Is your action plan the result of you alone putting it together or was there someone else involved	40	60	NA	NA
Participant #2		50	50	NA	NA
Participant #3		70	30	NA	NA
Participant #4		40	60	NA	NA
Participant #5		100	0	NA	NA
Participants below not included Nov. '14					
Participant #6		NA	NA	60	40
Participant #7		NA	NA	80	20
Participant #8		NA	NA	60	40
Participant #9		NA	NA	60	40
Participant #10		NA	NA	100	0
Participant #11		NA	NA	90	10
Participant #12		NA	NA	100	0
Participant #13		NA	NA	60	40
Participant #14		NA	NA	Not sure	Not sure
		Access/Availability	Quality	Access/Availability	Quality
Participant #1	Of any issues with services, are they related to quality or access/availability?	50	50	70	30
Participant #2		70	30	70	30
Participant #3		100	0	100	0
Participant #4		30	70	50	50
Participant #5		50	50	60	40
Participants below not included Nov. '14					
Participant #6		NA	NA	80	20
Participant #7		NA	NA	80	20
Participant #8		NA	NA	70	30
Participant #9		NA	NA	80	20
Participant #10		NA	NA	50	50
Participant #11		NA	NA	70	30
Participant #12		NA	NA	40	60
Participant #13		NA	NA	70	30
Participant #14		NA	NA	30	70

		Theirs Nov. 2014	Someone else Nov. 2014	Theirs April 2015	Someone else April 2015
Carer #1	Was the action plan of the person for whom you care developed by themselves or with other/s?	95	5	NA	NA
Carer #2		10	90	NA	NA
Carer #3		NA	NA	70	30
Carer #4		NA	NA	80	
		Recovery model Nov. 2014	Non-R. Model Nov. 2014	April 2015	April 2015
Service Provider Rep's	Of all the service providers you are aware of, how many operate in a Recovery Approach/person centred way?	10	90	NA	NA
		A result of PIR Nov. 2014	Not result of PIR Nov. 2014	April 2015	April 2015
	Of those service providers which/who do operate in a recovery/person centred way, how many do so as a result of PIR?	30	70	NA	NA
		Will Nov. 2014	Will not Nov. 2014	Will April. 2015	Will not April 2015
Support FACILITATORS	Of all the PIR registered participants that you are aware of (not just those whom you support) how many will achieve the goals of their action plans?	80	20	70	30
		Service providers Nov. 2014	Participant Nov. 2014	Service providers April 2015	Participant April 2015
	Of those who will not, why – because of the participant or because of service providers ?	70	30	70	30

		Service availability Nov. 2014	Service quality Nov. 2014	Service availability April 2015	Service quality April 2015
	Of the service providers being responsible for the failure to achieve the action plan goals, is it to do with lack of access to services or service quality?	30	70	50	50
	In your own org. what is the support for the 'recovery process'?	NA	NA	√ 70	X 30
		Will achieve Nov. 2014	Will not achieve Nov. 2014	April 2015	April 2015
S.F's. Line Managers	Of all the PIR registered participants (not just those registered with your organisation) how many will achieve the goals of their action plans?	80	20	NA	NA
		Service Providers Nov. 2014	Self Nov. 2014	April 2015	April 2015
	Of those who will not, why – participant or service providers	70	30	NA	NA
		Availability/access Nov. 2014	quality Nov. 2014	April 2015	April 2015
	Of the service providers, is it lack of access or related to service quality?	30	70	NA	NA

		Will achieve Nov. 2014	Not achieve Nov. 2014	Will achieve April 2015	Not achieve April 2015
Consortium members	Of all those persons with persistent and severe mental health illness in your catchment, how many are impacted by what happens at this interface?	60	40	60	40
		Positively Nov. 2014	Negatively Nov. 2014	Positively April 2015	Negatively April 2015
	Of those who are impacted, how many are impacted positively or negatively?	40	60	30	70 (Indigenous results elevates this figure)
		availability/access. Nov. 2014	quality Nov. 2014	availability/ access. April 2015	quality April 2015
	Is the quality of service or the service availability the bigger issue?	60	40	40	60
		Recovery Model Nov. 2014	Non-recovery Nov. 2014	Recovery Model April 2015	Non-recovery April 2015
	Of the service providers involved, how many operate in a recovery approach way?	30	70	50	50
		Result of PIR Nov. 2014	Not a result of PIR Nov. 2014	Result of PIR April 2015	Not a result of PIR April 2015
	Of those service providers which do, how many do so as a result of Hume PIR?	50	50	70	30

Appendix 2 Statistics

November 2014			April 2015		
Participants	Pending	Exited	Participants	Pending	Exited
40	6	3	86	-	6
Support Facilitators (SF)	SF Host Organisations			Support Facilitators (SF)	SF Host Organisations
8	5			10	6